

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365740	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/18/2025
NAME OF PROVIDER OR SUPPLIER Majestic Care of Clyde		STREET ADDRESS, CITY, STATE, ZIP CODE 700 Helen Street Clyde, OH 43410	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, resident interview, staff interview, review of self reported incident, review of facility investigation, and review of facility policy, the facility failed to prevent sexual abuse. This affected three (#12, #15, and #25) of four residents reviewed for abuse. The facility census was 57.</p> <p>Findings include:</p> <p>1. Review of the medical record revealed Resident #25 was admitted on [DATE]. Diagnoses included atherosclerotic heart disease of native coronary artery without angina pectoris, diabetes mellitus due to underlying condition with hyperglycemia, essential hypertension, hemiplegia affecting right dominant side, schizoaffective disorder, major depressive disorder, and cognitive communication deficit.</p> <p>Review of the Minimum Data Set (MDS) assessment, dated 04/21/25, revealed the resident was moderately cognitively impaired.</p> <p>Review of the medical record revealed Resident #25 had a guardian.</p> <p>Review of care plan, revised on 06/10/25, revealed Resident #25 had a history of aggressive/inappropriate behavior. Resident #25 has thrown chairs, urinated in the dining room, presented with verbal or physical aggression, acted impulsively, exposed himself, masturbated in public areas, wandered into female rooms and exposed himself, and moved to the secure unit for increased engagement.</p> <p>Review of care plan, revised on 06/17/25, revealed Resident #25 demonstrated cognitive impairment related to impaired decision making, poor logic, poor ability to understand cause and effect, and sexually inappropriate at times.</p> <p>Review of nursing progress note, dated 05/26/25 at 1:51 P.M., revealed Resident #25 was wandering in and out of female resident rooms. Resident #25 was found in Resident #12's room and when asked why he was in there, resident response was that he wanted to have sex. Resident #25 immediately removed and went to activities.</p> <p>Review of nursing progress note, dated 05/26/25 at 9:18 P.M., revealed Resident #25 was found in Resident #12's room, standing over the bed with his penis exposed. Resident was immediately removed and taken to the activities lounge.</p> <p>(continued on next page)</p>

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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Self-Reported Incident (SRI) #260924, dated 05/28/25, revealed during a clinical review it was noted in a progress note on 05/26/25 nursing staff found Resident #25 had been in Resident #12's room standing over the bed with his penis exposed. Staff interviews conducted revealed staff reporting they discovered Resident #25 feeling Resident #12's breasts over her clothing and his penis was exposed. Residents had been immediately separated and redirected with increased monitoring provided throughout the night. Staff reported the residents were upset about being separated but no behaviors were noted after the incident. Skin evaluations were conducted with no areas of concern. Resident #12's room was moved further from Resident #25's room to keep him from wandering into her room. Psychiatric services were consulted with medication review with recommendations. Both residents present with moderate impairment. All resident's observed on the secured unit were interviewed/observed with no concerns of abuse identified. Psychosocial support provided by contracted services and staff were educated.</p> <p>Review of witness statements, dated 05/28/25, revealed Certified Nursing Assistant (CNA) #108 verified she found Resident #25 in Resident #12's room. Resident #25's pants were down and he was facing towards Resident #12's bed.</p> <p>Review of witness statements, dated 05/28/25, revealed CNA #131 verified Resident #25 was next to the residents bed with his penis exposed. Resident #25 and Resident #12 were holding hands, looking at each other smiling. Resident #12 had her brief on and was laying in the bed while Resident #25 was touching her breast. When the residents were separated Resident #12 was upset stating that she liked it when he touched her.</p> <p>Review of nursing progress note, dated 06/09/25, revealed Resident #25 was observed touching himself in front of another resident (Resident #15). Resident #25 was calm before the incident, no other behaviors were observed. Resident effected was not harmed nor exhibited any behaviors before or after the incident. All necessary parties were notified.</p> <p>Interview on 06/17/25 at 9:43 A.M. with Licensed Practical Nurse (LPN) #109 verified Resident #25 has touched his penis under his clothing in front of other residents.</p> <p>Interview on 06/17/25 at 10:52 A.M. with Registered Nurse (RN) #128 verified Resident #25 has exposed himself during night shift. RN #128 stated she has not observed him expose himself but has observed him in the lounge with his hands in his pants masturbating.</p> <p>2. Review of the medical record revealed Resident #12 was admitted on [DATE]. Diagnoses included spontaneous rupture of extensor tendons right ankle and foot, unspecified dementia, and obsessive compulsive disorder.</p> <p>Review of the MDS assessment, dated 06/02/25, revealed the resident was moderately cognitively impaired.</p> <p>Review of the medical record revealed Resident #12 had a guardian.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility SRI #260924, dated 05/28/25, revealed during a clinical review it was noted in a progress note on 05/26/25 nursing staff found Resident #25 had been in Resident #12's room standing over the bed with his penis exposed. Staff interviews conducted revealed staff reporting they discovered Resident #25 feeling Resident #12's breasts over her clothing and his penis was exposed. Residents had been immediately separated and redirected with increased monitoring provided throughout the night. Staff reported the residents were upset about being separated but no behaviors were noted after the incident. revealed Resident #12 will lay in bed naked in view of others and refuses to don clothes.</p> <p>Interview on 06/17/25 at 12:50 P.M. with Resident #12 states she does not remember the incident and states she feels safe at the facility.</p> <p>3. Review of the medical record revealed Resident #15 was admitted on [DATE]. Diagnoses included vascular dementia, major depressive disorder recurrent severe with psychotic symptoms, age related osteoporosis, essential hypertension, and muscle weakness.</p> <p>Review of the MDS assessment, dated 03/28/25, revealed the resident is rarely understood.</p> <p>Review of the medical record revealed Resident #15 had a guardian.</p> <p>Review of the care plan, initiated on 06/12/25, revealed Resident #15 exhibits behavior of inappropriate touching (attempting to rub another person's back, reaching for a leg, shoulder rubbing or bumping into others). History of making crude, sexually oriented profane, or suggestive remarks.</p> <p>Interview on 06/17/25 at 9:43 A.M. with Licensed Practical Nurse (LPN) #109 verified Resident #25 has touched his penis under his clothing in front of other residents.</p> <p>Interview on 06/17/25 at 9:59 A.M. with CNA #120 verified Resident #25 stood in front of Resident #15 and exposed his penis.</p> <p>Interview on 06/17/25 at 10:25 A.M. with CNA #200 verified Resident #25 has stood in front of Resident #15 and touch his penis under his shorts or expose himself to the resident.</p> <p>Interview on 06/18/25 at 3:15 P.M. with the DON verified the unidentified resident in Resident #15's nursing progress note date 06/09/25 was in reference to Resident #25 touching himself in front of Resident #15.</p> <p>Review of policy, Abuse, Mistreatment, Neglect, Exploitation, and Misappropriation, dated 09/06/24, verified residents have the right to be free from abuse, neglect, exploitation, and misappropriation of resident property. This includes sexual abuse. Sexual abuse is a non-consensual sexual contact of any type with a resident.</p> <p>This deficiency represents non-compliance investigated under Master Complaint Number OH00166360.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, review of self reported incidents, and review of facility policy the facility failed ensure all allegations of abuse were reported and reported timely. This affected three (#12, #15, and #25) of four residents reviewed for abuse. The facility census was 57.</p> <p>Findings include:</p> <p>1. Review of Self-Reported Incident (SRI) #260924, dated 05/28/25, revealed during a clinical review it was noted in a progress note on 05/26/25 nursing staff found Resident #25 had been in Resident #12's room standing over the bed with his penis exposed. Staff interviews conducted revealed staff reporting they discovered Resident #25 feeling Resident #12's breasts over her clothing and his penis was exposed. Residents had been immediately separated and redirected with increased monitoring provided throughout the night. Staff reported the residents were upset about being separated but no behaviors were noted after the incident. Skin evaluations were conducted on involved and like residents with no areas of concern. Resident #12's room was moved further from Resident #25's room to keep him from wandering into her room. Psychiatric services were consulted with medication review with recommendations. Both residents present with moderate impairment. All resident's observed on the secured unit were interviewed/observed with no concerns of abuse identified. Psychosocial support provided by contracted services and staff were educated.</p> <p>Review of the medical record revealed Resident #25 was admitted on [DATE]. Diagnoses included atherosclerotic heart disease of native coronary artery without angina pectoris, diabetes mellitus due to underlying condition with hyperglycemia, essential hypertension, hemiplegia affecting right dominant side, schizoaffective disorder, major depressive disorder, and cognitive communication deficit.</p> <p>Review of the Minimum Data Set (MDS) assessment, dated 04/21/25, revealed the resident was moderately cognitively impaired.</p> <p>Review of nursing progress note, dated 05/26/25 at 9:18 P.M., revealed Resident #25 was found in Resident #12's room, standing over the bed with his penis exposed. Resident was immediately removed and taken to the activities lounge.</p> <p>Review of the medical record revealed Resident #12 was admitted on [DATE]. Diagnoses included spontaneous rupture of extensor tendons right ankle and foot, unspecified dementia, obsessive compulsive disorder.</p> <p>Review of the MDS assessment, dated 06/02/25, revealed the resident was moderately cognitively impaired.</p> <p>Interview on 06/18/25 at 2:20 P.M. with the Director of Nursing (DON) verified SRI #260924 was not reported timely. The DON verified the incident occurred on 05/26/25 and was not reported until it was discovered on 05/27/25 after a clinical review meeting.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. Review of nursing progress note, dated 06/09/25, revealed Resident #25 was observed touching himself in front of another resident. Resident #25 was calm before the incident, no other behaviors were observed. Resident effected was not harmed nor exhibited any behaviors before or after the incident. All necessary parties were notified.</p> <p>Review of the medical record revealed Resident #15 was admitted on [DATE]. Diagnoses included vascular dementia, major depressive disorder recurrent severe with psychotic symptoms, age related osteoporosis, essential hypertension, and muscle weakness.</p> <p>Review of the MDS assessment, dated 03/28/25, revealed the resident is rarely understood.</p> <p>Review of SRI's, dated June 2025, revealed there was no report of alleged abuse with Resident #25 and Resident #15.</p> <p>Interview on 06/17/25 at 9:59 A.M. with CNA #120 verified Resident #25 stood in front of Resident #15 and exposed his penis.</p> <p>Interview on 06/17/25 at 10:25 A.M. with CNA #200 verified Resident #25 has stood in front of Resident #15 and touch his penis under his shorts or expose himself to the resident.</p> <p>Interview on 06/17/25 at 12:07 P.M. with the DON verified an allegation of abuse was not reported as a SRI for all allegations of abuse including the incident on 06/09/25 when Resident #25 was observed touching himself in front if another resident as indicated in the progress note.</p> <p>Interview on 06/18/25 at 3:15 P.M. with the DON verified the unidentified resident in Resident #15's nursing progress note date 06/09/25 was in reference to Resident #25 touching himself in front of Resident #15.</p> <p>Review of policy, Abuse, Mistreatment, Neglect, Exploitation, and Misappropriation, dated 09/06/24, verified the care team members should immediately report all allegations to the Administrator and to the Department of Health in accordance with the procedures in this policy. All incidents and allegations of abuse must be reported immediately to the Administrator or designee. If abuse is alleged the Administrator or designee will notify the Department of Health immediately but not later than two hours after the allegation is made.</p> <p>This deficiency represents non-compliance investigated under Master Complaint Number OH00166360.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, review of self reported incidents, and review of facility policy the facility failed ensure all allegations of abuse were investigated and thoroughly investigated. This affected three (#12, #15, and #25) of four residents reviewed for abuse. The facility census was 57.</p> <p>Findings include:</p> <p>1. Review of Self-Reported Incident (SRI) #260924, dated 05/28/25, revealed during a clinical review it was noted in a progress note on 05/26/25 nursing staff found Resident #25 had been in Resident #12's room standing over the bed with his penis exposed. Staff interviews conducted revealed staff reporting they discovered Resident #25 feeling Resident #12's breasts over her clothing and his penis was exposed. Residents had been immediately separated and redirected with increased monitoring provided throughout the night. Staff reported the residents were upset about being separated but no behaviors were noted after the incident. Skin evaluations were conducted on involved and like residents with no areas of concern. Resident #12's room was moved further from Resident #25's room to keep him from wandering into her room. Psychiatric services were consulted with medication review with recommendations. Both residents present with moderate impairment. All resident's observed on the secured unit were interviewed/observed with no concerns of abuse identified. Psychosocial support provided by contracted services and staff were educated.</p> <p>Review of the medical record revealed Resident #25 was admitted on [DATE]. Diagnoses included atherosclerotic heart disease of native coronary artery without angina pectoris, diabetes mellitus due to underlying condition with hyperglycemia, essential hypertension, hemiplegia affecting right dominant side, schizoaffective disorder, major depressive disorder, and cognitive communication deficit.</p> <p>Review of the Minimum Data Set (MDS) assessment, dated 04/21/25, revealed the resident was moderately cognitively impaired.</p> <p>Review of nursing progress note, dated 05/26/25 at 9:18 P.M., revealed Resident #25 was found in Resident #12's room, standing over the bed with his penis exposed. Resident was immediately removed and taken to the activities lounge.</p> <p>Review of nursing progress note, dated 06/09/25, revealed Resident #25 was observed touching himself in front of another resident (Resident #15). Resident #25 was calm before the incident, no other behaviors were observed. Resident effected was not harmed nor exhibited any behaviors before or after the incident. All necessary parties were notified.</p> <p>Review of the medical record revealed Resident #12 was admitted on [DATE]. Diagnoses included spontaneous rupture of extensor tendon right ankle and foot, unspecified dementia, and obsessive compulsive disorder.</p> <p>Review of the MDS assessment, dated 06/02/25, revealed the resident was moderately cognitively impaired.</p> <p>Interview on 06/17/25 at 2:09 P.M. with the Director of Nursing (DON) verified the police were not notified of the alleged abuse involving Resident #12 and Resident #25 in SRI #260924.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. Review of the medical record revealed Resident #15 was admitted on [DATE]. Diagnoses included vascular dementia, major depressive disorder recurrent severe with psychotic symptoms, age related osteoporosis, essential hypertension, and muscle weakness.</p> <p>Review of the MDS assessment, dated 03/28/25, revealed the resident is rarely understood.</p> <p>Interview on 06/17/25 at 9:59 A.M. with CNA #120 verified Resident #25 stood in front of Resident #15 and exposed his penis.</p> <p>Interview on 06/17/25 at 10:25 A.M. with CNA #200 verified Resident #25 has stood in front of Resident #15 and touch his penis under his shorts or expose himself to the resident.</p> <p>Interview on 06/17/25 at 12:07 P.M. with the DON verified an investigation was not conducted for an allegation of abuse related to the incident described in a progress note on 06/09/25 affecting Resident #15 and Resident #25.</p> <p>Review of policy, Abuse, Mistreatment, Neglect, Exploitation, and Misappropriation, dated 09/06/24, verified once the Administrator and the Department of Health are notified, an investigation of the allegation violation will be conducted.</p> <p>This deficiency represents non-compliance investigated under Master Complaint Number OH00166360.</p>		