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	03/16/2026

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, staff interview and review of facility policy, the facility failed to dispose of expired medications. One of two medications rooms and two of four medications carts were reviewed. This had the potential to affect all 70 residents residing at the facility. Findings include:Review of the most recent consulting pharmacist report dated 03/02/26 revealed audits were completed for medication rooms, medication and treatment carts and cold storage (refrigerators) and expired medications found in medication carts and treatment carts and items not stored per manufacturer guidelines.Observation and interview on 03/11/26 at 8:30 A.M. with Licensed Practical Nurse (LPN) #155 of the [NAME] medication room revealed one opened bottle of sodium chloride (mineral) one gram (gm) with an expiration date of 09/2025 and an open date of 02/2026, one unopened bottle of zinc (mineral) 50 milligrams (mg) with an expiration date of 01/2026, one opened bottle of aspirin 325 milligrams (mg) with an expiration date of 12/2025, one unopened bottle of vitamin B12 500 micrograms (mcg) with an expiration date of 12/2025, one opened bottle of vitamin B6 50 mg with an expiration date of 01/2026 and an open date of 06/18/25, one opened bottle of vitamin B1 100 mg with an expiration date of 11/2025 and an open date of 07/14/24, one HypoPen glucagon injection one mg per 0.2 milliliter (ml) with an expiration date of 08/2025, and three intravenous (IV) medicine balls of Meropenum (antibiotic) one gm/100 ml with expiration dates of 02/09/26. LPN #155 verified the expired medications.Observation and interview on 03/11/26 at 8:45 A.M. with LPN #120 of medication cart for Central Avenue revealed one opened bottle of acidophilus (probiotic) with an expiration date of 10/2025 and an open date of 02/03/26 and one opened bottle of aspirin 325 mg with an expiration date of 12/2025 and an open date of 03/23/25. LPN #120 verified the expired medications.Interview on 03/11/26 at 9:40 A.M. with the Director of Nursing (DON) revealed the expectation was for the floor nurses to check the medication rooms routinely for expired medications. Review of the facility policy titled Medication Storage, dated 01/02/2024, revealed the pharmacy and all medication rooms are routinely inspected by the consultant pharmacist for discontinued, outdated, defective, or deteriorated medications with worn, illegible, or missing labels.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations and interview, the facility failed to ensure expired food items were not kept in the kitchen. The had the potential residents who utilized cream for their beverages. The facility census was 70.Findings include:Observation on 03/09/26 at 8:19 A.M. revealed the dry storage area of the kitchen contained four large containers of expired coffee creamer. Two expired on 12/24/19 and two expired in 03/2020.Interview on 03/09/26 at 8:20 A.M. with Dietary Manager #107 confirmed there were expired coffee creamers in the dry storage area. She stated they were not used by the kitchen, but were used by activity staff.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, policy review, and staff interview, the facility failed to ensure residents were educated on and had the opportunity to receive the updated annual COVID-19 vaccine, if they desired to do so. This affected four (Residents #2, #5, #7, and #68) of five residents reviewed for immunizations.Findings include:1. Review of Resident #2's medical record revealed the resident was admitted to the facility on [DATE]. Her diagnoses included chronic obstructive pulmonary disease (COPD), adult onset diabetes mellitus, heart failure, chronic ischemic heart disease, and personal history of COVID-19. Review of Resident #2's informed consents for immunizations revealed it was absent for any evidence of the resident having been educated on the COVID-19 vaccine for the 2025-2026 respiratory illness season (October thru March) or that the updated COVID-19 vaccine was even offered to the resident. Her immunization record revealed the last time a COVID-19 vaccine had been given to the resident was on 10/09/24. On 03/16/26 at 10:50 A.M., an interview with Registered Nurse (RN) #110 confirmed there was no documented evidence of Resident #2 had been educated on the COVID-19 vaccine or given the opportunity to receive that vaccine during the 2025- 2026 respiratory illness season. The facility's prior Infection Preventionist no longer worked in the facility and they did not have access to any consents for immunizations other than what had already been provided. 2. Review of Resident #5's medical record revealed the resident was originally admitted to the facility on [DATE]. His diagnoses included chronic obstructive pulmonary disease (COPD), adult inset diabetes mellitus, dementia, and a personal history of COVID-19. Review of Resident #5's informed consents revealed there was no evidence of the resident having been provided education in the COVID-19 vaccine or that he was afforded the opportunity to receive the COVID-19 vaccine for the 2025- 2026 respiratory illness season, if he chose to receive it. The last documented COVID-19 vaccine given to the resident was on 10/09/24. On 03/16/26 at 10:50 A.M., an interview with Registered Nurse (RN) #110 confirmed there was no documented evidence of Resident #5 had been educated on the COVID-19 vaccine or given the opportunity to receive that vaccine during the 2025-2026 respiratory illness season. The facility's prior Infection Preventionist no longer worked in the facility and they did not have access to any consents for immunizations other than what had already been provided. 3. Review of Resident #7's medical record revealed the resident was admitted to the facility on [DATE]. Her diagnoses included dementia, personal history of traumatic brain injury, adult onset diabetes mellitus, and morbid obesity. Review of Resident #7's informed consents revealed there was no documented evidence of the resident having received education on the COVID-19 vaccine or that she had been offered to receive the updated COVID-19 vaccine for the 2025- 2026 respiratory illness season, if she chose to do so. On 03/16/26 at 10:50 A.M., an interview with Registered Nurse (RN) #110 confirmed there was no documented evidence of Resident #7 had been educated on the COVID-19 vaccine or given the opportunity to receive that vaccine during the 2025-2026 respiratory illness season. The facility's prior Infection Preventionist no longer worked in the facility and they did not have access to any consents for immunizations other than what had already been provided. 4. Review of Resident #68's medical record revealed she was admitted to the facility on [DATE]. Her diagnoses included Parkinson's disease, personal history of a traumatic brain injury, and personal history of COVID-19. Review of Resident #68's informed consents revealed there was no evidence of the resident having been given education on the COVID-19 vaccine or that she had been offered the updated annual COVID-19 vaccine, if she wanted it. On 03/16/26 at 10:50 A.M., an interview with Registered Nurse (RN) #110 confirmed there was no documented evidence of Resident #68 had been educated on the COVID-19 vaccine or given the opportunity to receive that vaccine during the 2025- 2026 respiratory illness season. The facility's prior Infection Preventionist no longer (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	worked in the facility and they did not have access to any consents for immunizations other than what had already been provided. Review of the facility's policy on Infection Prevention and Control Program revised 07/17/25 revealed it was the purpose of the facility to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines. Under the section for COVID-19 immunizations, the policy indicated residents would be offered the COVID-19 vaccine when vaccine supplies were available to the facility. Education about the vaccine, risks, benefits, and potential side effects would be given to residents or their representatives prior to offering the vaccine. Documentation would reflect the education provided and details regarding whether or not the resident received the vaccine.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview, and policy review, the facility failed to ensure a resident receiving psychotropic medications signed consent for the use of those medications, after the risks and benefits associated to their use were explained to the resident. This affected one (Resident #5) of five residents reviewed for unnecessary medications.Findings include:Review of Resident #5's medical record revealed he was admitted to the facility on [DATE]. His diagnoses included Schizo-affective disorder, dementia, Bipolar disorder, major depressive disorder, and anxiety.Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #5 was able to make himself understood and was able to understand others and cognitively intact. Resident #5 had verbal behaviors directed at others and other behaviors not directed at others. Resident #5 received anti-psychotic medications, anti-anxiety medications, and anti-depressants during the review period. Review of Resident #5's physician's orders revealed on 05/13/25, an order to administer Duloxetine HCL (Cymbalta) 60 milligrams (mg) by mouth (po) twice a day for major depressive disorder. On 05/06/25, an order for Remeron 7.5 mg po at bedtime for the targeted behaviors of angry outbursts. On 02/24/26, an order to receive Clonazepam 0.25 mg po three times a day for anxiety, and had previous order for that medication at a different dose prior to the most recent order. Review of the Informed Consents for Medications revealed Resident #5 had been provided education on the risks and benefits for the use of his antipsychotic medications to include Invega, Olanzapine (Zyprexa), and Aripiprazole (Abilify) on 10/29/24 and signed consent for the use of those psychotropic medications. There was an Informed Consent for Medication form filled out for the resident's use of Duloxetine and Remeron, but it was not signed by Resident #5 to provide documented evidence that the risks and benefits of those medications were explained to the resident and he gave consent for their use. A Psychoactive Medication Consent and Management Agreement was provided for the Clonazepam upon request that had an effective date of 03/11/26 at 11:33 A.M. (date the consent form was requested by the facility). That form indicated the date the consent was given for the use of that medication was 02/24/26 (date of the latest order). It was signed by Resident #5 by him adding his initials to the form. The progress note dated 02/24/26 revealed the nurse practitioner was in to visit and decreased Resident #5's Clonazepam to 0.25 mg three times a day. The resident and his family were made aware of the new order. On 03/11/26 at 9:15 A.M., an interview with Registered Nurse (RN) #110 confirmed Resident #5's Informed Consent for Medications for the resident's use of Duloxetine and Remeron was not signed by Resident #5. RN #110 acknowledged without the resident signing receipt, there was no documented evidence to support he had been informed of the risks and benefits associated with those medications and gave an informed consent for their use. On 03/11/26 at 1:25 P.M., an interview with the Director of Nursing (DON) revealed she was not able to find a signed consent for Resident #5's use of Remeron and Duloxetine providing documented evidence he had been educated on the risks and benefits of those medications and provided signed consent to receive those medications. The DON further indicated the Psychoactive Medication Consent and Management Agreement that the facility provided on the Clonazepam was dated for 03/11/26 and was not signed by Resident #5 until that same morning. The DON indicated the progress note by the nurse that documented the nurse practitioner's visit and changed to the dose of the Clonazepam was all they had that showed the resident and family was aware of the order for the Clonazepam. The DON acknowledged they did not provide evidence of the resident having been educated on the risks and benefits of that psychotropic medications use, prior to 03/11/26. Review of the facility's policy on Psychotropic Medication Use revised 07/02/25 revealed an resident receiving a psychotropic medication or a medication used for a mood or behavior indication was required to have an informed consent prior to initiation or with an increase in dosage. All medication-related activities must be documented or recorded in the resident's medical record, including but not limited to informed consents, reviews, gradual dose reductions (GDRs), and changes.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, resident and staff interviews, and policy review, the facility failed to ensure the rooms were kept in good repair. This affected one (#8) of one resident reviewed for environmental concerns. The facility census was 70.Findings include: Record review revealed Resident #8 admitted to the facility on [DATE] with diagnoses including hemiplegia and hemiparesis following cerebrovascular accident and anxiety disorder.Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #8's cognition was intact.Interview and observation on 03/10/26 at 9:00 A.M. with Resident #8 revealed his room had large white patches on the wall next to his window, black scuffs on the bottom of the walls in the entry way of the room, a missing wheel to the left upper side of his bed, the lower bathroom door had a plastic cover to it which had cracked and was loose with sharp edges, in the bathroom the paper towel holder had been moved and paint had peeled away and not repaired, two holes in the bottom of the bathroom wall under the toilet paper holder and behind the toilet, and the toilet paper holder was moved to a different part of the wall leaving a patch of paint which did not match the rest of the room. Resident #8 stated he did not like the condition of his room and wished they would fix it up but it had been this way for a while. Resident #8 stated he would not let his home be in disrepair. Interview on 03/12/26 at 11:30 A.M. with Certified Nursing Assistant (CNA) #138 confirmed multiple white patches of plaster on the wall near the window, black scuffs on the walls in the entry way, the bathroom door cover was cracked and broken, two holes were in the bottom of the bathroom walls, and confirmed the toilet paper and paper towel holders had been moved but the areas were not repaired.Review of the policy titled Resident Rights dated 01/02/24 revealed residents have the right to a safe, clean, comfortable and homelike environment.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, policy review, and interview, the facility failed to ensure a resident was comprehensively assessed and provided medical necessity for a resident to reside in the memory care unit. This affected one (#24) of one resident reviewed for restraints. The facility census was 70.Findings include:Record review revealed Resident #24 admitted to the facility on [DATE] with diagnoses including schizophrenia and dementia.Review of an elopement risk assessment dated [DATE] revealed Resident #24 was not at risk of elopement.Review of a late entry interdisciplinary team (IDT) note dated 07/28/25 at 8:39 A.M. by Assistant Director of Nursing (ADON) #500 revealed the IDT reviewed a situation with Resident #24 and due to increased falls and attempting to drink hand sanitizer throughout the facility, the resident and family were agreeable to move to the locked memory care unit to increase activity time and monitor closely.Review of an order dated 09/06/25 revealed Resident #24 resided on the secure unit to meet his physical, mental, spiritual, emotional well-being and safety needs.There was no additional documentation to support Resident #24 residing in the memory care unit. Interview on 03/16/26 at 3:45 P.M. with the Administrator verified there was no assessment and no other medical necessity for Resident #24 prior to admitting the resident to the locked unit. The Administrator stated it was based of needs of the resident.Review of a policy titled Restraint Free Environment dated 01/02/24 revealed physical restraints are any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews and medical record review, the facility failed to monitor potential side effects of psychotropic medications for Resident #64. This affected one (#64) of five residents reviewed for unnecessary medications. The facility census was 70.Findings include:Review of Resident #64's medical record revealed the resident was admitted on [DATE] and diagnoses included depression and anxiety disorder.Review of the current physician's order list for March 2026 revealed the following active orders: Duloxetine HCl Capsule Delayed Release Particles 20 milligrams (mg) one one capsule by mouth two times a day for depression with a start date of 11/20/25 and Lorazepam oral tablet one mg, give one tablet by mouth two times a day for restlessness; anxiety and give one tablet by mouth every one hour as needed for restlessness, anxiety with a start date of 12/20/25. There were no physician orders to monitor for side effects of the antidepressant or antianxiety medications.Review of Resident #64's care plan initiated on 10/03/25 revealed Resident #64 received psychotropic medication (or psychotropic like medication) and was at risk for adverse side effects.Review of Medication Administration Records dated December 2025, January 2026 and February 2026 revealed no documentation of the assessment for adverse side effects of psychotropic medications.Interview on 03/12/26 at 8:10 A.M. with Licensed Practical Nurse (LPN) #143 confirmed that when any resident is ordered a psychotropic medication, the nursing staff was expected to monitor for behaviors and medication side effects. LPN #143 stated an order to monitor for side effects of psychotropic medication should be present on the physician's order list and the nursing staff documents the assessment of side effects in the medication administration record. LPN #143 confirmed Resident #64 was ordered an antianxiety and antidepressant medication and staff were not monitoring side effects of psychotropic medications.Interview on 03/12/26 at 1:19 P.M. with the Director of Nursing (DON) confirmed the facility should monitor side effects of psychotropic medications for all residents with current psychotropic medication orders. The DON stated the facility monitors these side effects using the medication side effect monitoring tool, which is reflected in the medical chart as a monitoring order on the clinical physician's order list. The DON stated that ideally, the order to monitor side effects of psychotropic medications would be placed simultaneously with the order for psychotropic medication.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview, and policy review, the facility failed to ensure a resident, who was transferred out of the facility to the hospital, received a transfer notice and a bed hold notice, at or around the time of the transfer. This affected one (Resident #74) of three closed records reviewed for transfer/ discharges. Findings include:Review of Resident #74's closed medical record revealed the resident was admitted to the facility on [DATE]. Diagnoses included acute kidney failure, kidney transplant status, retention of urine, and anxiety disorder. The progress note dated 12/29/25 at 6:30 A.M. revealed Resident #74 had a change in condition and was sent to the emergency room for an evaluation. He was admitted to the hospital and did not return to the facility. There was no evidence of a transfer notice or a bed hold notice was provided too the resident and/ or his family at/ or around the time of his transfer in Resident #74's medical record. On 03/11/26 at 8:55 A.M., an interview with the Administrator verified the facility did not have a transfer notice or a bed hold notice for Resident #74's transfer to the hospital on [DATE]. The Administrator stated she checked with social services, and since the resident was covered under an advantage plan, he did not require those notices. The Administrator reported the resident would have been treated as a discharge from the facility on that date. On 03/12/26 at 10:42 A.M., an interview with Social Service Assistant (SSA) #175 revealed he had been the facility's social worker up until three weeks ago. SSA #175 was now the facility's business office manager. SSA #175 was the facility's social worker at the time of Resident #74's transfer to the hospital on [DATE]. SSA #175 confirmed he did not issue a transfer notice or a bed hold notice to Resident #74, when the resident was transferred to the hospital on [DATE]. SSA #175 indicated it was his understanding that he did not have to provided the transfer notice to residents discharged from the facility and, due to the resident's payer source, he was considered a discharge from the facility when he was transferred to the hospital. He did not think he had to provide a bed hold notice either to residents whose payor status was other than Medicaid. SSA #175 acknowledged transfer notices were to be given to residents who were transferred from the facility to the hospital. He further acknowledged all residents should have the option to hold a bed at the facility, regardless of payor status, as they had the option to pay privately to do so. Review of the facility's policies on Bed Hold Notices revised 07/29/25 revealed the purpose of the policy was to ensure residents and their representatives were informed of their rights and the facility's procedures regarding bed holds during temporary absences, including hospitalizations or therapeutic leaves. Bed hold was defined as a means of holding or reserving a resident's bed while the resident was absent from the facility for therapeutic leave of hospitalization. At the time of the transfer for hospitalizations or therapeutic leaves, the facility would provide to the resident and/ or their representative written notice which specified the duration of the bed hold policy and address information explaining the return of the resident to the next available bed. In the event of an emergency transfer of a resident, a written notice of the facility's bed hold policy would be provided within 24 hours, as stipulated in the State's plan. The written bed hold notice information would be given to the resident and/ or their representative and a signed and dated copy of the written bed hold notice information would be kept by the facility in the resident's medical record.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, policy review, and staff interview, the facility failed to ensure comprehensive resident-centered care plans were in place. This affected one (#12) of 23 residents reviewed for care plans.Findings include:Record review revealed Resident #12 admitted to the facility on [DATE] with diagnoses including dementia, anxiety disorder, paranoid personality disorder, and suicide ideations.Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #12's cognition was severely impaired, she had behaviors including delusions, and other behaviors one to three days in the review period.Review of the care plan dated 02/03/26 revealed there was no care plan related to Resident #12 having a history of suicidal ideations.Interview on 03/11/26 at 12:43 P.M. with Director of Nursing (DON) confirmed Resident #12 did not have a care plan in place to address her history of suicidal ideations.Review of the policy titled Comprehensive Care Plan dated 11/01/24 revealed the facility should develop and implement a comprehensive person-centered care plan for each resident consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. The comprehensive care plan should be developed within seven days after the completion of the comprehensive MDS. The care plan should reflect resident specific interventions that reflect the resident's needs and preferences and align with the resident's cultural identity, as indicated. The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and policy review, the facility failed to ensure protocol was followed after an incident of suicidal ideation. This affected one (#12) of one resident reviewed for suicidal ideation. The facility census was 70.Findings include:Record review revealed Resident #12 admitted to the facility on [DATE] with diagnoses including dementia, anxiety disorder, paranoid personality disorder, and suicide ideations.Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #12's cognition was severely impaired, she had behaviors including delusions, other behaviors one to three days in the look back period, and wandered one to three days in the look back period.Review of the nursing note dated 11/10/25 at 2:01 A.M. by Registered Nurse (RN) #113 revealed Resident #12 was suicidal and stated she would kill herself. Resident #12 had been looking for her jackets and there was no jacket. RN #113 told her the jackets were dirty and sent to laundry which was closed at night. Resident #12 screamed and kept stating she was going to kill herself. RN #113 stayed with resident to calm her down, hugged her, told her she was loved, and gave her some comfort food. Resident #12 was resting in bed with eyes closed and would continue to be monitored. There was no evidence a provider was notified of the incident, no new orders, and no evidence a room search was completed.Review of the behavioral health note dated 11/20/25 revealed staff reported Resident #12's behaviors have been at baseline, no reports of increased anxiety, insomnia, or troubles with appetite. Provider reviewed nursing notes in the clinical record and found Resident #12 had an episode where suicidal comments were made, staff were able to redirect resident and no further incidents. Review of an interdisciplinary team (IDT) note dated 11/24/25 at 2:34 P.M. by previous Director of Nursing (DON) revealed the IDT and behavioral health nurse practitioner discussed Resident #12's previous suicidal statements, resident had no plan or means and was upset about clothing items. Resident #12 was admitted with a diagnosis of suicidal ideations and no other behaviors were noted. Provider was updated.Review of the care plan dated 02/03/26 revealed there was no care plan related to Resident #12 having a history of suicidal ideations.Interview on 03/11/26 at 8:53 A.M. with Licensed Practical Nurse (LPN) #155 revealed if a resident stated they want to harm themselves, you should ensure a safe environment by checking their room, have an aide sit with them, and go tell the nursing management and go from there.Interview on 03/11/26 at 10:51 A.M. with Life Story Program Director (LSPD) #179 revealed if someone stated they wanted to harm themselves, she would tell the nurse so they could complete an assessment and in her role as the social worker for the unit she would provide empathy and support then document it in a progress note.Interview on 03/11/26 at 12:43 P.M. with the Director of Nursing (DON) confirmed there was no documented evidence of a care plan related to suicidal ideation, notification to the physician, and no social services follow up or support for Resident #12. The DON stated Resident #12 was seen by a provider but did acknowledge it was 10 days after the incident and staff did not report the incident to the provider, but they found out by reading nursing notes. The DON stated it was an isolated incident despite having a diagnosis of suicidal ideation upon admission to the facility.Interview on 03/12/26 at 2:15 P.M. with Social Services Assistant (SSA) #175 revealed if an incident of suicidal ideation was discovered, he would speak with nursing and make an immediate intervention to address the issue then reach out to behavioral health to assess the resident as soon as possible. SSA #175 stated he thought he was aware of the incident with Resident #12 the following morning and it was discussed but was unable to state his involvement in addressing the issue. SSA #175 stated anything he did would be documented in the computer.Review of an undated standard operating procedure titled Suicidal Thoughts and Ideation revealed the initial response should be to immediately report any suicidal thoughts or ideations to the DON and/or social services and the resident should be kept in a (continued on next page)

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	365578	A. Building B. Wing	03/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	staff member's line of sight throughout the assessment, notification, and coordination of services. Interview the resident for any thoughts, plans, behaviors, and intent to harm self. Utilize assessment tools such as brief interview for mental status (BIMs) and patient health questionnaire (PHQ) -9, assess the resident's risk factors including but not limited to history of prior suicide attempts of self-injurious behaviors, current or past psychiatric disorder and/or recent changes in psychiatric treatment such as medication, treatment, provider, or recent discharge from in-patient psychiatric setting; mood or behavioral symptoms; family history of suicide; triggering events; access to objects used to harm self; consider protective factors; objectively and thoroughly document and care plan the resident's mood and behavioral symptoms as well as all actions or interventions taken by care team members in the medical record including but not limited to the initial response, risk assessment, orders, one-to-one care, assessment of the resident's environment, referrals made, accommodations, notifications, and psychosocial follow-ups; immediately notify the provider; notify responsible party; implement any new orders; organize mental health referrals; if imminent risk is identified, coordinate a possible hospitalization; mood and behavioral symptoms will be monitored daily and documented in the medical record; psychosocial follow-up will be completed; and all staff will be trained annually on risk factors and warning signs of suicide as well as how to respond to a resident with suicidal ideation.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to ensure a resident receiving an anti-hypertensive medication had his blood pressure obtained and recorded at the time of the anti-hypertensive medications administration, when the physician's orders included parameters to notify the physician if the resident's systolic blood pressure (SBP) was greater than 100 millimeters of mercury (mmHg). This affected one (Resident #5) of five residents reviewed for unnecessary medications.Findings include: Review of Resident #5's medical record revealed he was admitted to the facility on [DATE]. His diagnoses included the diagnosis of hypertension (high blood pressure). Review of Resident #5's physician's orders revealed the resident had an order in place to receive Metoprolol Succinate (a beta blocker used in the treatment of hypertension) Extended Release (ER) 25 milligrams (mg) by mouth every night at bedtime for hypertension. The order included a parameter to call the physician, if the resident's SBP (top number of a blood pressure reading) was less than 100 mmHg. The order had been in place since 08/20/25. Review of Resident #5's medication administration record (MAR) for February and March 2026 revealed the resident was receiving his Metoprolol Succinate 25 mg by mouth every night at bedtime as ordered. The MAR included the parameter to call the physician if the resident's SBP was less than 100 mmHg. The MAR did not include a place for the nurse administering that medication to record the resident's blood pressure at the time of the administration. There was no documented evidence on the MAR for either month that the resident's blood pressure had been checked. Review of Resident #5's blood pressure readings recorded under the Weights and Vitals Summary in the electronic medical record (EMR) revealed the facility was only sporadically obtaining and recording the resident's blood pressure. There were no blood pressures recorded for the month of February 2026, and two blood pressures recorded for the month of March 2026. One of the blood pressure readings recorded for March 2026 (03/06/26 at 1:47 A.M.) was noted to have a SBP less than 100, when the nurse recorded a blood pressure of 90/48. It was unclear what the resident's blood pressure was when the Metoprolol Succinate was administered on 03/05/26 at bedtime, due to no blood pressure being obtained and recorded for that time of the administration. On 03/11/26 at 12:10 P.M., an interview with the Director of Nursing (DON) confirmed Resident #5's physician's order for the use of Metoprolol Succinate did include parameters to notify the physician, if the resident's SBP was less than 100 mmHg. The DON confirmed the MARs for February and March 2026 did not show evidence of Resident #5's blood pressure being monitored at the time the Metoprolol Succinate was being administered. The DON acknowledged, without documenting a blood pressure at the time of the medication's administration, the nurses would not be able to show evidence they were following the parameters included in the order on when to notify the physician of the resident having a SBP less than 100 mmHg.

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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 record review, interview, and policy review, the facility failed to complete lab work as physician ordered. This affected one (#68) of five residents reviewed for unnecessary medications. The facility census was 70.Findings include:Record review revealed Resident #68 admitted to the facility on [DATE] with diagnoses including Parkinson's disease and edema.The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #68's cognition was intact.Review of the physician orders revealed on 07/30/24, Resident #68 would have the following laboratory (lab) blood draws every three months (August, November, February, and May): complete blood count (CBC), basic metabolic panel, vitamin D, B12, lipid panel, liver panel, and prealbumin.The care plan dated 03/28/25 revealed Resident #68 was at risk for fluid imbalance due to diuretic use related to edema. Interventions included lab work as ordered. Review of the laboratory results revealed Resident #68 last had lab work completed on 08/28/25. There were no lab results for November 2025 and February 2026 as physician ordered.Interview on 03/12/26 at 9:49 A.M. with the Administrator verified Resident #68 did not have labs drawn as physician ordered in November 2025 or February 2026. Administrator stated a stat order had been placed for a lab draw at this time.Review of the policy titled Physician Orders dated 01/02/24 revealed the facility will maintain a schedule of diagnostic tests (laboratory and radiology) in accordance with the physician's orders. Documentation of diagnostic tests, results and date/time of physician notification will be maintained in the resident's clinical record.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview and policy review, the facility failed to ensure a resident received timely dental services. This affected one (#25) of one resident reviewed for dental care. The facility census was 70.Findings include:Review of the medical record for Resident #25 revealed an admission date of 11/30/23 with diagnoses including dementia with behavioral disturbance, depression, dysphagia, and anxiety disorder.Review of the dental consult dated 09/11/25 revealed Resident #25 had a referral to an oral surgeon to extract of all symptomatic teeth.The progress note dated 09/16/25 authored by Transportation Aide (TA) #176 revealed they a faxed referral to Dental Clinic #1. On 10/15/25 a progress note authored by TA #176 indicating a referral was faxed to referral to Oral Surgery and Dental Implants #2. On 10/22/25, a telephone call placed to Oral Surgery and Dental Implants #2 asking if they take Medicaid. On 11/07/25, an email was sent to Family Dental #3 by TA #176. The dental consult dated 01/13/26 revealed Resident #25 had a referral to an oral surgeon to extract of all symptomatic teeth. There was no further documentation attempting to get Resident #25 seen by an oral surgeon for dental extractions until 03/12/26.Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #25 had severe cognitive impairment, no obvious or likely cavity or broken natural teeth, no facial pain and no difficulty chewing.The progress note dated 03/08/26 authored by Registered Nurse (RN) #165 revealed Resident #25 was having tooth pain and assessed to have a right upper tooth missing and cold sensitivity.Interview on 03/12/26 at 11:33 A.M. with TA #176 verified no appointment was made for oral surgeon consult for extractions for Resident #25. TA #176 stated she attempted to call others but did not document and verified she did not contact insurance to find a provider.Review of the facility policy titled Dental Services dated 12/16/25 revealed to ensure residents/patients receive timely, appropriate, and safe dental care to maintain oral health, prevent complications and support overall well-being. Care team members will assist the resident/patient, if necessary or requested, with making dental appointments and arranging transportation to and from the dental services location.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to ensure the resident's medical record had accurate documentation for care related to a resident's Jackson Pratt (JP) drain. This affected one (Resident #60) of 23 residents reviewed for medical record accuracy.Findings include:Review of Resident #60's closed medical record revealed the resident was admitted to the facility on [DATE]. Her diagnoses included a malignant neoplasm of her rectum and status post colostomy placement. She remained in the facility until 03/04/26, when she was discharged home. Review of Resident #60's initial skin evaluation completed on 01/28/26 revealed one JP drain (a closed-suction medical device used after surgery to remove excess fluid from the body, preventing infection and promoting healing; it consisted of a silicone tube connected to a bulb that, when squeezed, created a gentle vacuum to pull fluid into a collection chamber) was present to her lower abdominal area. The other two JP drains were indicated to be in the right lower extremity. She also had three small post-surgical incisions to her abdomen, with one to the umbilical area, one above her umbilical area, and a third one to the left lower quadrant of her abdomen. Review of Resident #60's physician's orders revealed the resident had orders in place to drain her abdominal JP drain and record the output every shift (day and night shift). Her orders also included the need to drain JP drain #2 (site not specified) and JP drain #3 (site not specified) and to record the outputs from those drains every shift, as well. The orders regarding the JP drains had been in place since 01/28/26. Review of Resident #60's treatment administration records (TAR) for February 2026 revealed there were two separate times when the nurses failed to document the amount of drainage that was emptied from the resident's JP drains to the abdomen and for JP drain #3 that month. There were no amount of drainage that had been emptied and recorded from those to drain sites on 02/11/26 night shift or 02/26/26 day shift. JP drain #2 did not have an amount of drainage that was emptied and recorded for night shift on 02/11/26. Review of Resident #60's TAR for March 2026 revealed the nurse failed to record the amount of drainage that was emptied from the JP drain to the resident's abdomen and JP drain #3 on 03/02/26 for the night shift. The resident was discharged on 03/04/26. Review of Resident #60's progress notes revealed there was nothing documented in the progress notes to show evidence of the resident's drainage amounts being emptied and recorded or evidence that the treatments to the surgical wounds on the resident's left and right lower abdomen were completed as ordered. No refusals of any treatments were noted in the progress notes to support the lack of documentation for the above dates of concern. On 03/12/26 at 8:30 A.M., an interview with the Director of Nursing (DON) verified the resident did not have the outputs recorded from her JP drains for days and/ or nights identified above. The DON stated the only other place the drainage amounts from those JP drains may have been recorded would be in the progress notes. If they could not be found there, then they would not have documented evidence they were emptied and the amount of drainage was recorded for those dated. The DON acknowledged the progress notes were checked with no drainage amounts from the JP drains being recorded for any of the dates previously mentioned.