STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365632	A. Building B. Wing	01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Majora Lane Ctr for Rehab & Nsg Care Inc	105 Majora Lane Millersburg, OH 44654

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on record review, observation, and interview, the facility failed to ensure Resident #11 was provided accommodations to ensure appropriate and dignified seating and had access to fluids if needed This affected one resident (#11) out of three residents reviewed for dignity. The facility census was 62.Findings Include: Review of Resident #11's medical record revealed an admission date of 12/11/25 with diagnoses including legally blind, cognitive communication deficit, difficulty walking, and high blood pressure.Review of Resident #11's physician orders revealed an order dated 12/12/25 for a regular texture diet with thin liquids.Observation on 01/05/26 at 2:20 P.M. revealed Resident #11 was lying in a recliner in the common area near the front desk and the facility main entrance. Resident #11 was lying at an angle with his bilateral legs hanging off the footrest to the left of the chair and his head hanging off the headrest and leaning against the hand rail. Resident #11 was not covered with a blanket. Observation on 01/06/2026 at 1:04 P.M. revealed Resident #11 was seated in a common area recliner at the front nurses' desk, near the facility's main entrance. Resident #11 was reclined back with his head leaning to his right side and against the hand rail. Resident #11 was restless with his bilateral feet hanging off the left side of the footrest. There was no music or TV playing. Resident #11 had nothing available if a drink was needed.Observation on 01/06/2026 at 1:56 P.M. Resident #11 continued lying at an angle in the common area recliner. He attempted to hold his right leg up on the footrest but it continued to fall off the footrest. Resident #11's head continued to be at an angle on the headrest and was still touching the hand rail. Facility staff, seated at the desk across from Resident #11, did not reposition Resident #11 in the recliner or offer a pillow for his use. There were several visitors walking past Resident #11 while he was lying in the recliner.Observation on 01/06/2026 at 2:19 P.M. Assistance Director of Nursing (ADON) stopped and talked with Resident #11 but did not offer to reposition the resident in the recliner. The Activities Coordinator (AC) #31 was passing ice cream and cake for residents. Resident #11 was not offered either cake or ice cream while he was seated in the common area recliner. There continued to be no water cup available for Resident #11 to use if needed. Observation on 01/06/2026 at 2:48 P.M. revealed Resident #11 requested to get out of the recliner and into the wheelchair. Staff members assisted Resident #11 into the wheelchair and he remained in the common area, next to the recliner. Resident #11 had nothing available if a drink was needed.An interview on 01/06/26 at 3:00 P.M. with the ADON confirmed Resident #11 had been lying in the recliner at an angle, was not repositioned and had no food or fluids within his reach if he needed them. The ADON stated Resident #11 was brought to the common area for safety reasons (for staff to keep the resident within their sight)This deficiency represents non-compliance investigated under Complaint Numbers 2660576 and 2623247.

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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, interview, and policy review, the facility failed to ensure the secured unit provided meaningful activities to meet Resident #9's needs. The facility also failed to ensure Resident #11 received preferred activities. This affected two residents (Resident #9 and #11) of three residents reviewed for activities but had potential to affect all 14 residents (#9, #10, #18, #20, #28, #31, #36, #37, #38, #40, #45, #49, #58, and #61) who resided on the secured unit. The facility census was 62. Findings include: 1. Review of the medical record revealed Resident #9 was admitted on [DATE] with diagnoses that included chronic congestive heart failure, cellulitis of right lower limb, venous insufficiency, dementia, type 2 diabetes, major depressive disorder, and anxiety. Review of a quarterly activity note dated 07/11/25 at 10:47 A.M. revealed Resident #9 continued to participate in most group activities. The resident liked to play bingo, do outdoor games, watch entertainers, and some of the crafts and church services. The resident interacted daily with other residents and staff. Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #9 had a brief interview for mental status (BIMS) score of 13 which indicated the resident was cognitively intact. Review of the plan of care revised 11/12/25 revealed Resident #9 needed encouragement to engage in structured leisure pursuits. Interventions revealed Resident #9 felt it was important to listen to music, to be around animals, watch television, play bingo, socialize with staff and peers, go outside during good weather, and participate in religious services. Resident #9 was to be invited, encouraged, and assisted to activities of interest. If the resident preferred to engage in independent leisure activities, staff would provide the resident with supplies for the resident ' s choice of independent activity preference. Review of the December 2025 Activity Calendar revealed music activities were scheduled twice, religious activities were scheduled eight times, food activities were scheduled 13 times, and bingo was scheduled 17 times. Review of the activity participation record for December 2025 revealed Resident #9 did not attend any of the music activities or religious activities. The resident attended four of the party and food activities, and eight bingo activities. Review of the January 2026 activity calendar revealed on 01/07/26 activities included bible study at 10:15 A.M., bread day at 1:15 P.M., and bread pass at 2:30 P.M. An observation on 01/06/26 at 1:07 P.M. revealed the resident was in the hallway, seated in her wheelchair. An interview with the resident was attempted however, the resident was not interviewable. An observation on 01/07/26 at 10:09 A.M. revealed Resident #9 was in the dining area on the secured unit. The resident was not involved in an independent or group activity. Attempts were made during the onsite survey to interview Resident #9 regarding activities on the secured unit however, the attempts were unsuccessful. An interview on 01/07/26 at 10:50 A.M. with Activity Coordinator #31 verified the activity staff did not go to the secured unit to do activities. Activity Coordinator #31 stated three or four residents who could sit for 15 to 30 minutes could be brought off the secured unit to participate in activities. Activity Coordinator #31 verified the residents on the secured unit (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	did not participate in the bread day activity but bread would be passed to the residents on the secured unit. An interview on 01/07/26 at 4:27 P.M. Program Director #28 for the secured unit stated the A.M. and P.M. Social Circle on the activity participation log could be puzzles, crafts, coloring, or other various activities. Program Director #28 verified movies and watching television were the same because there were movies on the television. Program Director #28 stated music was played during meals, and the television was on the rest of the time so those were activities that Resident #9 was involved in every day. Resident #9 participated in talking/conversation and resident-to-resident interaction because Resident #9 spent time out in the common areas and would speak to staff and other residents. Program Director #28 verified there was not an activity person assigned to the secured unit and the nursing staff did activities when able however, there were no daily, structured activities on the secured unit.2. Review of Resident #11 ' s medical record revealed an admission date of 12/11/25 with diagnoses including but not limited to legally blind, cognitive communication deficit, difficulty walking, and high blood pressure. Review of Resident #11 ' s activity care plan dated 12/12/25 revealed Resident #11 engages in leisure activities of choice with approaches including things important to him to listen to music and keep up with the news, to do group activities, go outside, religious services and having snacks between meals. Review of Resident #11 ' s daily activity logs dated 12/12/25 to 01/07/26 revealed the only time Resident #11 listened to music was when there was musical entertainment performing at the facility. The only entry for participating in crafts was marked on 01/06/26. There were no entries for listening to music and/or keeping up with the news. Observation on 01/05/26 at 2:20 P.M. revealed Resident #11 lying in a recliner in the common area near the front desk and the facility main entrance. Resident #11 was lying at an angle with his bilateral legs hanging off the footrest to the left and his head was hanging off the headrest and leaning against the handrail. Resident #11 was not covered with a blanket and there was no music playing. Observation on 01/06/2026 at 1:04 P.M. revealed Resident #11 was sitting in a recliner in the common area at the front nurse desk near the facility ' s main entrance. Resident #11 was reclined back with his head leaning to his right side, up against the handrail. Resident #11 was restless with his bilateral feet hanging off the left side of the footrest. There was no music playing and no TV playing. Observation on 01/07/26 at 10:15 A.M. revealed Resident #11 requested to go to his room and lay down in bed. Resident #11 was assisted into bed by Assistant Director of Nursing (ADON) and Certified Nursing Assistant (CNA) #61. Resident #11 was resting in bed with no music playing or his TV on. Interview on 01/07/26 at 10:23 A.M. with the Activity Coordinator (AC) #31 confirmed Resident #11 was seated in the recliner in the common area for the past two days with no music or news playing despite this being an important activity of choice for him. Review of the facility policy titled Resident Activity Preferences dated 03/21/19 revealed the facility will accommodate resident activity preferences through the comprehensive assessment and care planning process. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	This deficiency represents non-compliance investigated under Master Complaint Number 2696509 and Complaint Number 2623247.

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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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. Based on record review, observation and interviews, the facility failed to maintain range of motion for a resident with contracture. This affected one resident (#17) out of three residents reviewed for range of motion and positioning. The facility census was 62.Findings Include: Review of Resident #17 ' s medical record revealed an admission date 04/30/24 with diagnoses including but not limited to stroke, contractures, vascular dementia, high blood pressure, depression and anxiety. Resident #17 required assistance from staff to complete Activities of Daily Living (ADL) tasks and had intact cognition.Review of Resident #17 ' s physician orders revealed an order dated 11/08/24 for a Left hand palm protector to be applied in A.M. and removed at bedtime (HS). Check skin integrity every shift with application and removal notify nurse with any concerns and an order dated 07/31/25 patient to tolerate hand roll splint or palm protector nightly for decreased risk of worsening contracture and increased hand hygiene. Left hand is to be thoroughly washed and dried prior to donning splint and after removal.Review of Resident #17 ' s Activities of Daily Living (ADL) functional status care plan dated 11/06/24 revealed Resident #17 was to wear a palm protector to left hand for contracture.Review of Resident #17 ' s Treatment Administration Record (TAR) dated 12/01/25 to 01/06/26 revealed the order for a left-hand palm protector to be applied in A.M. and removed at bedtime (HS). Check skin integrity every shift with application and removal notify nurse with any concerns had been marked as being completed. The order for patient to tolerate hand roll splint OR palm protector nightly for decreased risk of worsening contracture and increased hand hygiene. Left hand is to be thoroughly washed and dried prior to donning splint and after removal had also been marked as being completed as ordered.Observation on 01/05/26 at 11:30 A.M. revealed Resident #17 sitting in a wheelchair in her room watching TV. There was no palm protector visible in Resident #17 ' s left hand.Observation on 01/06/26 at 9:10 A.M. revealed Resident #17 sitting in a wheelchair finishing breakfast meal. There was no palm protector visible in Resident #17 ' s left hand.Observation on 01/06/26 at 3:30 P.M. revealed Resident #17 participating in activities in the dining room. There was no palm protector visible in Resident #17 ' s left hand.Observation on 01/07/26 at 8:02 A.M. revealed Resident #17 was sleeping in bed and there was no palm protector or hand roll splint visible in Resident #17 ' s left hand.Interview on 01/07/26 at 9:35 A.M. with Registered Nurse (RN) #42 confirmed Resident #17 did not have a palm protector placed in her left hand. RN #42 stated the nurse or Certified Nursing Assistants (CNAs) will place the palm protector in Resident #17 ' s left hand. RN #42 further stated Resident #17 ' s palm protector could not be found in the room and had not been in the room for several days.This deficiency represents non-compliance investigated under Master Complaint Number 2696509.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on record review, observation, interview, and facility policy review, the facility failed to implement fall interventions for a fall risk resident. This affected one resident (#50) out of six residents reviewed for falls. The facility census was 62.Findings Include: Review of Resident #50 ' s medical record revealed admission date 09/02/25 with diagnoses including but not limited to high blood pressure, hallucinations, weakness and cognitive communication deficit. Review of Resident #50 ' s Falls Risk Observation dated 09/02/25 revealed Resident #50 was at moderate risk for falls with a score of eight, (a score of 10 or higher represents a high risk for falls). Further review revealed Resident #50 ' s Falls Risk Observation dated 10/09/25 revealed Resident #50 was at a high risk for falls with a score of 14.Review of Resident #50 ' s Safety Event - Fall Without Injury Event dated 10/21/25 at 12:14 A.M. revealed Resident #50 was observed lying on the floor beside the bed. Fall interventions in place at the time of the fall included bed in lowest position.Review of Resident #50 ' s fall care plan revised 10/21/25 revealed fall intervention implemented for a perimeter mattress to the bed to assist in defining edges of the bed.Observation on 01/08/26 at 9:46 A.M. revealed Resident #50 ' s bed had a regular flat mattress in place with no perimeter sides observed.An interview on 01/08/26 at 9:53 A.M. with the Assistant Director of Nursing (ADON) confirmed Resident #50 ' s bed did not have a perimeter mattress in place, instead had a regular flat mattress. The ADON stated Resident #50 had moved into the room sometime in October.Review of the facility policy titled Fall Investigation dated 05/01/25 revealed a member of the interdisciplinary team will review current interventions and implement additional fall interventions based on residents' risk factors. This deficiency represents non-compliance investigated under Master Complaint Number 2696509.

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F 0744 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 dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, self-reported incident review, interviews, facility assessment review, and dementia training review, the facility failed to ensure staff had the skills necessary to provide direct care in a way to relieve and accommodate Resident #38's distress. The facility also failed to ensure staff approached Resident #59 appropriately after a behavior occurred. This affected two (Residents #38 and #59) of two residents reviewed for dementia care. The facility census was 62. Findings include: 1. Review of the medical record revealed Resident #38 was admitted on [DATE] with diagnoses that included dementia, depression, anxiety, insomnia, Meniere's disease, osteoarthritis, osteoporosis, psychosis, and mood disorder. The admission Minimum Data Set (MDS) dated [DATE] revealed Resident #38 had psychosis, physical and verbal behaviors directed towards others, behaviors not directed towards others, and rejection of care. Plan of care dated 10/20/25 revealed Resident #38 refused bathing at times. Interventions included to offer resident alternatives when refusals occur, allow resident to choose options when able, allow resident to have some control over situations when possible and allow the resident to make choices/decisions regarding care as able. Resident has the right to refuse care and treatments. Maintain a calm environment and approach the resident in a calm manner. Convey an attitude of acceptance toward the resident. Plan of care dated 10/21/25 revealed Resident #38 had alteration in communication related to being hard of hearing (wears hearing aids), impaired ability to express and comprehend verbal communication related to Alzheimer ' s disease, dementia, and Meniere ' s disease. Interventions included to approach the resident slowly and face resident when speaking, establish and maintain a consistent care routine for the resident, observe for any signs of frustration during daily routine and redirect with calm gentle verbal tones.Plan of care dated 10/22/25 revealed Resident #38 exhibited behavioral symptoms of physical aggression towards staff. Interventions included to encourage the resident to accept assistance with care as needed. If the resident becomes combative during care .stop, allow that choice, make sure resident is safe. Explain to the resident you will return later and try again. The resident had the right to refuse care and treatment. When the resident ' s behaviors begins or escalate, move the resident to a quiet, calm environment to promote safety and prevent injury.A progress note dated 10/17/25 at 1:16 A.M. revealed Resident #38 was confused and resistive to care at times. A progress note dated 10/21/25 at 12:45 A.M. revealed Resident #38 had been combative during care. A progress note dated 10/28/25 at 4:10 P.M. revealed Resident #38 had increased periods of restlessness, anxiety, and verbal aggression towards staff. The physician was notified and a new order was received for Vistaril (for anxiety) as needed. Review of Self-Reported Incident (SRI) #267145 dated 11/04/25 revealed staff alleged the nurse forced the aides to provide a shower. A written statement (no date) by Licensed Practical Nurse (LPN) #37 revealed during report with Registered Nurse (RN) #41 on 11/03/25, Resident Assistant (RA) #99 reported Resident #38 agreed to take a shower but was now being combative and pulled RA #99 ' s hair. RN #41 stated Resident #38 had dementia and told RA #99 to talk to the resident and change the subject. RN #41 told the staff to shower Resident #38 because the resident would usually calm down once the shower started. RA #99 went back to the shower room. After getting report, LPN #37 started passing medication. Certified Nursing Assistant (CNA) #100 (a trainee) came out of the shower room and stated under her breath, this is (expletive) ridiculous. CNA #100 went to the nurse ' s station and grabbed something and returned to the shower room. As CNA #100 was walking into the shower room, she stated the nurse should be taking care of this. LPN #37 then moved onto another resident to administer medications. LPN #37 was talking to a resident when CNA #100 stuck her head out of the shower room and stated we need (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	help in here. LPN #37 ignored CNA #100 because LPN #37 was talking with a resident. CNA #100 then stated, hello, I said we need help. LPN #37 told CNA #100 she was going to have to wait. LPN #37 finished up with the resident she was talking to and went to the shower room. LPN #37 spoke to Resident #38 and told the resident if she stood up, LPN #37 would take the resident back to her baby. Resident #38 stood up, the staff dried the resident and applied an incontinence brief. LPN #37 took the resident out to the medication cart and administered Resident #38 ' s medications. LPN #37 called the Director of Nursing (DON) to notify her RA #99 and CNA #100 would call the DON because LPN #37 made them mad. Staff Coordinator #8 called LPN #37 and said RA #99 messaged Staff Coordinator #8 threatening to go to the hospital because her hair was pulled. LPN #37 verified RA #99 had reported Resident #38 had pulled her hair. Later in the shift, RA #99 asked for acetaminophen (pain reliever) because of a headache. LPN #37 gave RA #99 the acetaminophen. After Resident #38 was showered, LPN #37 did not speak to RA #99 or CNA #100 before they left for the night. The facility investigation revealed on 11/03/25 three calls were made to CNA #100. CNA #100 did not answer the phone but texted Staff Coordinator #8 and stated she felt her safety was at risk and did not want to work at the facility anymore. A handwritten statement by CNA #57 dated 11/03/25 revealed RA #99 was with a new girl and had Resident #38 on their assignment. RA #99 and CNA #100 stated Resident #38 hit, bit, and broke a necklace. CNA #57 put Resident #38 to be with no behaviors.An interview on 11/03/25 with CNA #57 by Administrator and DON revealed RA #99 and CNA #100 had an attitude and stated they had given a resident a shower and they got beat up. CNA #57 put Resident #38 to bed and had no concerns. CNA #100 stated she was calling the state because LPN #37 forced them to give (Resident #38) a shower. CNA #57 stated LPN #37 did not force RA #99 and CNA #100 to give Resident #38 a shower. CNA #57 stated RA #99 and CNA #100 had an attitude about giving Resident #38 a shower before they even started the shower. CNA #100 was mad before Resident #38 was even showered. CNA #57 stated she had no concerns with Resident #38. An interview on 11/03/25 with LPN #37 by Administrator and DON revealed she was getting report from RN #41 when RA #99 came in and stated Resident #38 said she would get a shower but was now combative and the resident was already in the shower room. LPN #37 and RN #41 told RA #99 to try again later. LPN #37 went in at the end of the shower and Resident #38 was fine and had no behaviors when LPN #37 was in the shower room. LPN #37 stated she was talking with another resident when RA #99 and CNA #100 asked for help. RA #99 and CNA #100 were rude, and she told them she was with another resident and then needed to stop with the attitude. LPN #37 did not tell the staff to hold down Resident #38 ' s hands and did not tell the staff they had to shower Resident #38.A handwritten statement by RN #41 dated 11/04/25 revealed RA #99 came into the conference room while RN #41 was giving report to LPN #37. RA #99 reported Resident #38 was getting combative during the shower and asked what to do. RN #41 suggested giving Resident #38 a moment to calm down but to have two aides in the shower room to be safe. RN #41 encouraged one aide to watch/hold Resident #38 ' s hands so the resident did not grab, hit, or pull staff ' s hair. RA #99 said okay and left the conference room. RN #41 demonstrated how to hold a resident ' s hand as a distraction and not a restraint. A progress note dated 11/04/25 at 1:06 A.M. authored by Licensed Practical Nurse (LPN) #37 revealed Resident #38 received a scheduled shower and became physically aggressive with staff. The resident was hitting, pulling staff ' s hair, and attempted to spit on and bite staff. The resident was given space and another staff provided care with no issues. Resident #38 continued to be confused and was not easily redirected at times. The resident was incontinent of bladder and was cooperative with care. A progress note dated 11/12/25 at 8:15 A.M. revealed Resident #38 ' s behaviors were discussed in the weekly meeting. The targeted behaviors included restlessness, verbal and physical aggression with spitting, exit (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	seeking, and tearfulness. Medications were reviewed and no recommendations were noted. An interview on 01/08/26 at 6:02 A.M. CNA #94 revealed Resident #38 was combative at times but was easily redirected. An interview on 01/08/26 at 6:38 A.M. LPN #37 revealed RA #99 notified her that Resident #38 did not want to be showered. CNA #100 then came out of the shower room and was cursing under her breath. LPN #37 stated she had finished report, passed medications to a resident, and then was talking to another resident when CNA #100 stated they needed help. LPN #37 verified she did not know why she was needed in the shower room. When LPN #37 entered the shower room, RA #99 stated they could not do anything with Resident #38. LPN #37 stated Resident #38 was facing the wall. LPN #37 asked if she could dry Resident #38 off and take Resident #38 to her baby. LPN #37 stated Resident #38 was not aggressive but was agitated. LPN #37 stated RA #99 and CNA #100 were also agitated. A different CNA provided care for Resident #38 the rest of the shift and there were no other concerns. LPN #37 verified she did not ask another staff member to provide care, but RA #99 or CNA #100 must have asked CNA #57 to provide the care for Resident #38. LPN #37 verified that Resident #38 was usually easily redirected. LPN #37 stated RA #99 frequently worked the dementia unit and CNA #100 was new and was being trained. LPN #37 verified she knew that RA #99 and CNA #100 reported Resident #38 did not want to be showered, and she had been asked three times by RA #99 and CNA #100 for help before she entered the shower room. LPN #37 verified she did not know if there had been a change in Resident #38 ' s condition when CNA #100 had asked for help. LPN #37 verified the staff were agitated and were providing care for Resident #38 who they reported being aggressive. LPN #37 verified if a resident became combative or agitated the staff should stop what they were doing. LPN #37 verified she did not immediately enter the shower room when staff were agitated to make sure Resident #38 was safe. The facility assessment dated [DATE] revealed all new and existing staff, including individuals providing services to residents under contract and volunteers, consistent with their expected roles, will receive training based on the conditions of the populations served. The facility uses an on-line education tool called Relias and/or in person education for the facility staff. Staff, contractors and volunteers receive training in the following core areas: communication, resident rights and facility responsibility, and abuse/neglect/exploitation. The nursing staff (RN ' s and LPN ' s) will also receive core training in the following areas, consistent with their roles: person-centered care and dementia management training and resident abuse prevention training, and care of the cognitively impaired. Nurse aides will also receive the following core training: dementia management training and resident abuse prevention training, care of the cognitively impaired, person-centered care. The resident acuity is determined by a review of evidence based on MDS data from the time of the last assessment. The average number of resident with behavioral symptoms and cognitive performance was 12.66%. Dementia Management Training Inservice Outline for Caring for the Patient with Dementia included to be patient, supportive, and friendly. Pay close attention to your non-verbal language and your tone of voice.Review of the job description for RN/LPN Charge Nurse revealed the nurse insured resident ' s personal hygiene regimen was completed as indicated. Monitors and talks with residents to be sure that they have been given appropriate care. Review of the job description for State Tested Nursing Assistant (aka CNA) revealed the CNA provides all basic care services as required by the resident, assists new employees in following established facility policies and procedures, identified special resident problems and reports them immediately to the charge nurse, provides nursing care to residents without violating resident rights, seeks assistance when confronted with a resident problem that requires special assessment, controls angry feelings appropriately, and demonstrates warm, caring feelings about resident by responding appropriately to the needs expressed. 2. Resident #59 was admitted [DATE] with (continued on next page)

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	365632	A. Building B. Wing	01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Majora Lane Ctr for Rehab & Nsg Care Inc	105 Majora Lane Millersburg, OH 44654

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	diagnoses that included type 2 diabetes mellitus, congestive heart failure, paroxysmal atrial fibrillation, depression, chronic kidney disease, history of transient ischemic attack, generalized anxiety disorder, and dementia without behavioral disturbance. Plan of care dated 12/10/24 revealed Resident #59 exhibited verbal aggression, hallucinations, making false accusations, yelling and argumentative with staff, made insulting comments about staff and other residents, and made threatening statements. Interventions included to resident from group activities when behavior was unacceptable, observe and report socially inappropriate or wandering behaviors that were disruptive to other residents. When resident began to become socially inappropriate/disruptive or was wandering, provide comfort measures for basic needs. When the resident ' s behavior begins or escalate move resident to a quiet, calm environment to promote safety. Avoid over-stimulation (noise, crowding, large groups, or other noted behavioral residents), if not tolerated by the resident. Observe for behavior that endangers the resident and/or others, staff to carefully intervene to promote safety of resident, other residents and staff. A handwritten statement dated 10/26/25 by Licensed Practical Nurse (LPN) #32 revealed her daughter was visiting LPN #32, staff, and residents on 10/26/25. The child wanted to go outside to get fresh air in the center courtyard during the resident ' s smoke time with Certified Nursing Assistant (CNA) #58. LPN #32 ' s child was running circles out and around the pavilion playing kind of a game of BOO in the dark. During this time, Resident #59 became suddenly agitated and swung her arm with a closed fist and intentionally hit/punched her (LPN #32 ' s) child in the stomach. The child entered the facility crying and holding her stomach. LPN #32 asked what happened and the child stated the lady with red streaky hair punched her in the stomach. LPN #32 looked at the child ' s stomach and there was a bright red mark across her abdomen. LPN #32 verified with CNA #58 that Resident #59 did punch the child. Resident #59 was wheeling into the building and LPN #32 approached the resident beside the nurse ' s station and asked the resident if she punched her daughter. Resident #59 confirmed with a smirk and stated she told the child to go inside before she hit her. LPN #32 told Resident #59 that a lot of children come into the facility and the resident did not have the right to hit children. Resident #59 could be charged with assault and potentially taken to jail. LPN #32 also stated that because she was a staff member she would not pursue any criminal charges, but if it was someone else ' s child Resident #59 may not be as fortunate. LPN #32 reassured Resident #59 she would make sure her daughter was not around Resident #59 again. A timeline typed up by the facility revealed on 10/27/25 Administrator received a message from Resident #59 ' s daughter stating a staff members daughter was running around outside and when the resident told her to stop, the child ran in and told her mother the resident hit her. The mother of the child told Resident #59, you are lucky you are in here. The Administrator talked with Resident #59 about the incident. The resident stated a little girl, around 12, was running around and on the chairs and Resident #59 told her to stop. The little girl ran inside and got her mom/grandma who was a nurse. The nurse (LPN #32) came out and stated you are lucky you are here. The resident stated the child had been outside for all the smoke breaks on 10/26/25. Administrator talked with Resident #7 who stated they saw a little girl outside when they went to smoke but did not see anything happen. Administrator talked with CNA #58 who reported the child went out with her when the residents went out to smoke. CNA #58 stated the child did not do anything wrong and Resident #59 hit the child in the belly. CNA #58 stated the child went inside and CNA #58 pushed Resident #2 back to her room. CNA #58 was walking back when she heard LPN #32 say to Resident #59, If I wasn ' t a staff member here, you would be leaving in a cop car because it was assault. Administrator interviewed Resident #2 who stated they witnessed Resident #59 hit the child and did not hear LPN #32 say anything other than, she was close to pressing charges, you do (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not hit other people ' s kids. Administrator called LPN #32. LPN #32 stated she was upset but did not yell at Resident #59 but was stern. LPN #32 told the resident You did not know whose kid that was and if I was not an employee someone could press charges on you for assault. You do not put your hands on someone else ' s kid. Administrator talked with CNA #77 who revealed LPN #32 was upset but did not do anything unprofessional other than say, you are lucky I do not call the cops and press charges. As LPN #32 went back to the unit she was working on, she said she was (expletive for being mad).Review of SRI #266837 dated 10/27/25 revealed a reported allegation of emotional/verbal abuse to Resident #59 by LPN #32. The SRI revealed Resident #59 had a brief interview for mental status (BIMS) score of 12 which indicated cognitive impairment. A handwritten statement dated 10/27/25 of an interview with Resident #59 with Administrator and Director of Nursing (DON) revealed the little girl was out at all smoke breaks. Resident #59 stated the little girl had no business out there and that the little girl was all over the chairs and running around. Resident #59 denied anything happening between her and the child but stated the child ran in and told her mom (LPN #32) she had been hit. Resident #59 stated when she came into the facility, LPN #32 said you are lucky you are here. Resident #59 stated it did not matter because LPN #32 did not scare her. A handwritten statement dated 10/27/25 by CNA #77 revealed it was a little before 8:00 P.M. when LPN #32 came up and was very upset. LPN #32 went to talk to another staff member and was being a little louder due to anger but did not say anything inappropriate. When LPN #32 came back down the hall, CNA #77 asked what happened. LPN #32 stated Resident #59 just punched her daughter, and the resident was lucky that LPN #32 did not call the cops and press charges. LPN #32 stated she was (expletive meaning mad) and went back down the hallway. A statement by Resident #2 dated 10/27/25 revealed the residents were outside smoking. Resident #59 did not like it that LPN #32 ' s daughter (seven years old) was out there because Resident #59 was trying to talk to CNA #77. Resident #59 told the child to go in and see her mother and to quit bothering them. Resident #59 then told the child Come over here so I can pop ya. The child ended up close enough to Resident #59 and her arm hit the child in the stomach. A handwritten statement dated 10/28/25 by CNA #58 revealed she was outside with the residents smoking at 7:00 P.M. LPN #32 ' s daughter followed CNA #58 outside and was running around playing. Resident #59 got very frustrated with the child running around and hit the child in the stomach. CNA #58 was pushing residents back inside and saw LPN #32 approach Resident #59 and asked if she hit LPN #32 ' s daughter. Resident #59 said she did. LPN #32 then said Resident #59 was lucky LPN #32 was a staff member or the resident would be leaving in a cop car with assault charges. A handwritten statement dated 10/29/25 by Resident Assistant (RA) #99 revealed RA #99 was sitting at the nurse ' s station when LPN #32 approached her and asked where Resident #59 was. RA #99 stated Resident #59 was outside. LPN #32 walked back down the hall and when LPN #32 saw Resident #59, LPN #32 told Resident #59 you ' re lucky I am a staff member and not a visitor because I ' d call the cops on you. It ' s not okay for you to hit other people ' s children at all. If she was bothering you that much, you should ' ve told CNA #58. Resident #59 started back talking to LPN #32, so LPN #32 walked away and RA #99 took Resident #59 to her room. An interview on 01/07/26 at 11:11 A.M. LPN #32 stated her daughter was only at the facility for an hour to visit herself and other residents. LPN #32 stated her daughter was seven years old and went outside when staff took residents out to smoke. LPN #32 verified that CNA #58 was outside to monitor residents that were smoking to ensure they were safe and not to monitor LPN #32 ' s child. LPN #32 verified she was not outside and did not witness the interaction between her child and Resident #59. LPN #32 also verified she was not Resident #59 ' s nurse but did confront the resident about hitting her child. LPN #32 stated she was not threatening the resident but educating the resident about (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hitting children. LPN #32 verified that Resident #58 had dementia and the facility was considered the resident ' s home. An interview on 01/07/26 at 2:23 P.M. Administrator stated LPN #32 stated she was not threatening Resident #59 but was just educating the resident about hitting children. The facility assessment dated [DATE] revealed all new and existing staff, including individuals providing services to residents under contract and volunteers, consistent with their expected roles, will receive training based on the conditions of the populations served. The facility uses an on-line education tool called Relias and/or in person education for the facility staff. Staff, contractors and volunteers receive training in the following core areas: communication, resident rights and facility responsibility, and abuse/neglect/exploitation. The nursing staff (RN ' s and LPN ' s) will also receive core training in the following areas, consistent with their roles: person-centered care and dementia management training and resident abuse prevention training, and care of the cognitively impaired. Nurse aides will also receive the following core training: dementia management training and resident abuse prevention training, care of the cognitively impaired, person-centered care. The resident acuity is determined by a review of evidence based on MDS data from the time of the last assessment. The average number of resident with behavioral symptoms and cognitive performance was 12.66%. Dementia Management Training Inservice Outline for Caring for the Patient with Dementia included to be patient, supportive, and friendly. Pay close attention to your non-verbal language and your tone of voice.Review of the job description for RN/LPN Charge Nurse revealed they are to interact with all residents, families, visitors, and employees in a mature, responsible manner to ensure a positive and professional living and working environment. Conduct all work activities in resident areas with respect for the rights and wishes of residents, including the maintenance of a pleasant and quiet environment. Consistently remains calm during stressful situations and vents emotions and frustrations appropriately. This deficiency represents non-compliance investigated under Master Complaint Number 2696509 and Complaint Number 2623247.

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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 medical record review and staff interview the facility failed to maintain accurate medical records. This affected three residents (Resident #10, Resident #41, and Resident #43) of twenty-five residents reviewed for accurate medical records. The facility census was 62.Findings include: 1. Review of the medical record for Resident #41 revealed admission to facility on 12/10/25 with diagnoses including morbid obesity, depression, chronic venous stasis (poor blood return in lower legs), lymph edema (chronic swelling related to poor fluid movement in body), anemia, pulmonary hypertension (elevated blood pressures related to air pressures in lungs), Review of Resident #41's initial Minimum Data Set (MDS) completed on 12/16/25 revealed a brief interview for mental status (BIMS) score of 15/15 (no impaired memory and cognition). Further review revealed Resident #41 was dependent and requiring maximum assistance of two persons for bed mobility (turning), transferring, showering, and dressing lower body. Review of Resident #41 orders by the Nurse Practitioner dated for 12/15/25 revealed Aquaphor to be applied to bilateral lower extremities three times a day. Further review of the Medication Administration Record (MAR) revealed Aquaphor application times of 7:00 A.M. to 11:00 A.M., 2:00 P.M. to 4:30 P.M., and 7:00 P.M. to 11:00 P.M. Review of the MAR on 01/06/25 at 1:59 P.M. revealed the Aquaphor had not been signed off as being administered for the 7:00 A.M. to 11:00 A.M. time frame. Review of the MAR on 01/06/26 at 4:10 P.M. revealed the Aquaphor being signed off as administered by Registered Nurse (RN) #42. Observation and interview on 01/06/26 at 4:20 P.M. of Resident #41 revealed no visible Aquaphor present on bilateral lower legs. Resident #41 reported no one had applied any Aquaphor to her legs all day. Observation and interview on 01/06/26 at 4:22 P.M. with the Administrator revealed verification that Resident #41 did not have any Aquaphor visible on lower legs and that the MAR was signed off as being administered already for the 2:30 P.M. to 4:30 P.M. time slot. Interview on 01/06/26 at 4:24 P.M. with RN #42 revealed she had just signed off the Aquaphor administration for Resident #41 and had not yet administered it and was getting ready to go apply the Aquaphor to Resident #41 legs. 2. Review of medical record for Resident #43 revealed admission to facility on 12/30/23 for diagnoses including heart failure, stroke affecting right side with paralysis, concentration and memory deficits following stroke, language deficits following stroke, morbid obesity, depression, incontinence of feces and urine, and high blood pressure. Review of the most recent annual comprehensive assessment on the MDS completed on 12/25/25 revealed Resident #43 to have a BIMS score of 3/15 indicating severe cognitive/memory impairment. Further review of the MDS assessment revealed Resident #43 to be on a bladder and bowel incontinence program for frequent urinary and fecal incontinence. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the most recent care plan updated on 12/25/25 for Resident #43 revealed a care plan initiated on 01/19/24 for Resident #43 to be on a routine bowel and bladder program including to have staff check and offer toileting assistance every two hours. Review of the Bladder Program Service Delivery Record for November 2025, December 2025, and January of 2026 revealed numerous blank areas to identify if Resident #43 was checked for incontinence or assisted to the toilet. Further review for December 2025 revealed no documentation on 12/06/25, 12/09/25, 12/11/25, 12/12/25, 12/14/25, 12/15/25, 12/17/25, 12/19/25, 12/20/25, 12/21/25, 12/22/25, 12/24/25, 12/25/25, 12/29/25, and 12/30/25 on the Bladder Program Service Delivery Record. Interview on 01/07/26 at 1:55 P.M. with Certified Nursing Assistant (CNA) #57 revealed that the CNAs are to perform incontinence checks and toileting assistance every two hours and record if the resident is incontinent or not in the logbook at the nurses desk. CNA #57 demonstrated the location of the logbook containing residents who are bowel and bladder programs. CNA #57 reviewed the Bladder Program Service Delivery Record for December of 2025 for Resident #43 and verified missing documentation for several dates. CNA #57 reported that sometimes the aides forget to sign the logs including herself. 3. Review of the medical record revealed Resident #10 was admitted on [DATE] with diagnoses that included Alzheimer's disease, schizoaffective disorder, bipolar, severe protein-calorie malnutrition, anxiety, paranoid schizophrenia, cerebral palsy, and major depressive disorder. The plan of care dated 10/25/23 revealed Resident #10 was at risk for altered nutrition. Resident #10 liked sweets, pop, milk, ice cream, pudding, and yogurt. The resident had variable oral intakes from zero to 100%. The resident accepts supplements. The annual Minimum Data Set (MDS) dated [DATE] revealed Resident #10 had a brief interview for mental status (BIMS) score of seven which indicated severe cognitive impairment. Interventions included supplements as ordered and offer menu alternatives as needed On 11/05/25, Resident #10 weighed 90 pounds.On 12/01/25, Resident #10 weighed 87 pounds. A dietician note dated 12/03/25 at 10:46 A. M. revealed Resident #10 had a significant weight loss of 8.4% in the last 90 days and 13% in the last 180 days. The resident ' s meal intakes remained variable. Resident #19 received a house supplement four times a day, fortified ice cream with lunch and dinner, and preferred milk at meals. Review of the meal intake documentation revealed on 12/06/25 and 12/07/25 the only meal documented was dinner. There was no documentation for meal intakes on 12/20/25. On 12/25/25,12/31/25, 01/02/26, 01/03/26, 01/04/26 the only meal documented was at dinner. A dietician note dated 01/07/26 at 12:30 P.M. revealed Resident #10 ' s body mass index was 14.93 and was below healthy range for age. Resident #10 ' s intakes were widely variable from one percent to a hundred percent. An interview on 01/07/26 at 1:23 P.M. Regional Dietician Consultant #98 verified the meal intakes were not always documented. If a resident refused a meal, the documentation should reflect the refusal. Regional Dietician Consultant #98 stated she would interview the staff to see how Resident #10 was eating. The lack of documentation had been addressed with the certified nursing assistants in the past. An interview on 01/07/26 at 4:08 P.M. Director of Nursing verified meal documentation for Resident #10 was missing in the electronic record. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This deficiency represents non-compliance investigated under Master Complaint Number 2696509.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on record review, observation, interview and facility policy review, the facility failed to maintain transmission-based precautions. This deficient practice affected two residents (#17 and #70) out of three residents reviewed for transmission-based precautions. The facility census was 62.Findings Include: 1. Review of Resident #17 ' s medical record revealed admission date 04/30/24 with diagnoses including but not limited to stroke, contractures, vascular dementia, high blood pressure, depression and anxiety. Resident #17 required assistance from staff to complete Activities of Daily Living (ADL) tasks and had intact cognition.Review of Resident #17 ' s physician orders revealed an order dated 11/04/25 for enhanced barrier precautions (EBP) related to chronic wounds and urinary catheter use.Review of Resident #17 ' s EBP care plan dated 01/05/25 revealed Resident #17 requires EBPs related to chronic wound and indwelling medical device of urinary catheter use, with approaches including but not limited to EBP supplies may be placed in resident room, post signage to alert caregivers of the need for enhanced barrier precautions, and utilize the use of personal protective equipment (PPE) gowns and gloves during high contact resident care activities when in room, shower room, or in therapy.Observation on 01/06/26 at 9:02 A.M. revealed on the wall beside Resident #17 ' s room door a notification sign for EBP during high contact resident care and hanging on the door was PPE storage with gowns and gloves available for use. Resident #17 was observed being transferred via mechanical lift from bed to wheelchair by Certified Nursing Assistants (CNAs) #61 and #65. Neither CNA #61 and #65 were wearing PPE gowns or gloves.Interview on 01/06/26 at 9:30 A.M. with CNA #61 confirmed neither CNA #61 nor #65 were wearing gowns or gloves while transferring Resident #17 from bed to wheelchair via a mechanical lift. CNA #61 stated we should have put on the gowns and gloves before transferring her.2. Review of Resident #70 ' s medical record revealed admission date 12/31/25 with diagnoses including but not limited to Covid, intracranial hemorrhage, and fall with injuries at home.Review of Resident #70 ' s physician orders revealed an order dated 01/01/26 for Airborne transmission-based precautions; resident to remain in room and all services brought to the room.Observation on 01/05/26 at 11:15 A.M. revealed Resident #70 ' s door was closed and there was an airborne precautions notification sign visible on the wall beside the room door. Notification sign indicated everyone must: clean hands when entering and before leaving room and to wear gown, gloves, mask and eye protection when entering the room. Healthcare professionals must in addition to the above precautions, use an N95 mask. There was a PPE hanging storage device on the door which included gowns, gloves, masks and eye protection.Observation on 01/05/26 at 2:10 P.M. Resident #70 ' s room revealed there was no hand sanitizer available to clean/sanitize hands after exiting the room. The nearest hand sanitizer dispenser was down the hallway from Resident #70 ' s room. There was no disinfectant wipes available and no designated area to remove and disinfect the used eyewear. There was no used eyewear devices observed in the room or in the PPE storage device hanging on the door.Interview on 01/05/26 at 2:15 P.M. with the Assistant Director of Nursing (ADON) confirmed the lack of hand sanitizer available once exiting the room, the lack of disinfectant wipes and an area to clean/disinfect used eyewear and the lack of used eyewear noted in the PPE hanging storage device. The ADON stated there should be disinfectant wipes to clean the eyewear and the cleaned eyewear can be placed in the PPE storage for future use.Review of the facility ' s policy titled Isolation - Categories of Transmission-Based Precautions dated 07/01/25 revealed it is the facility ' s policy that appropriate precautions shall be used either al all times (Standard Precautions) or for individuals who are documented or suspected to have infections or communicable diseases that can be transmitted to others (Transmission-based Precautions).This deficiency represents non-compliance investigated under Master Complaint Number 2696509.