STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365578	A. Building B. Wing	01/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Majestic Care of New Lexington	920 South Main Street New Lexington, OH 43764

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interview, the facility failed to provide ordered treatment of a thoracic abscess, daily weights and monitoring intake and outputs for a resident on fluid restrictions. This affected two residents (#39, #66) of eight resident records reviewed. The census was 63. Findings include:1. Record review revealed Resident #66 was admitted to the facility on [DATE] with diagnoses including methicillin susceptible staphylococcus aureus (MSSA) infection, endocarditis, and altered mental status. Resident #66 discharged from the facility on 12/26/25. Review of an email sent to the facility on [DATE] revealed Resident #66 would need a wound vac and orders were attached. Review of an order dated 12/04/25 revealed Resident #66's wound needed a wound vac for a wound to left chest at pressure setting 125 (standard) with no wound vac cover, the wound vac dressing would need changed three times a week and as needed, cover with white foam and wound cleanser would be normal saline. The suction was to be continuous. Review of a hospital Discharge summary dated [DATE] revealed Resident #66 would continue with cefazolin with end date of 01/18/26 and needed weekly labs while on antibiotics. Resident #66 was seen by the physician for discharge and the wound vac was in place. There was no order for the wound vac to be discontinued. Review of an order dated 12/12/25 revealed on 12/13/25, Resident #66 would start receiving cefazolin (antibiotic) sodium injection solution reconstituted 2 grams use 2000 milligrams (mg) intravenously every eight hours for infection for 40 days. The end date would be 01/22/26. Review of an order dated 12/13/25 revealed Resident #66 would receive the following wound treatment to his left chest: sodium hypochlorite external solution 0.125% apply to left chest surgical incision wound topically every day shift for infection of the wound, pack with Dakins moistened 4 by 4s, and cover with dry dressing or Tegaderm. Change daily and as needed. Review of a medication administration record for December 2025 revealed the administration of IV antibiotic cefazolin was marked as completed for 6:00 A.M. dose on 12/13/25, but medication was not available for 2:00 P.M. and 10:00 P.M. doses on 12/13/25 or for the 6:00 A.M. and 2:00 P.M. doses on 12/14/25. Review of a nursing note dated 12/14/25 at 1:08 P.M. revealed a call was made to the pharmacy due to receiving none of Resident #66's medications from them. Pharmacy reported Resident #66's medications left the pharmacy on 12/13/25 and were still enroute. There was no evidence of (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident/representative notification or of physician notification/new orders to hold medication or use a substitute medication from back up until Resident #66's medications arrived. Review of a care plan dated 12/15/25 revealed Resident #66 had a diagnosis of bacterial endocarditis, the goal was for symptoms of the infection to be resolved and interventions included but were not limited to administer medications as ordered, document abnormal findings and notify physician, and encourage activity as tolerated. Review of a treatment record for December 2025 revealed Resident #66 did not receive wound care on 12/15/25, 12/17/25, 12/24/25, or 12/26/25 which was the date of discharge. There were no corresponding nursing notes to document why treatment was not completed. Review of an MDS dated [DATE] revealed Resident #66's cognition was mildly impaired, he had no behaviors, and received intravenous (IV) medications. Interview on 01/06/25 at 1:53 P.M. with the Director of Nursing (DON) confirmed there was no evidence in the medical record for Resident #66's wound vac was ordered, was to be discontinued, or that he refused the wound vac. Additional interview on 01/06/25 at 3:52 P.M. with the DON confirmed Resident #66 did not receive his IV medications as ordered due to not arriving from pharmacy, the providers were not notified, and new orders were not received to either hold medications or use medications in stock in medication storage pod. Additionally, the DON confirmed Resident #66 did not receive wound care as ordered on 12/15/25, 12/17/25, 12/24/25, or 12/26/25. 2. Review of Resident #39's medical record revealed he was admitted to the facility on [DATE]. Diagnoses included urinary tract infection, cord compression, extradural and subdural abscess, chronic kidney disease, pressure ulcer unstageable and diabetes. Review of the admission minimum data set (MDS) assessment dated [DATE] revealed his cognition was intact. He required set up or clean up assistance for eating, oral hygiene, dependent for toileting, shower/bathing, dressing, personal hygiene and turning and repositioning. Resident #39 has an indwelling catheter and is frequently incontinent of bowel. a. Review of the medical record revealed on 12/04/25 a physicians order to obtain daily weight and notify the physician if there was a weight gain greater than three (3) pounds in a day or five (5) pounds in a week was obtained. Further review revealed no documented evidence of weights for December 2025 for 12/04/25, 12/05/25, 12/06/25, 12/07/25,12/08/25, 12/09/25, 12/10/25, 12/11/25, 12/12/25, 12/14/25, 12/17/25, 12/18/25, 12/19/25, 12/23/25, 12/25/25 and 12/30/25. This was verified during interview on 01/06/26 at 3:02 P.M. with the Director of Nursing. b. Review of the medical record revealed on 12/03/25 a physician's order for Meropenem intravenous solution one gram intravenously every eight hours for a thoracic epidural abscess until 01/13/26. Further review revealed no documented evidence it was administered on 12/04/25, 12/26/25 and 12/20/25. This was verified during interview on 01/06/26 at 3:02 P.M. with the Director of Nursing. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c. Review of the medical record revealed on 12/03/25 a physicians order to monitor intake and output every shift for fluid restriction and congestive heart failure. Further review revealed no documentation of the intake and output on day shift 12/04/25, 12/07/25, 12/10/25, 12/11/25, 12/12/25, 12/23/25, and 12/29/25 and for night shift 12/09/25, 12/11/25, 1215/25, 12/16/25, 12/17/25, 12/21/25, and 12/29/25. This was verified during interview on 01/06/26 at 11:49 A.M. with the Director of Nursing. This deficiency represents non-compliance investigated under Complaint Number 2702525.

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on closed record review, interview, and policy review, the facility failed to provide care and services to prevent pressure ulcers from developing or worsening. This affected two residents (#39 and #65) of six residents reviewed for skin breakdown. The facility census was 63.Actual Harm occurred on 09/08/25 when Resident #65, who was assessed to be high risk for skin breakdown developed two unstageable pressure ulcers (full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because the wound bed is obscured by slough or eschar) to her right and left heels. On 09/10/25 Resident #65 developed a Stage II (partial-thickness loss of skin with exposed dermis, presenting as a shallow open ulcer) pressure ulcer to her coccyx. The facility failed to identify the ulcers to the heels prior to them being unstageable and failed to ensure comprehensive, individualized and effective interventions were in place to prevent the development of the pressure ulcers. Findings include: 1.Review of Resident #65's closed medical record revealed Resident #65 was admitted to the facility on [DATE] with diagnoses including psychosis, traumatic brain injury, and schizophreniform.Review of an order dated 06/28/25 revealed Resident #65 had a full code status in place.Review of a care plan dated 06/29/25 revealed Resident #65 was at risk for skin breakdown and had dry callous areas to feet. The goal was for Resident #65 to be free of skin breakdown. Interventions included check for incontinence and provide incontinence care as needed and notify nurse of any redness or irritation (06/29/25), preventative skin care as ordered/indicated (06/29/25), and skin inspection weekly and as needed- document and notify physician of abnormal findings (06/29/25).Review of a skin risk evaluation dated 07/01/25 revealed Resident #65 was at high risk for skin breakdown related to age greater than [AGE] years old, dementia, and encephalopathy.Review of a nursing note dated 07/01/25 at 10:12 A.M. by Licensed Practical Nurse (LPN) #203 revealed Resident #65's age was identified as a high risk for pressure ulcer development and should immediately proceed to integrated care plan interventions to preserve the resident's skin integrity. Resident #65 was a new admission with progressive cognitive disease and care team would provide an escalated level of care to ensure resident's safety and skin preservation. Review of Resident #65's care plan and physician orders revealed no evidence the facility provided an integrated care plan with interventions to preserve skin integrity following the evaluation and note dated 07/01/25. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #65's cognition was intact, she was able to walk and complete transfers independently, was continent, did not have a condition or chronic disease that may result in a life expectancy of less than six months, she did not have skin issues, and had a pressure reducing device for chair and bed.Review of an order dated 07/05/25 revealed staff were to apply Remedy Prevent Silicone Cream (creates a breathable, water-resistant film, protecting fragile skin from moisture, dryness, irritation, redness, and cracking) to Resident #65's bilateral feet for callous and dry areas every day and night shift.Review of a nursing note dated 08/20/25 at 4:14 P.M. revealed Resident #65's son approached the nurse and reported the resident was on the floor in her bathroom doorway. Upon entering the room, the resident was lying on her left side with feet in the bathroom and trunk in the room, the resident was unable to verbalize what happened, she did have her pants at hip level but not quite over buttocks. Resident #65 was incontinent of bowel. Resident #65 was known to have poor balance with a walker and was receiving therapy. Resident #65 reported she was trying to get away from the man. Range of motion and assessments were completed with no injuries identified. Resident #65's fall on 08/20/25 reflected a decline for the resident and thereby placed the resident at an increased risk of skin integrity issues including the development of pressure ulcers. This decline was not recognized by (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	the facility and the facility failed to provide an integrated/escalated plan of care to ensure the resident's safety and skin preservation.Review of a weight note dated 08/25/25 revealed Resident #65 weighed 125.8 pounds. Prior weights included: On 08/18/25 the resident weighed 122 pounds, on 08/11/25 the resident weighed 122.4 pounds, on 08/04/25 the resident weighed 121 pounds, and on 07/28/25 the resident weighed 128 pounds.The decrease/fluctuation in the resident's weight reflected a decline for the resident and thereby placed the resident at an increased risk of skin integrity issues including the development of pressure ulcers. These weight changes were not recognized by the facility and the facility failed to provide an integrated/escalated level of care to ensure the resident's safety and skin preservation.Review of a provider note dated 08/26/25 by Certified Nurse Practitioner (CNP) #305 revealed staff were concerned of Resident #65's increased confusion. The note revealed the resident did have an MRI on 06/13/25 with no acute abnormalities. Resident #65 had muscle weakness and debility. Resident #65 was feeling tired, continued with a moist, non-productive cough, and all labs, records, medication, and nursing notes were reviewed. The note did not include information related to skin integrity and/or skin prevention interventions. Review of an order dated 08/28/25 revealed Resident #65 was placed on contact isolation precautions for presumptive shingles every shift. Review of a skin evaluation assessment dated [DATE] revealed Resident #65 did not have any new skin issues. (Please note that the surveyor view of this assessment did not include the name of the staff person completing the assessment.)Record review revealed on 09/04/25 Resident #65 weighed 117 pounds (this represented an 8.8 pound weight loss over ten days (from 08/25/25)). Review of a nursing note dated 09/04/25 at 2:24 P.M. by Registered Nurse (RN) #324 revealed Resident #65 was set for a significant change MDS due to a decline in ADLs noted; however, since the resident had a urinary tract infection, urinary retention, and shingles the note revealed RN #324 would re-assess need for significant change assessment once acute illnesses had resolved.Review of Resident #65's medical record including turn and reposition documentation revealed no documented evidence Resident #65 was turned or repositioned on 09/04/25. Additionally, there was no documentation for dayshift for turning and repositioning Resident #65 on 09/06/25. Review of a skin evaluation assessment dated [DATE] revealed Resident #65 did not have any new skin areas. Review of a skin evaluation assessment dated [DATE] revealed Resident #65 had new skin areas. The assessment noted to the right heel an area measuring 8.5 centimeters in length by 8.5 cm width with deep purple center that gradually lightens to purple/deep red and extends to yellowish red; to the left heel a 5.5 cm by 7.5 cm area with deep purple center that gradually lightens to purple/deep red and extends to yellowish red. The assessment documentation noted a treatment was applied. However, this skin assessment did not identify a stage of the pressure wounds.Review of an order dated 09/08/25 revealed Resident #65 was to be encouraged to be up in chair during wake hours for wound healing every shift.Review of an order dated 09/08/25 (following the identification of the pressure ulcers) revealed Resident #65 should offload bilateral heels while in bed every shift.Review of an order dated 09/08/25 revealed skin prep left heel, place Optifoam heel non-adhesive foam and wrap with kerlix twice daily and as needed.Review of an order dated 09/08/25 revealed skin prep right heel, place Optifoam heel non-adhesive foam and wrap with kerlix twice daily and as needed.Review of a nursing note dated 09/08/25 at 11:32 A.M. by LPN #203 revealed she was notified Resident #65 had discoloration to her bilateral heels. Right heel area was measuring at 8.5 by 8.5 by unknown depth closed without drainage, soft to touch, non-blanchable without drainage, non-blanchable with deep purple center that gradually extends to lighter purple/deep red surrounded by yellowish-red tissue. Left heel area measuring 5.5 by 5.7 by unknown depth closed without drainage, soft to touch, non-blanchable with deep purple center that gradually extends to light (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	purple/deep red surrounded by yellowish red tissue. Resident (#65) did voice areas to be tender to touch but no complaints of pain when not touched. Resident was unable to rate the pain but grimaced when heels were touched. Resident (#65) with previous decline due to UTI, urinary retention and suspected shingles, provider was notified. New orders were received at this time to discontinue compression stockings, start liquid protein 30 mL, offload heels while in bed, encourage to be up in chair while awake, skin prep with Optifoam twice daily and as needed, and a referral to dietician. Family was aware of new orders.Record review revealed on 09/09/25 Resident #65 weighed 116 pounds (a additional one pound weight loss in five days). Review of a provider note dated 09/10/25 at 1:40 P.M. authored by Physician #300 revealed Resident #65 now had a developing pressure injury to her sacrum and an unstageable (pressure ulcer) to each heel.Review of a nursing note dated 09/10/25 at 5:40 P.M. revealed Resident #65 had new areas to coccyx (pressure injury) and right inner thigh (discoloration), Depends (urinary incontinence brief) elastic in leg pinched resident causing discoloration. Treatment orders were put in place, air mattress intervention for pressure injury. Staff were educated on proper alignment of Depends to prevent pinching of skin. Provider and family notified.Review of a nursing note dated 09/10/25 at 6:29 P.M. by LPN #203 revealed Resident #65's pressure injury to sacrum measured 3.5 (cm) by 3.5 (cm) by 0.1 (cm) at a Stage 2 (II) with light serous drainage noted, discomfort to site with cleansing no signs/symptoms of infection noted. Provider and family were aware and orders were in place at this time to promote wound healing. Review of an E-interact change in condition form dated 09/10/25 revealed Resident #65 had a steady decline in health status. Family was considering hospice but requested the resident be sent to the emergency room for evaluation to see if there were any treatable conditions prior to making (hospice) decision. The form included Resident #65 had no changes observed but needed more assistance with activities of daily living (ADLs), general weakness, and decreased mobility. Resident #65 was transferred to the emergency room per family request.Review of a nursing note dated 09/10/25 at 11:27 P.M. revealed Resident #65 was admitted to the hospital for failure to thrive. The resident returned to the facility on [DATE]. The resident returned to the facility on [DATE] and passed away on 10/28/25.Interview on 01/06/26 at 3:52 P.M. with the Director of Nursing (DON) confirmed Resident #65 did not have a comprehensive (integrated/escalated) plan of care in place with preventative interventions for skin breakdown prior to the skin breakdown occurring. In addition, the DON confirmed prior to the skin breakdown the resident experienced an overall decline that included more limited mobility, decline in cognition, a UTI, potential shingles, urinary retention, and edema. The DON confirmed Resident #65 developed two unstageable pressure areas on 09/08/25 to her heels and one Stage II area on 09/10/25 to her sacrum. The DON also confirmed Resident #65 had been losing weight during that time. The DON confirmed overall decline could lead to wound (pressure ulcer) development. Interview on 01/07/26 at 10:03 A.M. with Regional Nurse #307 revealed the areas on Resident #65's heels did not ever open up meaning they were deep tissue injuries and not unstageable areas because they were closed areas. Regional Nurse #307 stated Resident #65 had severe cognitive concerns so wounds would have happened regardless. However, no additional information was provided to support the wounds were avoidable due to the resident's cognitive loss. Identification of the cognitive loss, decline in overall status and increased dependence on staff should have prompted the facility (in July 2025) to implement comprehensive integrated/escalated interventions to decrease the risk of pressure ulcer development which had not been done. Interview on 01/07/26 at 10:20 A.M. with Physician #300 revealed he thought Resident #65's skin breakdown was largely due to nutrition issues, sepsis and immobility. During the interview, Physician #300 revealed he felt the wound on the resident's sacrum could be a Kennedy ulcer. However, there was no information (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	in the resident's medical record to support this. Physician #300 confirmed he did not document suspicions of a Kennedy ulcer and confirmed he did not look at the resident's skin every time he saw her. Review of National Pressure Ulcer Advisory Panel Pressure Injury Stages (dated 2018) revealed an unstageable pressure injury was a full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a stage 3 or 4 pressure injury would be revealed. Stable eschar (in example dry, adherent, intact without erythema or fluctuance) on an ischemic limb or the heel(s) should not be removed.Review of a policy titled Wound Management Policy, dated 05/30/24, revealed it was the policy of the facility to ensure residents who do not have skin integrity impairments do not develop a new condition affecting the skin and that those residents with impaired skin integrity are recognized by our care team, treated timely, and interventions to heal were not exhausted until the skin was healed. The three constructs of the wound program were prevention of skin conditions, optimization of healing solutions, and prevention of impaired skin sequela. The skin was the largest organ of the body and impairment could result in additional medical complexities for the resident known as sequela. The facility would have a system in place to prevent the condition of skin impairment from evolving and eroding the health of the resident affected. The RCT would act to prevent and/or treat the following complexities associated with skin impairments: infection, pain, mental anguish, and failure to thrive. 2. Review of Resident #39's medical record revealed he was admitted to the facility on [DATE] with diagnoses including urinary tract infection, cord compression, extradural and subdural abscess, chronic kidney disease, pressure ulcer unstageable and diabetes. Review of Resident #39's admission MDS assessment dated [DATE] revealed his cognition was intact. He required set up or clean up assistance for eating, oral hygiene, dependent for toileting, shower/bathing, dressing, personal hygiene and turning and repositioning. Resident #39 had an indwelling catheter and was frequently incontinent of bowel. Review of the physician's orders revealed an order dated 12/03/25 for cleaning of a sacrococcygeal pressure ulcer. The order identified to cleanse with soap and water; pat dry; apply Triad hydrophilic dressing in a dime thick layer over wound and wound edges; leave open to air. When cleansing, remove top layer of ointment only then reapply. Do not scrub ointment off skin every day and night shift for wound care instructions. Review of physician orders revealed an order dated 12/15/25 that changed the cleaning of the sacrococcygeal pressure ulcer. The new order identified to cleanse with soap and water; pat dry; apply alginate dressing to wound bed and picture frame application of zinc barrier to peri-wound, cover with ABD every day shift and as needed. Review of the treatment record for December 2025 revealed no documented evidence Resident #39's sacrococcygeal pressure ulcer treatment was completed on dayshift on 12/07/25, 12/10/25, 12/11/25, 12/12/25 and 12/15/25, 12/16/25, 12/23/25 and 12/29/25 and on night shift on 12/10/25 and 12/24/25.On 01/06/26 at 11:49 A.M. interview with the Director of Nursing verified there was no evidence treatments were completed as ordered for Resident #39's sacrococcygeal wound.This deficiency represents non-compliance investigated under Complaint Number 2702525.

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interview, the facility failed to obtain laboratory services as ordered. This affected one resident (#39) of eight resident records reviewed. The census was 63. Findings included:Review of Resident #39's medical record revealed he was admitted to the facility on [DATE]. Diagnoses included urinary tract infection, cord compression, extradural and subdural abscess, chronic kidney disease, pressure ulcer unstageable and diabetes.Review of the admission minimum data set (MDS) dated [DATE] revealed his cognition was intact. He required set up or clean up assistance for eating, oral hygiene, dependent for toileting, shower/bathing, dressing, personal hygiene and turning and repositioning. Resident #39 had an indwelling catheter and was frequently incontinent of bowel. Further review revealed a physician's order on 12/04/25 for a complete blood count (CBC), e-diff (electronic differential), platelets, basic metabolic profile (BMP) without glucose, hepatic function panel weekly in the morning every Thursday for Meropenem (antibiotic) therapy and send the results to the physician. Review of the medical record revealed there was no evidence of laboratory results on 12/11/25 and 12/25/25. On 01/06/26 at 8:49 A.M. interview with the Director of Nursing verified there was no evidence the labs were completed as ordered.This deficiency represents an incidental finding of non-compliance investigated under Complaint Number 2702525.