| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 365632 | A. Building<br>B. Wing | 06/02/2026 |

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| Majora Lane Ctr for Rehab & Nsg Care Inc | 105 Majora Lane<br>Millersburg, OH 44654 |

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

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|---|---|
| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, Self-Reported Incident review, witness statement review, policy review, and interview, the facility failed to ensure Resident #21, who was diagnosed with dementia with behaviors, was assessed as severely cognitively impaired and had a history of sexually inappropriate behaviors, had appropriate care-planned interventions in place to protect Resident #23's right to be free from alleged sexual abuse by Resident #21. This affected one resident (#23) of four residents reviewed for abuse. The census was 52. Findings include: Review of the medical record for Resident #21 revealed an admission date of 04/24/25 with diagnoses of dementia with behavioral disturbances, Alzheimer's disease, restlessness and agitation, altered mental status, vascular dementia, diastolic congestive heart failure, chronic obstructive pulmonary disease (COPD), anxiety disorder, diabetes, and malaise. Resident #21's responsible party was his daughter. Resident #21 was initially admitted to the Speret hall (the secured memory-care unit) then was moved off the secured memory-care unit to the 300-hall on 10/08/25. Review of the skilled nursing facility (SNF) documents in the electronic medical record (EMR) dated 04/24/25 revealed Resident #21 had been admitted from another SNF. Review of the nurse practitioner progress note dated 04/05/26 revealed Resident #21 was a poor historian due to cognitive/psychiatric impairment. Resident #21 had history of Alzheimer's disease and dementia with behaviors. The resident was alert and oriented times one to two (alert to person and/or place). He was able to answer some questions during history and physical interview, but most answers were nonsensical. Per staff, the resident did make comments about where his wife was and all these pretty women. The assessment/plan for the dementia with behavioral disturbance revealed the behaviors included sexually inappropriate behaviors (verbal comments/hand holding attempts). Review of the physician orders revealed Resident #21 was ordered Tagamet HB (Cimetidine) oral tablet 200 milligrams (mg) (a medication used off label to manage hypersexuality or inappropriate sexual behaviors) with instructions to give one tablet by mouth two times a day related to dementia with other behavioral disturbance, which was started on 04/16/25. Review of the physician orders from April 2025 revealed Resident #21 was ordered Tagamet HB (cimetidine) tablet 200 mg one tablet oral twice a day for dementia. Review of the Nursing admission - Clinical admission Documentation assessment dated [DATE] revealed Resident #21 was admitted from another skilled nursing facility (SNF). Resident #21 was alert and oriented to place only and was admitted with a psychiatric diagnosis, behaviors and/or medications. Review of the Social Service - Social History assessment dated [DATE] authored by Licensed Practical Nurse (LPN)/Social Service Coordinator (SSC) #65 revealed Resident #21 was alert and oriented to person only, forgetful/confused and lacked safety awareness. Resident #21 had physical, verbal, other behaviors not directed towards others and was impulsive. Review of the nursing progress note dated 05/11/25 timed 5:13 A.M. authored by Registered Nurse (RN) #66 revealed an unnamed Certified Nurse Aide (CNA) reported to this nurse increased inappropriate sexual behaviors such as commenting on the CNA's appearance and attempting to touch the staff member while providing routine care. Redirection and distraction attempted, somewhat effective. Resident's safety ensured, noted to be in bed at this time with call<br>(continued on next page) |

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

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

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | light within reach. Care plan continued. Review of the nursing progress note dated 05/13/25 authored by the Speret Hall Program Director (SHPD) #79 revealed Resident #21 was discussed in the weekly behavior meeting yesterday. Target behaviors were discussed which included: restlessness and tearfulness. Medications were reviewed. Recent behaviors were discussed related to being inappropriate and making inappropriate comments to staff with no recommendations noted. Care plans reviewed and updated as needed. Resident to follow-up with psychiatric services. There was no evidence of what specific inappropriate sexual behaviors were exhibited by Resident #21. Review of Physician #80's progress note dated 07/15/25 revealed Resident #21 was diagnosed with dementia and to watch for worsening behaviors. Review of the pharmacy Note To Attending Physician/Prescriber dated 08/13/25 revealed Resident #21 was triggering for falls at the facility. The note stated to please review the following medications that could be contributing to falls which included: Cimetidine 200 mg twice a day which caused dizziness and drowsiness. The pharmacist recommended to discontinue Cimetidine 200 mg twice a day and start 300 mg in the morning or 100 mg twice a day. Review of the physician orders from August 2025 revealed Resident #21 was ordered Cimetidine tablet 100 mg twice a day. Review of the nursing progress note dated 09/26/25 timed 7:36 A.M. authored by SHPD #79 revealed Resident #21 was discussed in the weekly behavior meeting this week. Target behaviors discussed included: tearfulness. Medications were reviewed. Recent behaviors discussed related to inappropriate sexual behaviors. There were no recommendations noted. The care plan was reviewed and updated as needed. The resident continued with psychiatric services. There was no evidence of what specific inappropriate sexual behaviors were exhibited by Resident #21. Review of the nursing note dated 10/06/25 timed 5:34 P.M. authored by SHPD #79 revealed interdisciplinary (IDT) meeting was held today and discussed the resident needing a specialized unit. The IDT meeting recommended to transfer the resident off the unit with a compatible roommate on the 300-hall. The Nurse practitioner was updated and agreeable with the transfer. It noted they spoke with the resident, his daughter, and family, related to the resident not meeting requirements for the unit and would like to transfer to another unit. Resident and family agreeable to transfer tomorrow to a new room. Review of the psychiatric nurse practitioner progress note dated 01/13/26 revealed Resident #21's had recent and remote memory impairment, limited insight and limited judgement. Per staff, the resident was more restless and agitated around bedtime. Diagnoses were noted as dementia with behavioral disturbance and he was ordered Zoloft 75 mg (an antidepressant medication) orally once a day and Tagamet 100 mg twice a day. The plan was to start Remeron 7.5 mg orally at night for restlessness. Review of the nurse practitioner progress note dated 01/15/26 revealed Resident #21 had anxiety/depression with occasional inappropriate sexual behaviors. The resident was on Zoloft as well as cimetidine. Review of the cognitive loss/dementia care plan updated 02/03/26 revealed Resident #21 had impaired cognition related to Alzheimer's disease, dementia, impaired decision making, short-term memory loss, long-term memory loss, poor safety awareness, disorientation to time and place, confusion, brief interview for mental status less than 13 and unable/unwilling to participate with Minimum Data Set (MDS) interview. The interventions were generalized and not individualized to Resident #21 such as being more restless and agitated around bedtime and monitoring for worsening behaviors. There was no documentation in this care plan about Resident #21's sexually inappropriate behaviors, and no evidence of comprehensive, individualized care planned interventions for sexually inappropriate behaviors. Review of the behavioral symptoms care plan updated 03/12/26 revealed Resident #21 exhibited the following symptoms of physical aggression, verbal aggression, wandering and other which included: argumentative and yelling at peers for items; expressed delusions related to people being present when not here, agitation, shouting at times, and he used bedside table to lean on at times. The interventions were generalized and not individualized to Resident #21 such as being more restless and agitated around bedtime and monitoring for worsening behaviors. There was no documentation in this care plan about Resident #21's sexually inappropriate behaviors, and no evidence of<br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | comprehensive, individualized care planned interventions for sexually inappropriate behaviors. Review of the nursing progress note dated 05/02/26 timed 12:41 A.M. authored by RN #66 revealed the front nurse notified this nurse that Resident #21 was observed in a peer [Resident #23's] room on an opposing unit, without clothing. The nurse promptly responded, approached the resident and assisted him back to his assigned unit. Safety was ensured and reassurance was provided. A skin assessment was completed with no new issues noted. The resident's family was contacted. The Administrator and DON were notified by an unnamed LPN and 15-minute checks were initiated. Review of the MDS 3.0 annual assessment dated [DATE] revealed Resident #21 was severely cognitively impaired, and required partial/moderate assistance with dressing, oral hygiene, toileting, bathing, personal hygiene, bed mobility and transfers. There was no documentation that Resident #21 displayed any behaviors. Review of the medical record for Resident #23 revealed an admission date of 09/03/25 with diagnoses of Alzheimer's disease, cognitive communication deficit, obesity, episodic tension-type headache, and noninfective gastroenteritis and colitis. Resident #23's brother was her emergency contact. Resident #23 resided on the 300-unit in a private room upon admission and on 03/11/26 was moved to the 200-hall in a private room. Review of the Social Service - Social History assessment dated [DATE] revealed Resident #23 was alert and oriented to person, place and time, forgetful/confused and lacked safety awareness. Resident #23's was assessed as being moderately cognitively impaired. Resident #23 was a missionary for 29-years and traveled on a ship to multiple countries and was never married. Review of the nursing and social services progress note from September 2025 to April 2026 revealed there was no evidence Resident #23 exhibited sexual behaviors. Review of the MDS 3.0 quarterly assessment dated [DATE] revealed Resident #23 was severely cognitively impaired, required set-up or clean-up assistance with eating and oral hygiene, and required supervision or touching assistance with dressing, putting on/taking off shoes, toileting, bathing, personal hygiene, bed mobility, transferring and walking 10 feet, 50 feet and 150-feet. Review of the social service progress note dated 05/01/26 timed 10:45 P.M. authored by LPN/SSC #65 revealed at 7:30 P.M., this nurse was informed that when staff entered Resident #23's room to pass snacks, the aide noted there was a box of pop behind the door and Resident #23 and a male peer [Resident #21] were both lying in the resident's bed, undressed and lying side by side. Resident #21 was assisted in redressing and escorted out of room and returned to his room with no incident. Undersigned spoke to Resident #23 who denied having felt pressured into the situation, she voiced consent and smiled stating, that was the first time I was going to have sex and we didn't get that far. Resident #23 denied having had either resident touch the other in any way. A head-to-toe assessment was completed with no issues noted. The resident stated, I feel embarrassed, and was reminded that physical urges and intimacy were normal and natural for all adults. The Administrator, Assistant Director of Nursing (ADON) #74 and Physician were notified of the situation with no new orders. Resident #23 would be monitored every 15 minutes for 24 hours. A message was left for the resident's brother to return the call for an update. The brother had not returned the call as of the end of the shift. Review of the nursing progress note dated 05/02/26 timed 5:04 P.M. revealed staff called and updated the resident's brother about an incident yesterday. The brother voiced understanding and thanked staff for the update. Review of Self-Reported Incident #274054 dated 05/01/26 revealed a sexual abuse allegation involving Residents #21 and #23, found naked in a room together. The sexual abuse allegation was unsubstantiated. Review of the witness statement dated 05/01/26 authored by Hospitality Aide (HA) #73 revealed upon passing snacks, this aide knocked and entered the resident's room to find two residents (unnamed) appearing to be naked lying side-by-side in bed, uncovered. HA #73 immediately notified a Certified Medication Aide (CMA)/nurse. Review of the witness statement dated 05/01/26 authored by CMA #67 revealed HA #73 was passing snacks to find two residents (unnamed) in a resident room and appearing to be naked. CMA #67 immediately got the nurse to report the event. Review of the witness statement dated 05/01/26 authored by MDS RN #75 revealed this RN was approached by CMA #67. CMA #67 alerted MDS RN #67 that Hospitality Aide (unnamed) was<br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | passing night snacks and knocked on the resident's room and then entered. Upon entering, she noted that there were two residents in the room, naked and lying in bed together. MDS RN #75 went to resident's room and knocked on door and then entered. The door noted to have been barricaded with a box of soda. The male resident (unnamed) opened the door. Both residents were noted to be naked. The female resident (unnamed) noted to be lying in bed and the male resident was at the door talking to this nurse. MDS RN #75 then asked the aide to retrieve the other nurse on the floor. Other nurse came to the room to separate them and ensure safety. The male resident was taken back by his nurse (unnamed) to his hall. Review of the undated witness statement authored by LPN/SSC #65 revealed on Friday, 05/01/26 at approximately 7:00 P.M. to 7:15 P.M., LPN/SSC #65 was notified that while passing snacks, a HA attempted to enter Resident #23's room and noted that a box was behind the door making opening it more difficult than normal. The staff member entered to find the resident and a male peer (unnamed) lying in Resident #23's bed side-by-side and neither were dressed. Undersigned entered the room to note the same observation and encouraged the male peer (unnamed) to be assisted to redress by a staff member and the female resident (unnamed) was encouraged to redress. The female resident reported that she had never had sex and was about to for the first time, but they didn't get that far. The female denied having felt coerced into the situation and was a consenting participate in the intended activities. A head-to-toe was completed while the resident (unnamed) went into bathroom to redress. Resident's (unnamed) most recent BIMS was noted at a five (severely cognitively impaired). It noted the undersigned went to the back hall to locate the male resident's nurse to assist with returning him to his unit and to ensure complete understanding and assessment of the situation to ensure that both families were provided clear details on events as noted. Upon the undersigned's return to the front hall, the male resident was redressed and seated in his wheelchair that was in the female resident's room. The undersigned spoke to the male peer. Undersigned inquired of the resident who he believed he was with and he responded, my girlfriend, [Resident #21's wife's name]. The male resident was returned to his room on the other unit with both resident's stating that they were consenting to the intended activity and that neither felt pressured or forced in any way. Male resident's most recent BIMS was four (severity cognitively impaired). LPN/SSC #65 notified the Administrator and ADON #74 of incident and notified Physician #80 of the situation and both resident's were placed on 15-minute checks for 24-hours. Interview on 05/26/26 at 3:15 P.M. with CNA #60 revealed Resident #21 displayed sexual behaviors and said weird things to women about body parts, such as nice boobs and nice butt. When Resident #21 resided on the secured memory care unit, he would try to grab staff and rub their back. Resident #21 hadn't displayed sexual desires towards any other resident beside Resident #23. Resident #21 was confused, could walk and self-propel himself in his wheelchair. Interview on 05/26/26 at 3:20 P.M. with CNA #61 revealed Resident #23 used to reside on the 300-unit until she got a private room on the 200-unit. Residents #21 and #23 saw each other in the dining room and Resident #23 would come to the 300-unit to sit and talk to Resident #21. Interview on 05/26/26 at 3:25 P.M. with RN #62 revealed Resident #23 used to reside on the 300-unit and recently moved to the 200-unit. Observation on 05/26/26 at 3:35 P.M. revealed Resident #21 was in bed with a blanket covering his body including his head. Interview, during the observation, with Resident #21 revealed when asked if he had a friend named [Resident #23's name], Resident #21 stated, that name sounds familiar. When asked if he remembered getting into bed with Resident #23, Resident #21's response was unclear. Interview on 05/26/26 at 3:45 P.M. with CNA #63 revealed CNA #63 had seen the residents talk in the dining room and by the nurses station. Interview on 05/26/26 at 4:30 P.M. and on 05/27/26 at 4:40 P.M. with LPN/SSC #65 revealed LPN/SSC #65 was working as a floor nurse the evening of 05/01/26 when a newer aide (unnamed) was passing snacks. The newer aide observed the residents and retrieved CMA #67, then CMA #67 retrieved LPN/SSC #65. Residents #21 and #23 were side-by-side, shoulder-to-shoulder lying in Resident #23's bed, completely naked. LPN/SSC #65 retrieved the 300-hall nurse since that was where Resident #21 resided. Resident #21 and #23 were friends, sat together in the dining room and were both confused. Resident #21 thought<br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Resident #23 was his wife as Resident #23 looked like Resident #21's wife. Residents #21 and #23 were both embarrassed. Resident #23 stated, I'm quite embarrassed, it was the first time I was going to have sex but I didn't get to. LPN/SSC #65 did a head-to-toe assessment on Resident #23 with no concerns. LPN/SSC #65 stated both Residents #21 and #23 were unable to make their own decisions. LPN/SSC #65 notified Resident #21's daughter who consented to the relationship. LPN/SSC #65 asked Resident #21's daughter if there were any grounds Resident #21's daughter was uncomfortable with, Resident #21's daughter responded, no not really. Resident #23's brother returned the facility's call the next morning (05/02/26), and spoke to RN #62 and couldn't believe people their age wanted to have sex. LPN/SSC #65 stated she did not have a conversation with Resident #23's brother about consent. LPN/SSC #65 stated she had last observed Resident #23 entering the dining room for dinner between 4:00 P.M. and 4:30 P.M. on 05/01/26. Interview on 05/27/26 at 8:40 A.M. and 4:50 P.M. with RN #66 revealed on 05/01/26, RN #66 was working in the back [300 and 400-unit] and LPN/SSC #65 came to get RN #66 to notify her of what happened with Residents #21 and #23. The residents were dressed when RN #66 arrived to Resident #23's room and both were very embarrassed. RN #66 did a skin assessment on Resident #21 with no concerns and Resident #21 stated he was down there for a visit with his girlfriend and we didn't get to touch. Resident #21 had a history of asking female staff members if they were married and typical old man things. Residents #21 and #23 were friends and would hang out and read magazines together in the common areas. RN #66 called Resident #21's daughter and the daughter was embarrassed on Resident #21's behalf. RN #66 had last observed Resident #21 sitting by the 300-400 unit nurses station at approximately 6:00 P.M. to 6:30 P.M. when RN #66 arrived to work then received nurse-to-nurse report. Observation and interview on 05/27/26 at 9:10 A.M. revealed Resident #23 was lying in bed, awake. When asked about the male resident who got into bed with her a couple of weeks ago, Resident #23 responded, that was weird and she didn't know who he was and he just came in; Resident #23 could not remember the male resident's name. When asked if he got into bed with her, Resident #23 stated, he didn't get into bed with me. Interview on 05/27/26 at 9:25 A.M. with Resident #21's daughter revealed she was notified that Resident #21 had wandered into another resident's room, Resident #21 thought the female resident was Resident #21's wife, they were both naked and nothing happened. Resident #21's daughter revealed Resident #21 had dementia and didn't know where he was at. Interview on 05/27/26 at 10:05 A.M. with CMA #67 revealed she was working with a trainee aide (unnamed) and the trainee aide was passing snacks when the trainee aide looked at CMA #67 and stated, you should probably get the nurse. CMA #67 got LPN/SSC #65. Residents #21 and #23 were naked and embarrassed. CMA #67 stated Resident #21 did not have an erection. Interview on 05/27/26 at 11:55 A.M. with Resident #23's brother revealed he was notified that Resident #23 and a male resident were in the same bed and planning on having sex. Resident #23 stated, at their age, I couldn't comprehend that but again, I don't know what to make of it and he mentioned there was not a lot he could do. Interview on 05/27/26 at 2:10 P.M with Hospitality Aide (HA) #73 revealed on 05/01/26, HA #73 was passing snacks for the evening and knocked on Resident #23's door around 7:00 P.M., and there was a box behind the door and HA #73 proceeded in. Residents #21 and #23 were lying side-by-side, not touching, naked in her bed. HA #73 notified the nurse (unnamed). The nurse went into the room to talk to them. HA #73 and the nurse assisted the residents to get dressed. HA #73 stated Resident #21 did not have an erection. Interview on 06/01/26 at 11:15 A.M. with CNA #77 revealed Resident #21 was able to dress and undress her upper body however Resident #21 needed assistance dressing and undressing her lower body. Interview on 06/01/26 at 11:35 A.M. with Regional Registered Nurse (RRN) #76 verified Resident #23 had a history of sexually inappropriate behaviors and verified his sexually inappropriate behaviors were not documented in his care plans to ensure appropriate individualized interventions were implemented. Review of the facility's Abuse, Mistreatment, Neglect, Misappropriation of Resident Property and Exploitation policy dated 2016 revealed abuse was defined as, the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or<br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | mental anguish. It included verbal abuse, sexual abuse, physical abuse and mental abuse. Exploitation was defined as taking advantage of a resident for personal gain through manipulation, intimidation, threats or coercion. Sexual abuse was defined as non-consensual sexual contact of any time with a resident. Willful was defined as meaning the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. The facility's procedure would include: the assessment, care planning and monitoring of resident's with needs and behaviors which might lead to conflict or neglect such as resident's with a history of aggressive behaviors, or if resident had behaviors such as entering other resident's rooms. This deficiency represents non-compliance investigated under Complaint Number 3024629 and Incident Number 3021070. |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, Self-Reported Incident review, witness statements, policy review, and interview, the facility failed to ensure staff immediately reported an allegation of mistreatment to the Administrator. This affected one (Resident #27) of four residents reviewed for abuse and had the potential to affect all 14 residents (#2, #6, #7, #8, #9, #17, #20, #26, #27, #28, #29, #30, #34, and #47) who resided on the Speret hall (the secured memory care unit) whom the alleged perpetrator cared for. The census was 52. Findings include: Review of the medical record for Resident #27 revealed an admission date of 01/31/26 with diagnoses of dementia without behavioral disturbance, neurocognitive disorder with Lewy bodies, anxiety, fracture of femur, depression, and anemia. Resident #27 resided on the secured-memory care unit. Review of the Minimum Data Set (MDS) 3.0 quarterly assessment dated [DATE] revealed Resident #27 was severely cognitively impaired, had physical behaviors four to six days during the assessment, rejected care one to three days during the assessment and required substantial/maximal assistance with all activities of daily living except eating. Review of the Self-Report Incident #274881 dated 05/23/26 revealed one aide alleged that another aide was sometimes rough with care and tone when she spoke to residents. The category of allegation/suspicion was physical abuse and emotional/verbal abuse. The alleged perpetrator was Certified Nursing Assistant (CNA) #69. CNA #68 felt like CNA #69 was rough by rushing the transfer and change in plane, from standing-to-sitting, with Resident #27. Review of the witness statement dated 05/23/26 authored by the Administrator revealed the Administrator had received a voicemail to return a call back to CNA #68. The Administrator called CNA #68 and CNA #68 felt uneasy on a couple things and wanted to tell someone. CNA #68 stated she witnessed CNA #69 and another aide (unnamed) putting Resident #27 in recliner and CNA #68 felt they did it in a rough manner. The Administrator asked for a date, or what nurse was on; CNA #68 could not remember. The Administrator educated CNA #68 that if CNA #68 felt something wasn't right, to notify nurse right away so the nurse could look into it and if needed, the nurse could call the Administrator. Review of the witness statement dated 05/23/26 authored by CNA #68 revealed CNA #68 stated one time she felt CNA #69 was rough, when putting Resident #27 in a recliner in the Speret hall dining room (secured memory care unit), but couldn't remember a date or time, or what nurse was on, but stated probably Registered Nurse #66, as she was the nurse on back there. Interview on 05/27/26 at 1:55 P.M. with CNA #68 revealed initially upon talking to Assistant Director of Nursing (ADON) #74 and the Administrator, CNA #68 felt a previous incident needed reported from a couple of weeks ago involving a tiny, Amish man [indicating Resident #27] who had behaviors such as being combative. CNA #69 and CNA #72 arm-in-arm transferred Resident #27 to change his incontinence brief. CNA #69 and CNA #72 flung him forward and swung him backwards into a recliner. CNA #68 felt the incident with Resident #27 was abusive. When CNA #68 was asked why she waited to report the incident involving Resident #27, CNA #68 stated it was her first couple of weeks working at the facility, she didn't know the people, didn't want confrontation, didn't know how to go about it, and she was scared. Interview on 06/01/26 at 12:25 P.M. with the Administrator verified CNA #68 should have immediately reported the allegation of abuse if CNA #68 felt abuse had occurred. Review of the facility's Abuse, Mistreatment, Neglect, Misappropriation of Resident Property and Exploitation policy dated 2016 revealed mistreatment was defined as inappropriate treatment or exploitation of a resident. All incident and allegations of abuse, neglect, exploitation, mistreatment and misappropriation of resident property and all injuries of unknown source must be reported immediately to the Administrator or designee. This deficiency represents non-compliance investigated under Complaint Number 3024629. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 365632 | A. Building<br>B. Wing | 06/02/2026 |

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

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

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, Centers of Disease Control guidance, policy review and interview, the facility failed to implement written infection control policies and procedures for Enhanced Barrier Precautions (EBP) during a two-person staff transfer of Resident #27 within the resident's room. This affected one (Resident #27) of three residents reviewed for transfers. The census was 52. Findings include: Review of the medical record for Resident #27 revealed an admission date of 01/31/26 with diagnoses of dementia without behavioral disturbance, neurocognitive disorder with Lewy bodies, anxiety, fracture of femur, depression, and anemia. Review of the Minimum Data Set (MDS) 3.0 quarterly assessment dated [DATE] revealed Resident #27 was severely cognitively impaired, had physical behaviors four to six days during the assessment, rejected care one to three days during the assessment and required substantial/maximal assistance with transfers. Resident #27 resided on the secured-memory care unit. Review of the infection care plan revised on 03/18/26 revealed Resident #27 required enhanced barrier precautions (EBP) related to a chronic wound with interventions which included to 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. Review of the wound care nurse practitioner progress note dated 06/01/26 revealed Resident #27 had a stage-three pressure ulcer to the right buttock and sacrum. Review of the June 2026 physician orders revealed Resident #27 was ordered EBP's; the order began 03/16/26. Observation on 06/01/26 at 1:00 P.M. revealed the Centers of Disease Control (CDC) Enhanced Barrier Precautions sign was posted on the wall out of Resident #27's room. The sign indicated to, wear gloves and a gown for the following high-contact resident care activities which included transferring. There was a door caddy hanging within Resident #27's room with PPE within the door caddy. Certified Nursing Assistant (CNA) #60 and CNA #78 donned gloves only, and each CNA arm-in-arm transferred Resident #27 from his wheelchair to his bed; CNA #60 and #78 did not don gowns before or during the transfer. Interview, after the observation, with CNA #60 and CNA #78 verified they did not don a gown during the transfer. Both CNA's believed they didn't need to don a gown anymore because the resident's buttock wound was closed and CNA's didn't think Resident #27's EBP order had been updated to reflect that. Interview on 06/01/26 at 1:05 P.M. with Assistant Director of Nursing (ADON) #74 revealed Resident #27's had a stage-three pressure ulcer on his buttock and the wound was not closed. ADON #74 verified CNA #60 and CNA #78 should have donned a gown when transferring Resident #27 within his room. Interview on 06/01/26 at 1:08 P.M. with Regional Registered Nurse (RRN) #76 verified the CNA's should have donned a gown when transferring Resident #27 within his room. Review of the facility's EBP policy revised 05/01/25 revealed EBP were used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high-contact resident care activities that provided opportunities for transfer of Multidrug-resistant Organisms (MDROs) to staff hands and clothing. EBP were indicated for resident's with any of the following: chronic wounds and/or indwelling medical device even if the resident was not known to be infected or colonized with a MDRO. For the purpose of this policy, chronic wounds did not include shorter-lasting wounds . Examples of chronic wounds included pressure ulcers. For residents identified requiring EBP's, staff would wear gloves and gowns when performing the following high-contact resident care activities while in a resident room, shower room and during therapy: transferring. Review of the CDC's Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs) guidance revised 04/02/24 revealed expand the use of PPE and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. MDROs may be indirectly transferred from resident-to-resident during these high-contact care activities. Nursing home residents with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDROs. The use of gown and<br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | gloves for high-contact resident care activities is indicated, when Contact Precautions do not otherwise apply, for nursing home residents with wounds and/or indwelling medical devices regardless of MDRO colonization as well as for residents with MDRO infection or colonization. Examples of high-contact resident care activities requiring gown and glove use for Enhanced Barrier Precautions include: transferring. This deficiency is based on an incidental finding discovered during the course of this complaint investigation. |