

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365754	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/01/2024
NAME OF PROVIDER OR SUPPLIER Majestic Care of Columbus LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 44 S Souder Ave Columbus, OH 43222	

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 0624</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Prepare residents for a safe transfer or discharge from the nursing home.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44070</p> <p>Based on closed record review, review of e-mail communication, facility policy review and interview the facility failed to ensure an orderly discharge for Resident #79, when the facility did not timely inform the resident of a planned discharge and packed the resident's belongings without her knowledge or involvement. This affected one resident (#79) of three residents reviewed for discharge. The facility census was 75.</p> <p>Findings include</p> <p>Review of the closed medical record for Resident #79 revealed an admitted [DATE] with diagnoses including diabetes, anxiety, delusion disorder and paranoid schizophrenia. Record review revealed the resident was discharged from the facility on 09/26/24.</p> <p>Record review revealed the facility issued Resident #79 a 30-day discharge notice on 05/23/24 due to the safety of individuals in the home being endangered. The notice reflected the resident would be discharged on [DATE] and provided the resident her rights to appeal the notice. The resident refused to sign the notice. However, an appeal was generated, and a hearing was held on 06/18/24. As a result of the hearing, the facility retained the right to discharge the resident to an appropriate location.</p> <p>Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #79 was cognitively intact with a Brief Interview of Mental Status (BIMS) score of 15 (out of 15) indicating the resident was cognitively intact. The assessment revealed the resident required only supervision and set up with activities of daily living and was ambulatory.</p> <p>Review of the resident's medical record revealed the facility had made multiple referrals to other skilled nursing facilities for the resident to transfer to following the discharge hearing. However, the resident was not accepted by these facilities due to identified behaviors she had and/or income issues.</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 0624</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of email communications from the facility previous Administrator (Administrator #100) and the Ombudsman dated 09/12/24 revealed Administrator #100 informed the Ombudsman Resident #79's behaviors had continued and the facility wanted to issue an immediate (discharge) notice and discharge the resident to a shelter. The Ombudsman responded and informed Administrator #100 a shelter was not appropriate as the resident met level of care for a long-term care facility and a homeless shelter would not be an appropriate discharge. The email noted the Ombudsman provided resources and education to Administrator.</p> <p>A progress note dated 09/24/24 revealed Facility #500 (a skilled nursing facility) came for an onsite visit (to see Resident #79) for possible admission and had discussion with the resident at that time. There was no evidence the resident was refusing transfer to this facility at the time of the onsite visit. A second note dated 09/26/24 revealed Facility #500 accepted Resident #79 for admission.</p> <p>Review of email communications from previous Administrator #100 on 09/26/24 at 8:50 A.M. to the Ombudsman revealed a facility had accepted Resident #79 and pick-up was scheduled for 1:00 P.M. this date. He also confirmed Resident #79 had not yet been informed and the facility wanted a police officer present when she was notified as we cannot physically make her get on the bus, but we are certainly within our right to let her know we have fulfilled our obligation to provide a safe discharge location, and she will have to leave the property. The email stated Administrator would inform the sister as well.</p> <p>Review of IDT discharge planning summary dated 09/26/24 revealed Resident #79 was to be transferred to the nursing home (Facility #500) and was independent with mobility.</p> <p>Review of email communications on 09/26/24 at 3:00 P.M. from Resident #79's sister to the Ombudsman revealed Resident #79 was outside without her wheelchair and personal items and the facility would not allow her back in. They packed all of her stuff while she was outside her room and then told her to get on the bus. The sister stated Resident #79 declined to get on the bus as the facility had refused to tell her where she was going and about the facility she was going to.</p> <p>A progress note documented on 09/26/24 at 8:51 P.M. revealed Resident #79 refused to get on the transport bus, refused to leave the property, and became aggressive. Police were contacted and subsequently escorted the resident off the property and facility staff informed the resident along with police that if she returned to the property, she would be trespassing.</p> <p>A note dated 09/27/24 at 1:44 P.M. revealed facility social services staff contacted [NAME] County Adult Protective Services (APS) and informed them of the situation as the resident had been discharged but her whereabouts were unknown by the facility. The note indicated APS was notified the resident was her own person and the note indicated there were no safety concerns at the time of discharge. A social services note revealed the facility contacted the accepting facility (Facility #500) on 09/27/24 at 1:45 P.M. and was informed Resident #79 had just arrived at their facility.</p> <p>Interview on 10/01/24 at 9:28 A.M. with Ombudsman #120 revealed Resident #79 had been given a discharge notice several months ago and the facility was informed by another Ombudsman they (the facility) was still responsible to ensure a safe discharge and that did not include a shelter or the streets. Ombudsman #120 revealed the accepting facility, Facility #500 had been contacted on 09/27/24 around 1:00 P.M. and they confirmed Resident #79 had arrived and been admitted .</p> <p>(continued on next page)</p>		

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<p>F 0624</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 10/01/24 at 9:36 A.M. with Ombudsman #110 revealed Resident #79 had been given a discharge notice in 05/2024 and had a hearing that upheld the facility's ability to discharge the resident in 06/2024. Ombudsman #110 revealed the facility had sent out several referrals and the resident had been denied (admission). She revealed the facility previous Administrator (#100) wanted to discharge the resident to the shelter and was informed that was not safe or appropriate and the facility needed to find a safe discharge plan. Ombudsman #100 also revealed numerous conversations by phone and email related to the discharge of Resident #79 on 09/26/24 and 09/27/24 where staff did not keep resident updated or provide a timely notice, packed her belongings without her knowledge and placed them on a transport bus and when the resident refused to get on the bus had the police remove her off the property. The Ombudsman voiced concerns the resident's whereabouts were then unknown from 09/26/24 at about 6:00 P.M. until about 1:00 P.M. on 09/27/24.</p> <p>Interview on 10/01/24 at 9:52 A.M. with Director of Nursing (DON) #130 from accepting Facility #500 and Unit Manager #140 revealed Resident #79 was scheduled to arrive to their facility on 09/26/24 in the afternoon but did not show up. They revealed Resident #79 called on 09/27/24 and asked about coming to the facility, and then arrived around 1:00 P.M. Unit Manager #140 revealed the resident was dropped off in a private car. The resident's personal belongings/equipment from the facility had arrived to the receiving facility the previous day.</p> <p>Interview on 10/01/24 at 11:10 A.M. with Scheduler #150 revealed on 09/26/24 facility staff packed Resident #79's belongings and placed them on the transport bus. She was not aware of the resident being involved in this process.</p> <p>Interview on 10/01/24 at 11:27 A.M. with previous Administrator #100 revealed he believed Resident #79 had been informed of her discharge, but when asked about the email communication from the Ombudsman, the Administrator verified the resident had not been told about the planned discharge until shortly before the resident was to get on the bus to transfer at which time the resident became combative and was refusing to get on the bus. Administrator #100 revealed the bus had stayed while they tried to convince the resident to get on it, but eventually the bus had to go to. The Administrator verified the resident's belongings were sent to the new facility at that time. Administrator #100 revealed due to the resident's aggression, the police were contacted. However, they were delayed in responding for about three to four hours. When police arrived, Resident #79 was informed by Administrator #100 and police that she had to leave and could not return to the facility property. Police escorted the resident to a back road behind the facility. The resident was told if she returned, she would be charged with trespassing. Administrator #100 revealed the facility chose to not press charges but just wanted the resident to leave.</p> <p>Interview on 10/01/24 at 12:00 P.M. with the facility current administrator, Administrator #175 revealed she was training the day (09/26/24) this situation occurred and could not confirm who or when Resident #79 was told about the transport and plan for discharge to the receiving facility which was about 45 minutes away. She also confirmed the facility packed up Resident #79's belongings without the resident's knowledge and placed them on the bus as an attempt to get her to leave and revealed even when the resident declined to get on the bus, her belongings were not returned to her in an attempt to get her to leave the property. Administrator #175 revealed the facility was unaware of the resident's whereabouts from 09/26/24 around 6:00 P.M. to 09/27/24 around 1:00 P.M. but stated that doesn't mean she was unsafe as she had street smarts.</p> <p>(continued on next page)</p>		

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<p>F 0624</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 10/01/24 at 3:34 P.M. with Social Services (SS) #180 and Corporate Social Services #185 revealed they were not sure who informed the resident of her discharge to Facility #500, transportation time, and overall plan for discharge prior to or on 09/26/24. SS #180 revealed she believed Resident #79 was aware of the possibility of the discharge because Facility #500's liaison had come to the facility to meet with Resident #79 on 09/24/24; however, she could not confirm any conversations after the meeting about being accepted or a plan for transfer at 1:00 P.M. on 09/26/24. SS #180 and Corporate Social Services #185 revealed it was possible the previous facility administrator may have kept it quiet as he wanted police presence when they told Resident #79; however, the police did not arrive to the facility on [DATE] until around 6:00 P.M.</p> <p>On 10/02/24 at 2:46 P.M. a telephone interview with Resident #79 verified she left the facility on [DATE] after being walked to the sidewalk by police and told not to come on the (facility) property. The resident had her cell phone with her. Resident #79 stated she contacted a friend where she stayed the night on 09/26/24 and then the friend drove her to the new facility about 45 minutes away on 09/27/24. During the interview, Resident #79 revealed she did not get on the (facility) bus (on 09/26/24) when facility staff asked her to because she was only told of the discharge about an hour before and also stated facility staff would not tell her where she was going or what the facility would be like. Resident #79 stated she arrived at the new facility (on 09/27/24) without any new injuries.</p> <p>On 10/03/24 at 4:23 P.M. a telephone interview with responding police Officer #1 and Officer #2 revealed they were called to the facility (on 09/26/24) but were delayed in responding due to other activity in the community. When they arrived at the facility, the administration provided them a copy of the legal notice to discharge Resident #79 and the resident's discharge paperwork with the new facility name on the paperwork. Officer #1 stated the facility said Resident #79 had new housing set up, she refused to get on the bus, and the bus left. The administration stated Resident #79 then attempted to re-enter the facility, was denied and became belligerent yelling and screaming about the facility evicting her. Officer #1 stated he did not observe Resident #79 or facility staff acting inappropriately while on the property. Officer #1 stated he did provide the resident the discharge paperwork from the facility which included the name of the facility she was being transferred to. The Officer also stated he put the new facility's phone number in Resident #79's personal cell phone. Officer #1 stated Resident #79 told him she was going to call her sister, and she was escorted off the property by the officers. There was no indication the resident was unsafe or in danger. Officer #2 added to the interview that he had knowledge of Resident #79 from prior interactions the police had at the facility in the past, but he had no experience of Resident #79 being belligerent in her interactions with the facility and its staff.</p> <p>On 10/04/24 at 10:40 A.M. a follow-up interview with DON #130 revealed their facility staff believed Resident #79 was going to arrive on 09/26/24 in the afternoon with a second resident being admitted to their facility from this transferring facility and it was the transferring facility providing the resident's transportation. However, upon arrival Resident #79 was not present and there was no additional communication from the transferring facility related to the status of the resident. DON #130 revealed the facility had been provided a transfer level of care (LOC) dated 05/31/24 that allowed for the resident's transfer from one nursing facility to the other, however a subsequent LOC following admission revealed the resident did not meet LOC and the facility was working with Home Choice to assist the resident to discharge to the community after a 60 day stay (which was required due to a break in nursing home stays). DON #130 revealed upon the resident's arrival to their facility on 09/27/24 there were no concerns with her condition or evidence of immediate harm to the resident. The resident was alert and oriented and pleasant.</p> <p>(continued on next page)</p>		

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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility policy titled, Transfer and Discharge, dated 01/02/24 revealed the facility shall ensure a safe and orderly transfer or discharge from the facility and assist in arrangement as needed for a transfer. This deficiency represents non-compliance investigated under Complaint Number OH00158325.		