STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365754	A. Building B. Wing	08/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Majestic Care of Columbus LLC	44 S Souder Ave Columbus, OH 43222

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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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44070 Based on record review and staff interview, facility failed to ensure Pre Admission Screening and Record Review's (PASRR) were completed accurately and timely upon change in condition and results were submitted to the state designated authority for review. This affected four Residents (#31, #69, #74, and #11) of 12 reviewed for PASSR. Facility census was 75. Findings include 1. Review of the medical record for Resident #31 revealed an admitted [DATE]. Diagnoses included dementia, paranoid schizophrenia, Alzheimer's disease, depression, unspecified psychosis, psychotic disorder, and mood disorder. Review of the PASRR dated 02/15/19 revealed schizophrenia and mood disorder were documented. Unspecified psychosis was diagnosed [DATE], Alzheimer's was diagnosed [DATE], and dementia and psychotic disorder was documented 07/08/24 and were not updated on the PASRR. Interview on 07/30/24 at 6:17 P.M. with Social Services Director (SSD) #214 confirmed Resident #31's PASRR was not updated with all mental disorders. 2. Review of the medical record for Resident #69 revealed an admitted [DATE]. Diagnoses included paranoid schizophrenia, Alzheimer's disease, dementia, and anxiety. Review of the PASRR dated 07/15/23 revealed schizophrenia and anxiety were documented. Alzheimer's disease was diagnosed on [DATE] and dementia with mood disturbance was diagnosed on [DATE]. There was not a current PASRR document which reflected the resident's diagnosis of dementia with mood disturbance. Interview on 07/30/24 at 6:17 P.M. with SSD#214 confirmed Resident #69's PASRR was not updated with all mental disorders. 49039 3. Review of Resident #74 medical record revealed the resident was admitted to the facility on [DATE] with diagnosis of unspecified mood disorder, an additional diagnosis of major depressive disorder was added on 07/08/24. (continued on next page)

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

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Minimum Data Set (MDS) 3.0 assessment dated [DATE] completed for Resident #74 revealed he was severely cognitively impaired. Section I of the MDS indicated an active diagnosis of mood disorder. Review of Resident #72 approval for level two services revealed diagnoses of mood disorder and cocaine abuse were listed. Interview on 07/20/24 at 4:51 P.M. conducted with SSD #214 confirmed Resident #74 had a current diagnosis of depression which was not included when the PASRR was submitted and SSD #214 confirmed an updated and accurate PASRR was not completed. 4. Review of Resident #11 medical record revealed he was admitted to the facility on [DATE] with diagnoses of type two diabetes mellitus and polyneuropathy. Resident had mental health diagnoses added on 07/01/24 and 07/08/24 which included sleep disorder, major depressive disorder, generalized anxiety disorder and bipolar disorder. Review of Minimum Data Set (MDS) 3.0 assessment dated [DATE] completed for Resident #11 revealed he was cognitively intact. Review of Resident #11's Preadmission Screening and Resident Review (PASRR) screen dated 06/03/24 revealed he had no mental health diagnoses. Interview on 07/20/24 at 4:51 P.M. with SSD #214 confirmed Resident #11 had current diagnoses of depression, bipolar disorder, and insomnia and an updated and accurate PASRR was not completed. Review of the facility policy, Resident Assessment-Coordination with PASARR Program, dated 09/18/23, revealed the policy stated, The Social Services Director shall be responsible for keeping track of each resident's PASARR screening status, and referring to the appropriate authority. Any resident who exhibits a newly evident or possible serious mental disorder, intellectual disability, or a related condition will be referred promptly to the state mental health or intellectual disability authority for a Level II resident review.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44070 Based on record review and staff interview, the facility failed to ensure a Pre Admission Screening and Resident Review (PASRR) was completed after resident remained in the facility over 30 days. This affected one Resident (#76) of one reviewed for initial PASRR's. Facility census was 75. Findings include Review of the medical record for Resident #76 revealed an admitted [DATE]. Diagnoses included chronic obstructive pulmonary disease, pulmonary embolism, diverticulosis, hydrocele, nutritional anemia, and dysuria. Review of the hospital exemption dated [DATE] revealed resident had no diagnosis of mental disorders. Record review found no evidence of facility completing a PASRR for Resident #76 after he remained in the facility after 30 days. Interview on [DATE] at 6:00 P.M. with Regional Nurse #271 revealed the facility had a consulting company to complete PASRR audits and help in completing the PASRR assessments. Interview on [DATE] at 6:15 P.M. with Social Services Assistant (SSA) #228 revealed facility used a consulting service who would complete audits and inform staff which PASSR's needed updated. Interview on [DATE] at 6:17 P.M. with Social Services Director #214 confirmed Resident #76 did not have a PASRR completed after the hospital exemption expired. She confirmed facility had no documentation or evidence to provide related to the PASRR being completed. Review of facility policy titled, Preadmission screening and Resident Review (PASRR), dated [DATE] revealed facility shall coordinate assessments with preadmission screening and resident review. A record of screening shall be maintained in the residents medical record. Exceptions for the preadmission include residents admitted directly from the hospital but if they remain in the facility for over 30 days the facility shall complete the state level one screening process and refer residents accordingly to the appropriate state designated authority for further evaluation.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41266 Based on observation, medical record review, staff interview, Physician (MD) interview, Wound Care Certified Nurse Practitioner (WCCNP) interview and review of facility policy, the facility failed to accurately assess an area of skin impairment, failed to notify the physician, and failed to implement treatments timely and as ordered. This affected one resident (#62) of two residents reviewed for skin impairment/pressure ulcers. The facility census was 75. Findings include: Review of the medical record for Resident #62 revealed an admitted [DATE]. Medical diagnoses included quadriplegia, paralytic syndrome, neuromuscular dysfunction of bladder, neurogenic bowel, personal history of traumatic brain injury (TBI), and contractures of left and right knees and left and right upper arms. Review of the significant change Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #62 had intact cognition. The assessment revealed the resident was non-ambulatory with impairments on both sides of his upper and lower extremities. Resident #62 was totally dependent on one to two staff to complete all activities of daily living (ADLs) and was incontinent of both bowel and bladder. The resident had a suprapubic catheter in place. Review of a Change in Condition Evaluation dated 05/02/24 and completed by Former Licensed Practical Nurse (LPN) #320 revealed Resident #62 had a new pressure wound. There was no additional information included in the evaluation. Review of the incident report dated 05/02/24 at 6:50 A.M. and completed by LPN #320 revealed a State tested Nurse Aide (STNA) reported to the nurse that wounds were found on Resident #62's left outer thigh while providing care. The resident denied being abused by any staff or residents. Resident #62 stated the wound may have been caused by his wheelchair, but he was not sure. LPN #320 assessed the wound, and a treatment was ordered. Measurements to left hip/upper thigh were documented as 7.0 centimeters (cm) long by 5.0 cm wide and 2.5 cm long by 4.0 cm wide and a small skin tear measured 2.0 cm long by 1.0 cm wide. The ordered treatment included to cleanse with normal saline (NS), apply calcium alginate and cover with border dressing. The incident report indicated MD #311, resident representative, the Director of Nursing Services (DNS), and the Executive Director (ED) were notified. Resident #62 was added to wound rounds and a new intervention was implemented to place pillows between Resident #62 and the chair while the resident was up in his wheelchair. The wound location was noted to be the left thigh (front). The incident report did not indicate how the resident obtained the wound other than it could have been caused by the resident's wheelchair. Review of a physician order dated 05/02/24, and electronically signed by MD #311, revealed Resident #62 had a left hip wound treatment to cleanse the area with NS, pat dry, apply calcium alginate with silver, and cover with bordered dressing twice daily. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a non-pressure ulcer note dated 05/06/24 at 8:42 A.M. revealed Resident #62's left hip wound measured 3.0 cm long by 2.0 cm wide. The wound was described as having scant amount of serosanguineous (a combination of serous fluid and blood) drainage. There was noted erythema (redness) with attached wound edges. Ordered wound treatment included to cleanse with wound cleanser, apply Hydrogel to the base of wound, secure with bordered foam, and change daily. Review of wound care documentation dated 05/06/24 at 4:57 P.M. revealed WCCNP #310 assessed a left hip wound on Resident #62. The wound and classified it as a skin tear/laceration. The note indicated Resident #62 had fragile skin. Recommendations included avoiding friction/shear, careful handling during ambulation/assistance/transfer, use of daily emollients, long sleeves and pants when possible and prevent the use of adherent tape directly on the skin. Additionally, Resident #62 was noted to be at risk for skin breakdown and additional recommendations to keep the resident's skin clean and dry, apply barrier cream as necessary to prevent skin breakdown and avoid pressure on any bony prominence by adhering to turning protocols were provided. Treatment orders included cleanse with wound cleanser, apply Hydrogel to the base of the wound, secure with bordered foam, and change daily. The treatment was selected to promote autolytic debridement and moist wound healing within the wound bed. Review of wound care documentation dated 05/13/24 at 9:26 A.M. revealed Regional Clinical Lead (RCL - wound care provider) #312 assessed Resident #62's left hip wound. The wound was described as a partial thickness skin tear/laceration with stable eschar (dead tissue). The area measured 2.5 cm long by 4.5 cm wide with no depth. The wound base was 100% eschar with epithelium (a thin layer of tissue that covers organs) exposed. The wound was crosshatched (a type of debridement used to promote vascularity and facilitate penetration of the ointment into subcutaneous tissue). The wound treatment recommendation remained unchanged and included to cleanse with wound cleanser, apply Hydrogel to base of wound, secure with bordered foam, and change daily. Review of the care plan, revised 05/13/24, revealed Resident #62 had a skin tear to his left hip. Interventions included assess and document skin condition weekly and as needed, encourage fluids, observe for increase in size of bruise or development of new bruising, observe for signs of pain and provide pain medication as needed, observe the resident's environment for potential causes for skin trauma, document abnormal findings and notify the physician, keep area clean and dry, lotion skin with daily care, observe for symptoms of infection, and treatments as ordered. Review of a progress note dated 05/17/24 revealed Resident #62's left thigh wound had dark eschar tissue over the wound bed. A treatment order was obtained to cleanse the wound with wound cleanser, pat dry, apply Hydrogel, and cover with bordered foam. Review of the Treatment Administration Record (TAR) for May 2024 revealed from 05/02/24 through 05/17/24, Resident #62 received the following left hip wound treatment: cleanse with NS, pat dry, apply calcium alginate with silver, cover with bordered dressing and complete dressing change twice daily. On 05/17/24, the treatment order was changed to cleanse wound with wound cleanser, pat dry, apply Hydrogel, cover with bordered foam and complete every shift (treatment was implemented 11 days after WCCNP #310 ordered it on 05/06/24). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of wound care documentation dated 05/20/24 revealed WCCNP #310 assessed Resident #62's left hip wound. The wound measured 2.8 cm long by 4.5 cm wide with no depth. The calculated area was 12.6 square cm. The wound remained a partial thickness skin tear/laceration with 100% eschar. The wound was surgically debrided with pre and post debridement measurements remaining the same. Additionally, the note indicated 50% of the wound was debrided to remove necrotic tissue and biofilm (a microbial colony that can form in a wound and cause delayed healing). No treatment order changes were made. Review of wound care documentation dated 05/28/24 revealed WCCNP #310 assessed Resident #62's left hip wound. The wound measured 2.8 cm long by 4.0 cm wide with no depth. The calculated area was 11.2 square cm. There were no changes noted to the wound. The wound was surgically debrided and pre and post debridement measurements remained the same as above. Additionally, 50% of the wound was debrided to remove biofilm. There were no changes made to treatments. Review of wound care documentation dated 06/03/24 revealed WCCNP #310 assessed Resident #62's left hip wound. The wound was classified as a full-thickness skin tear/laceration. The wound status was stable and measured 4.0 cm long by 4.2 cm wide and had a depth of 0.3 cm, with a total calculated area of 16.8 cm. The wound was 100% epithelial with a moderate amount of serosanguineous drainage. The wound was surgically debrided to remove necrotic tissue and biofilm. No eschar was noted in the wound base assessment. WCCNP #310 ordered the following treatment: cleanse with wound cleanser, apply Dakins (mechanical debridement solution) moistened fluffed gauze to the base of the wound, secure with bordered foam and change twice daily. Review of the TAR for June 2024 revealed from 06/04/24 through 06/17/24, Resident #62 received the following left hip wound treatment: Dakins (full strength) external solution 0.5% (Sodium Hypochlorite) apply to left hip topically every shift, cleanse wound bed with Dakins solution, rinse with NS, apply Dakins soaked gauze, cover with a small abdominal (ABD) pad and bordered dressing. There was no documentation that the facility implemented WCCNP #310's treatment orders dated 06/03/24. Review of a wound rounds progress note dated 06/10/24 at 12:31 P.M. revealed Resident #62's left hip wound had a large amount of brownish slough (dead tissue within a wound) on the wound bed, lots of drainage on old dressing and a foul odor. The wound bed was cleansed and treated as ordered. Review of wound care documentation dated 06/10/24 at 4:52 P.M. revealed WCCNP #310 assessed Resident #62's left hip wound. The wound status was noted as stalled. The classification remained a full-thickness skin tear/laceration. There was no odor post cleansing. The wound was 4.0 cm long by 4.2 cm wide with a 1.0 cm depth. The calculated area was 16.8 square cm. The wound base was 1-24% granulation and 50-74% slough. There was a moderate amount of serosanguineous drainage. 50% of the wound was surgically debrided to remove biofilm. Pre and post debridement measurements remained the same as above. Further review revealed no evidence of treatment changes. Review of wound documentation dated 06/17/24 revealed WCCNP #310 assessed Resident #62's left hip wound and noted the wound to be stable. Wound measurements and the wound base remained unchanged. Additionally, 50% of the wound was surgically debrided to remove biofilm. The wound measured 4.0 cm long by 4.2 cm wide with a 1.0 cm depth. A new treatment was ordered to include cleanse with wound cleanser, apply Santyl (enzymatic debridement agent) apply Dakins moistened fluffed gauze to base of the wound, secure with bordered foam and change daily. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a physician order dated 06/17/24 revealed the following left hip wound treatment for Resident #62: Santyl Ointment 250 units/gram (gm) (Collagenase) with instructions to apply to left hip topically every shift. Cleanse wound with wound cleanser, pat dry, apply Santyl, cover with NS moistened gauze to activate Santyl, and cover with bordered gauze. Review of wound care documentation dated 06/24/24 revealed WCCNP #310 assessed Resident #62's left hip wound. The noted stated the wound was improving without complications. However, the wound measured 4.0 cm long by 4.2 cm wide and had a depth of 2.0 cm (deeper than previous assessment). The classification remained a full thickness skin tear/laceration. The total calculated area was 16.8 square cm. The wound base remained 1-24% granulation and 50-74% slough. 50% of the wound was surgically debrided to remove biofilm. The pre and post debridement measurements remained the same as above and there was no change to treatment orders. Review of the TAR for June 2024 revealed from 06/17/24 through 06/26/24, Resident #62 received the following left hip wound treatment: cleanse wound with wound cleanser, pat dry, apply Santyl, cover with NS moistened gauze to activate Santyl and cover with bordered gauze. The treatment was completed twice daily. On 06/27/24, the facility implemented WCCNP #310's treatment orders from 06/17/24, 10 days after the new treatment was ordered. Review of wound care documentation dated 07/01/24 revealed WCCNP #310 assessed Resident #62's wound. The classification remained a full thickness skin tear/laceration. The status was noted as improving with delayed wound closure. The wound measured 4.0 cm long by 4.0 cm wide with a 2.2 cm depth (deeper than the previous assessment). The wound base was 25-49% granulation and 25-49% slough. 50% of the wound was surgically debrided to remove biofilm. The pre and post debridement measurements remained the same as above and there were no changes to the treatment orders. Review of a wound rounds note dated 07/08/24 revealed WCCNP #310 ordered the following wound treatment for Resident #62: cleanse wound with wound cleanser, pat dry, apply Hydrogel, cover with bordered foam dressing and change twice daily. Review of the physician orders confirmed the order was electronically signed by MD #311. Further review of the medical record revealed no evidence WCCNP #310 visited the facility on 07/08/24. Review of wound care documentation dated 07/12/24 revealed WCCNP #310 assessed Resident #62's left hip wound. The classification remained a full thickness skin tear/laceration. The status remained improving with delayed wound closure. The wound measured 4.0 cm long by 3.9 cm wide with a 2.1 cm depth. The total calculated area was 15.6 square cm. The wound base was 50-74% granulation and 1-24% slough. The note indicated the wound had exposed tissues, including tendon/ligament and muscle/fascia (not noted in previous assessments). 50% of the wound was surgically debrided to remove biofilm. The pre and post debridement measurements remained the same as above. WCCNP #310 continued the previous wound treatment, which included cleanse with wound cleanser, apply Santyl, Dakins moistened fluffed gauze to base of wound, secure with bordered foam, and change daily. (There was no evidence the wound treatment recommendation included Hydrogel as indicated in the physician order dated 07/08/24). Review of a physician order dated 07/15/24 revealed a wound treatment for Dakins (1/2 strength) External Solution (Sodium Hypochlorite) with instructions to apply to Resident #62's left hip topically every shift. cleanse wound bed with Dakins, pack with Dakins soaked gauze, and cover with bordered foam. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of wound care documentation dated 07/22/24 at 3:59 P.M. revealed WCCNP #310 assessed Resident #62's wound as unchanged and improving without complications. The wound measured 4.2 cm long by 4.5 cm wide with a 2.0 cm depth (larger than the previous assessment). The total calculated area was 18.9 square cm (approximately 3.0 cm larger than the previous assessment). The wound base was 50-74% granulation with no other description of the wound appearance. Exposed tissues included tendon/ligament and muscle/fascia. There was no evidence the wound was surgically debrided during the visit and the treatment remained unchanged. Review of wound care documentation dated 07/29/24 revealed WCCNP #310 assessed Resident #62's left hip wound as unchanged as a full thickness skin tear/laceration. The wound status was noted to be stable. The wound measurements remained unchanged from the previous assessment. The wound base was 50-74% granulation. Tendon/ligament and muscle/fascia remained exposed. 50% of the wound was surgically debrided to remove biofilm. The pre and post debridement measurements remained the same as above. However, a description of the procedure indicated a surgical excisional debridement of devitalized muscle was performed. The wound treatment remained unchanged. Review of the TAR for July 2024 revealed on 07/15/24, Resident #62's left hip wound treatment was changed to cleanse wound bed with Dakins, pack with Dakins soaked gauze, and cover with bordered foam. The treatment was completed twice daily. There was no evidence the physician order documented on 07/08/24 was implemented and review of WCCNP #310's notes confirmed there was no order to pack the wound with Dakins soaked gauze (order was for Dakins moistened fluffed gauze) as the facility implemented on 07/15/24. Observation and interview with Resident #62 on 07/31/24 at 12:26 P.M. revealed the resident was in his room sitting in his custom tilt wheelchair eating lunch meal. Resident #62 stated he did not know how he acquired the wound to his left hip but stated it was the worst. Resident #62 reported he had wounds to his right heel and hip that were improving but the wound on his left hip seemed to be getting worse. The resident did not have an explanation for why he thought the wound was worsening. Observation on 07/31/24 at approximately 3:30 P.M. of Resident #62's left hip wound revealed no concerns at the time of the observation and the wound treatment was completed as per the current treatment order. A telephone Interview on 07/30/24 at 4:33 P.M. with WCCNP #310 revealed he was familiar with Resident #62 and had been assessing and treating the resident's wounds weekly at the facility. WCCNP #310 stated the wound on Resident #62's left hip was initially a skin tear/laceration however, due to the resident laying on his left side, the wound got worse. WCCNP#310 stated he had kept the wound classification as a skin tear/laceration because that was the appropriate classification for the wound initially and it had just worsened. WCCNP #310 stated he started autolytic debridement wound treatments and then surgical debridement of the wound due to the wound continuing to worsen. WCCNP #310 confirmed the wound was a full thickness wound with exposed muscle and tendon as of his most recent assessment on 07/29/24. WCCNP #310 verified he was not made aware of Resident #62's wound until he completed rounds on 05/06/24 (four days after discovery). Additionally, WCCNP #310 confirmed he did not provide the initial treatment orders on 05/02/24 and stated he expected the facility to implement and treatment orders within 48 hours of his wound rounds. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 08/01/24 at 11:29 A.M. with Regional Registered Nurse (RRN) #271 confirmed the facility delayed implementing WCCNP #310's treatment orders and the treatments did not match the orders provided by WCCNP #310 on 05/06/24, 06/03/24, 06/17/24, and 07/12/24. Additionally, RRN #271 confirmed Resident #62's treatment orders were electronically signed by MD #311, who was identified in the medical record as being the resident's primary care physician; however, RRN #271 stated MD #311 no longer managed Resident #62's care and the orders should accurately reflect the provider who gave the order and not default to the primary care physician's name. A telephone interview on 08/01/24 at 4:58 P.M. with MD #311 revealed he no longer completed rounds at the facility and other physicians in the physician group had taken over resident care at the facility. While Resident #62's medical record indicated MD #311 was notified of the resident's skin impairment, MD #311 denied he was notified of any skin impairment and had not provided an order for any treatments on 05/02/24. Additionally, MD #311 acknowledged the facility continued to use his name and electronic signature on physician orders, despite him no longer seeing residents at the facility. MD #311 confirmed he had no knowledge of Resident #62's current condition. Review of the facility policy titled Skin Management, dated October 2019, revealed residents identified at risk for skin breakdown will have appropriate prevention interventions put into place. Alterations in skin integrity will be reported to the physician or nurse practitioner and responsible party. Treatment order will be obtained. The facility assigned wound nurse will complete further evaluation of the wounds identified and complete the appropriate skin evaluation. A plan of care will be initiated to include resident specific risk factors with appropriate interventions.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41266 Based on resident and staff interviews, medical record review, and facility policy review, the facility failed to adequately or accurately monitor and treat one resident's (Resident #54) increased pain level. The deficient practice affected one (Resident #54) of three residents reviewed for pain management. The facility census was 75. Findings Include: Review of the medical record for Resident #54 revealed an admitted on [DATE]. Medical diagnoses included encounter for surgical aftercare following surgery on the digestive system ([DATE]), irritable bowel syndrome (IBS), pain in unspecified knee, right ankle and joints in right foot, opioid use, tobacco use, chronic embolism and thrombosis of unspecified vein ([DATE]), chronic or unspecified gastric ulcer with perforation ([DATE]), diaphragmatic hernia without obstruction or gangrene ([DATE]), gastrostomy status ([DATE]), and acute gastric ulcer with perforation. Review of the annual Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #54 had intact cognition and scored 15 out of 15 on the Brief Interview for Mental Status (BIMS) assessment. The resident required supervision or touch assistance from staff to complete Activities of Daily Living (ADLs). Resident #54 used a walker and/or a manual wheelchair for ambulation/mobility. Review of Resident #54's clinical census revealed the resident was hospitalized from [DATE] to [DATE]. Review of the Medication Administration Record (MAR) dated [DATE] revealed Resident #54 had the following orders to treat the resident's pain: Oxycodone Hydrochloride (HCl) capsule (opioid) five milligrams (mg) with instructions to give one tablet by mouth every six hours (four times a day) for pain dated [DATE]. The medication was administered four times daily as ordered. The order was discontinued [DATE]. Oxycodone HCl oral tablet 10 mg with instructions to give one tablet by mouth every six hours for chronic pain dated [DATE] at 12:00 A.M. and discontinued on [DATE] at 8:05 A.M. The medication was administered on [DATE] at 12:00 A.M. and 6:00 A.M. for a pain level of eight out of ten, where ten was the worst possible pain for both administrations. Oxycodone HCl oral tablet 10 mg with instructions to give one tablet by mouth every six hours for moderate to severe pain dated [DATE] at 12:00 P.M. and discontinued on [DATE] at 12:55 P.M. The medication was administered on the following dates and times: [DATE] at 12:00 P.M. and 6:00 P.M., [DATE] at 12:00 A.M., 6:00 A.M., 12:00 P.M., and 6:00 P.M., and [DATE] at 12:00 A.M., 6:00 A.M., and 12:00 P.M. Resident #54's pain levels on a scale from zero to ten where ten was the worst pain were noted as: zero, eight, eight, two, seven, eight, zero, zero, and seven respectively. Acetaminophen Tablet (analgesic) instructions to give 650 mg by mouth every eight hours as needed for mild to moderate pain for mild pain one to three on a scale from one to ten where ten was the worst pain dated [DATE]. The medication was not administered at all during the month of [DATE]. (continued on next page)

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	365754	A. Building B. Wing	08/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Majestic Care of Columbus LLC	44 S Souder Ave Columbus, OH 43222

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ibuprofen tablet (non steroidal anti inflammatory) 600 mg with instructions to give one tablet by mouth every six hours as needed for mild to moderate pain with moderate pain being a level of four to seven on the pain scale dated [DATE]. The medication was administered on the following dates and times: [DATE] at 11:03 A. M. and 8:05 P.M. and [DATE] at 9:13 P.M. Resident #54's pain was noted to shoulder, back and not applicable respectively. The resident's pain levels were six, five, and three respectively. The medication was marked as effective for each administration. Lidocaine Pain Relief 4% Patch (local anesthetic) with instructions to apply to lower back topically as needed for lower back pain dated [DATE]. The order was on hold from [DATE] to [DATE] and discontinued on [DATE]. The medication was not administered to Resident #54 at all during the month of [DATE]. Monitor effectiveness of routine pain medication with a yes (Y) or no (N) every shift dated [DATE]. There was a Y placed twice daily from [DATE] through [DATE] when the order was placed on hold. Review of Resident #54's pain levels from [DATE] at 11:05 A.M. to [DATE] at 10:17 A.M. revealed the resident had a pain level of zero out of ten on the pain scale daily, except on [DATE] at 10:29 A.M., Resident #54 had a pain level of seven out of ten. Ibuprofen was not administered for the resident's moderate pain level. Review of Resident #54's pain levels from [DATE] at 11:03 A.M. through [DATE] at 12:20 P.M. revealed the resident's pain levels were: six, seven, five, two, eight, zero, eight, zero, zero, eight, eight, two, seven, seven, eight, three, zero, zero, zero, and seven respectively. In addition to the scheduled Oxycodone medication, Ibuprofen was not administered on [DATE] at 11:57 A.M. for a pain level of seven or [DATE] at 1:45 P.M. for a pain level of seven, or [DATE] at 12:20 P.M. for a pain level of seven. Acetaminophen was not administered on [DATE] at 10:59 P.M. for a pain level of two or [DATE] at 5:11 A.M. for a pain level of two. Ibuprofen was administered instead of Acetaminophen on [DATE] at 9:13 P.M. for a pain level of three. Review of the meal intakes for Resident #54 from [DATE] through [DATE] revealed Resident #54 ate , d+[DATE]% of meals on [DATE] and [DATE], ,d+[DATE]% of meals on [DATE] and [DATE], ,d+[DATE]% of meals on [DATE], and ,d+[DATE]% on meals on [DATE] and [DATE]. The resident was noted as not available for breakfast on [DATE]. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the progress notes for Resident #54 dated from [DATE] through [DATE] revealed on [DATE] at 11:03 A.M., Ibuprofen was administered for moderate pain. At 11:57 A.M., the as needed (PRN) administration was noted as effective. However, the follow-up pain level was noted as seven out of ten when ten was the worst pain. On [DATE] at an unknown time, Certified Nurse Practitioner (CNP) #315 assessed Resident #54 for pain located in her shoulder, low back, and hip. The resident was prescribed an opioid analgesic (Oxycodone) that exceeded the limits in the opioid prescribing rules for acute pain. Treatment with non-opioid medications was not a suitable alternative given Resident #54's condition. Resident #54 met exception criteria for having a medical condition that could not be managed within the average limit. Resident #54 reported left shoulder, left hip, and low back pain was not well controlled and described the pain as moderate to severe in intensity. The resident was tearful and stated she was not able to get out of bed related to uncontrolled pain. Resident #54 requested Oxycodone medication be increased. Resident #54's Oxycodone pain medication was increased from 5 mg every six hours for pain to 10 mg every six hours for pain. A change in condition evaluation was completed on [DATE] at 7:24 P.M. for uncontrolled pain. Resident #54 complained of pain to her left shoulder blade and back. The resident was very teary and stated the pain was so bad that she was not able to walk. The staff offered to send Resident #54 to the hospital for an evaluation but the resident refused and requested her pain medication be increased instead. There were no additional progress notes related to monitoring Resident #54's pain until [DATE] when a prn dose of Ibuprofen was administered. On [DATE] at an unknown time, Resident #54 was seen again by CNP #315 for an altered mental status. CNP #315's assessment revealed the resident's altered mental status was likely due to an illicit opioid overdose as the resident was administered Narcan and was immediately revived. Resident #54 and another resident left the facility and both had been difficult to arouse per the staff. Following Narcan administration, Resident #54 was alert to person however her speech was slow, slurred and nonsensical. Resident #54 complained of severe abdominal pain and demanded to be sent to the emergency room for an evaluation. On [DATE] at 1:00 P.M., Resident #54 was seen for a psychological follow-up visit. The resident was seen lying in her bed watching television and complained of a lot of pain in her abdomen. The staff also reported Resident #54 had been complaining of increased pain. On [DATE] at 2:25 P.M., a change in condition evaluation was completed for a severe abdominal pain. Resident #54 was sent to the emergency room for further evaluation. On [DATE] at 4:38 P.M., Resident #54 was transferred to the hospital via emergency medical services (EMS) due to complaint of severe abdominal pain. Review of the hospital records dated [DATE] to [DATE] revealed Resident #54 was admitted on [DATE] with the following diagnoses: gastric perforation, septic shock, hiatal hernia, status post (s/p) gastroplasty (weight loss surgery), history of fundoplication (a procedure that treats stomach acid reflux), acute kidney injury, bacteruria with a urinalysis showing 2+ blood with 44 red blood cells, leukocytes esterase positive, white blood cells 3,000, and many bacteria), and acute hypoxic respiratory failure (on a non-rebreather). Resident #54's chief complaint upon arrival to the emergency room (ER) was abdominal and back pain for the past week. Resident #54 had cold extremities (hypothermic) and was blue in color (hypoxic) and responded well to resuscitation. Resident #54 received emergency surgery which revealed the following post-surgery diagnoses: type III hiatal hernia, approximate two centimeter (cm) perforation at the gastric cardia. The resident was intubated and admitted to the intensive care unit (ICU) and listed as critically ill. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on [DATE] at 11:04 A.M. with Resident #54 revealed she had been hospitalized the end of [DATE] due to a bowel blockage and perforated bowel. The resident reported she complained of increased pain for approximately five days prior to being sent to the hospital by the facility staff. Resident #54 stated she spent several days in the hospital and was near death. The resident returned to the facility with a gastrostomy tube (G-tube) following having emergency surgery in the hospital. Interview on [DATE] at 11:30 A.M. with the Director of Nursing Services (DNS) #217 confirmed Resident #54's as needed pain medications were not administered as ordered related to the resident's pain levels. DNS #217 confirmed Resident #54 was not monitored regularly when an increased pain level was reported by the resident. DNS #217 confirmed pain medications were not accurately assessed for effectiveness after being administered. Review of the facility policy, Pain Management, dated ,d+[DATE], revealed the facility policy stated, physician orders for pain medication will be prescribed based upon the resident's intensity of pain. Residents receiving routine pain medication should be assessed each shift by the charge nurse during rounds and/or medication pass. Additional information including reasons for administration and effectiveness of pain medication will be documented on the MAR, or on the facility specific pain management flow sheet.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49039 Based on record review, observations and interviews the facility failed to follow legionella procedures outlined in facility policy to prevent the growth of legionella. This had the potential to affect all residents in the facility. The facility census was 75. Finding Include: Review of [NAME] care of Columbus legionella compliance log from 02/23/24 to 07/23/24 revealed water heater tank #1 and #2 were below required temperature ranges. Temperatures below ranges were noted for water heater tank #1 and #2 on 02/23/24 02/29/24, 03/06/24, 03/13/24, 03/19/24, 03/26/24, 04/10/24, 04/16/24, 04/23/24, 04/30/24, 05/07/24, 05/14/24, 05/21/24, 05/28/24, 06/04/24, 06/11/24, 06/18/24, 07/10/24, 07/16/24 and 07/24/24. Interview on 08/01/24 at 2:51 P.M. with Director of Maintenance (DOM) #277 and the Administrator confirmed hot water tank temperatures for heater #1 and heater #2 were recorded between 110-112 degrees F between 02/23/24 to 07/24/24. Interview on 08/01/24 at 2:55 P.M. with DOM #277 confirmed per legionella binder this surveyor was supplied temperatures should be set at 140 degrees Fahrenheit with a mixing valve present on all floors to reduce the temperature of water supply upon arrival to residents rooms. Observation on 08/01/24 at 3:11 P.M. of hot water temperatures with DOM #277 and Maintenance Assistant #206 confirmed water temperatures at tank #1 was identified at 113 degrees F and tank #2 was at 112 degrees F. Interview on 08/01/24 at 3:22 P.M. with the Administrator confirmed based off legionella binder this surveyor received with [NAME] of Columbus named in the policy the facility is required to maintain hot water boilers at or above 140 degrees F. Interview on 08/01/24 at 5:23 P.M. with DNS #217, Regional Nurse #271, the Administrator and Regional Administrator #300 confirmed per review with staff the facility was not following proper legionella procedures. Staff present confirmed temperatures should be above 140 degrees Fahrenheit and the facility has switch valves on all floors. Review of legionella education dated 05/01/23 received from the facility titled travel-associated infections and diseases representing population of travelers above the age of 50, current or former smoker, have chronic lung conditions, or are immunocompromised revealed legionella can amplify in water systems at temperatures of 77 degrees F to 108 degrees F. This document does not identify the temperature where legionella can survive, only identifies where they reproduce. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Review of National Service Center for Environmental Publications (NSCEP) publication named control of legionella in plumbing published 03/31/87 revealed [NAME] et al. conducted a study examining the relationship between the presence of nosocomial legionnaires disease and hot water temperatures in six buildings. L. pneumonia/Nosocomial Legionnaires disease was found in all four buildings where the hot water was maintained at 110-120 degrees Fahrenheit (F), and nosocomial legionnaires disease was found in three of these buildings. No organisms and no disease was found in the two buildings where hot water was maintained at 135 to 140 degrees F. The authors concluded that colonization and nosocomial Legionnaires Disease can be prevented by maintaining the hot water at 135-140 degrees F. Review of water management program dated 12/12/23 revealed the water management program used by our facility is based on the Centers for Disease Control and Prevention and ASHRAE recommendations for developing a Legionella water management program. the water management program includes . the control limits or parameters that are acceptable and that are monitored. Review of the Water Management Plan for Legionella, dated 07/24, states, [NAME] of Columbus promotes and encourages member facilities to proactively establish and maintain a healthy, infection-free environment for their residents, staff, and visitors. The policy notes, Legionella species are naturally occurring, ubiquitous aquatic organisms that thrive in warm water temperatures, with optimal growth occurring between 77 F and 120 F. It further specifies, To continuously eradicate Legionella bacteria, water should be stored at temperatures above 140 F. Facilities must have mixing valves and/or anti-scald valves to ensure that water delivered to residents does not exceed 120 F. The policy confirms that the water management team includes the Director of Nursing (DON)/Infection Preventionist/DNS #217. The facility's control procedures state, Hot water boilers should be set to 140 F or higher. Facility staff must record the temperature of each hot water device weekly and adjust if the temperature falls below 140 F to ensure compliance with the policy. Review of Center for Disease Control and Prevention dated 03/15/24 titled monitoring building water revealed legionella grows best within a certain temperature range (77-113 F). There's potential for Legionella growth in the absence of other legionella controls when warm water temperatures fall below 120 degrees F. Hot water guidance indicates to store hot water at temperatures above 140 degrees F. Ensure hot water in circulation doesn't fall below 120 F (49 C) an recirculate hot water continuously. Maintain water heaters at appropriate temperatures while following local and state anti-scald regulations. Review of ASHRAE guidelines dated 12/23 states, Water temperature is a significant factor that influences the survival and growth of legionella. It notes that Legionella generally grow on artificial media at temperatures between 77 degrees F and 113 degrees F, with the optimal temperatures for legionella growth generally ranging between 85 degrees F and 108 degrees F. Legionella growth slows and begins to die off at water temperatures between 113 degrees F and 120 degrees F. Therefore, maintaining a hot-water temperature above 120 degrees F at all points throughout the entire building hot-water system is necessary to control the growth of legionella. The review of temperature effects on legionella's survival and growth reveals that 77 degrees F to 120 degrees F is the optimal growth range. As temperatures rise above this range, growth slows, and legionella begins to die.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49039 Based on record review, staff interviews, and facility policy review, the facility failed to follow guidance within their antibiotic stewardship program to ensure antibiotics were ordered appropriately. This affected one (Resident #41) of three residents reviewed to proper antibiotic usage. The facility census was 75. Findings include: 1.Review of the medical record for Resident #41 revealed an admitted [DATE] with diagnoses of toxic encephalopathy, history of transient ischemic attack, hypertensive heart disease with heart failure and nuclear cataracts. Review of Resident #41's Minimum Data Set (MDS) 3.0 assessment completed 04/25/24 revealed he was moderately cognitively impaired and required moderate assistance with toileting and was frequently incontinent. Review of Resident #41's care plan initiated on 07/26/23 revealed he has episodes of incontinence of bladder due to diagnosis of benign prostatic hyperplasia and dementia. Interventions included observe for signs of urinary tract infection such as foul smelling urine or discolored urine, painful urination, abdominal or flank pain, change in mental status or fever. Review of May 2024 infection log revealed Resident #41 had new or marked increase in incontinence, urgency and frequency. Resident #41 returned from hospital with diagnosis of urinary tract infection. Macrobid (antibiotic) 100 milligrams (mg) capsule was initiated on 04/29/24 with end date of 05/06/24. Review of Resident #41's physician orders dated 04/26/24 indicated the resident was to be sent to the emergency room for evaluation and treatment. An additional order starting on 04/29/24 included Macrobid oral capsules 100 mg for the treatment of a urinary tract infection. Review of the local hospital record, with an admitted [DATE], showed that Resident #41 was found unresponsive by staff, potentially due to a seizure. Upon arriving at the hospital, the resident reported not feeling well but was back to his usual self shortly thereafter. The complete blood count (CBC) and electrolyte panel results were unremarkable, and hospital records revealed no diagnosis of a urinary tract infection. Review of prescription dated 04/28/24 revealed an order for cephalexin (Keflex) 500 mg capsule by mouth two times a day for 5 days. Review of infection screening evaluation completed 04/29/24 for Resident #41 revealed the tool is designed to identify if a resident has clinical findings needed to determine if they meet or have suspected infection based on McGeer's or Loeb's criteria. The tool stated the resident was above [AGE] years of age, had an active diagnosis of infection, and had a marked increase or urinary frequency/incontinence/urgency. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of progress notes dated 04/28/24 revealed Macrobid oral capsule 100 mg was ordered for treatment of urinary tract infection. Note dated 04/29/24 revealed hospital workup identified episode of hypoglycemia and orthostatic hypotension was the cause of change in mental status. Review of vitals revealed his pain level from 04/25/24 and 04/29/24 was zero and his temperature was within normal limits. Review of the medical record revealed no diagnosis of urinary tract infection when Macrobid was started, and no evidence was found supporting an increase in incontinence, frequency, or urgency beyond the resident's current baseline of incontinence. Examination of the laboratory report showed unremarkable results throughout the hospital stay, indicating no infection. Additionally, while a decrease in consciousness was noted, no decline in orientation or mental state was observed. Interview on 08/01/24 at 11:31 A.M. with Director of Nursing Services (DNS) #217 confirmed that the medical record did not contain evidence supporting the order for Macrobid for Resident #41's urinary tract infection. DNS #217 confirmed that the resident was not diagnosed with a urinary tract infection during his hospital stay.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44070 Based on observations, record review and resident and staff interview, facility failed to ensure resident rooms were kept in a clean and sanitary manner for two (Residents #29 and #55) and the facility failed to ensure it maintained resident rooms in safe, homelike and well maintained condition for nine (Residents #5, #17, #20, #22, #29, #30, #41, #65, and #69) of 11 reviewed for environment. The total facility census was 75. Findings include 1. Review of the medical record for Resident #29 revealed an admitted [DATE]. Diagnoses included schizoaffective disorder bipolar type, anxiety, personality disorder, tremor, and anemia. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #29 was cognitively intact with a BIMS of 15 and required set up and clean up assistance with toileting. Care plan dated 07/16/23 revealed resident had exhibited behavior symptoms of refusals of care including refusing to have room cleaned and became verbally aggressive when staff entered his room with interventions to explain to resident what your doing, before doing it, and give resident choices, maintain a safe environment for resident. Observation on 07/29/24 at 10:53 A.M. of Resident #29's room revealed a heavy stench of urine was present, the toilet had urine and toilet paper that had not been flushed, and the bathroom floor was sticky. Resident light in the toilet room did not work. Observation on 07/30/24 8:34 A.M. revealed Resident's room continued to have a strong stench of urine. The toilet had been flushed, and the toilet room floor remained sticky. Resident's bathroom light still did not work. Observation and interview on 07/31/24 at 4:20 P.M. with Resident #29 revealed he had told staff previously about the light being out and they had not fixed it. Observation and interview on 07/31/24 at 5:00 P.M. with Housekeeping Manager #305 confirmed Resident #29's bathroom light was out and also confirmed the bathroom floor was sticky from resident urinating on the floor. She revealed at times resident refused housekeeping services and when that happened the housekeeping staff would document refusals and also have the nurse sign acknowledging the refusals. Housekeeping Manager revealed staff should be sweeping and mopping the floors each day and they also do deep cleaning where the floors get waxed weekly. She revealed they had been told not to wax the bathroom floors as they should have been replaced over six months ago. Review of housekeeping documentation revealed Resident #29 declined housekeeping on 07/02/24, 07/03/24, 07/18/24 and 07/25/24. The forms also mentioned the broken light on 07/05/24, 07/12/24 and 07/27/24 with no repairs being completed. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Review of the medical record for Resident #55 revealed an admitted [DATE]. Diagnoses included neoplasm, hemiplegia and hemiparesis, peripheral vascular disease, chronic obstructive pulmonary disease, psychotic disorder with delusions and polyneuropathy, aortic aneurysm, vascular dementia, and delusion disorder. Revealed of wound assessments dated 07/29/24 revealed resident had right lower extremity wound with macerated tissue and a second wound of a skin tear. Review of progress notes dated 07/08/24 to 07/31/24 revealed no mention of resident having bleeding, bloody sheets or bloody flooring. Observation on 07/29/24 at 8:50 A.M. of Resident #55's room revealed a quarter size dried blood stain was on residents linens in an easily seen area. Resident also had an accumulation of blood drips in the size of about a hockey puck on the floor with a nickel size blood smear about six inches away from the larger drip. Observation and interview on 07/30/24 at 8:37 A.M. revealed Resident's room continued to have dried blood on the linens and on the floor by resident bed. These spots were easily visible if staff were to enter Resident's room. Resident revealed he did not know where the blood had come from or when it started but stated it had been there for at least a week on the linens and the floor. Resident revealed he would like his linens changed and floor cleaned up. Observation and interview on 07/31/24 at 4:29 P.M. with State tested Nursing Aide #224 revealed she was unaware of blood on residents linens and floor. She observed the blood in plain site and asked resident if he was okay with staff cleaning it up which resident agreed to. Observation and interview on 07/31/24 at 5:00 P.M. with Housekeeping Manager #305 confirmed Resident #55 bloody floor and linens were just cleaned up. She revealed staff had not informed her of the blood and facility used a special chemical on bloody fluids. She revealed at times resident refused housekeeping services and when that happened the housekeeping staff would document refusals and also have the nurse sign acknowledging the refusals. Review of housekeeping documentation revealed Resident #55 did not decline housekeeping from 07/01/24 to 07/31/24. Resident declined a deep clean but was okay with the standard clean which included sweeping and mopping. 3. Review of the medical record for Resident #5 revealed an admitted [DATE]. Diagnoses included Alzheimer's disease, diabetes, bipolar disease, hemiplegia and hemiparesis, malnutrition, unspecified convulsions and contractions of the left hand and knee. Review of the medical record for Resident #20 revealed an admitted [DATE]. Diagnoses included schizoaffective disorder, chronic obstructive pulmonary disorder, traumatic brain injury, vascular dementia, Parkinson's and edema. Review of the medical record for Resident #22 revealed an admitted [DATE]. Diagnoses included schizoaffective disorder, chronic obstructive pulmonary disorder, Alzheimer's disease, diabetes, dementia, anxiety, and unspecified psychosis. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365754	A. Building B. Wing	08/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Majestic Care of Columbus LLC	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.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the medical record for Resident #41 revealed an admitted [DATE]. Diagnoses included cerebrovascular disease, heart disease, hypertension, ataxia, vascular dementia, epilepsy and toxic encephalopathy. Observation on 07/30/24 at 10:40 A.M. revealed Resident #5, #20, #22 and #41 shared a room and shared a sink in the common area of the room. The sink had a vanity/cabinet that was missing the drawer under the sink leaving an empty space in the vanity from the drawer missing and the wall between the sink and the room door had areas of missing drywall. Observation on 07/31/24 at 12:30 P.M. revealed the vanity drawer remained off and the wall continued to have missing areas of drywall. Observation and interview on 07/31/24 at 5:00 P.M. with Housekeeping Manager #305 confirmed the drawer was missing from the sink vanity and several areas of drywall were missing from the wall between the sink and the resident room door. She took photographs and revealed she would inform the Maintenance Director for repairs to be completed. 4. Review of the medical record for Resident #17 revealed an admitted [DATE]. Diagnoses included diabetes, epilepsy, schizophrenia, chronic obstructive pulmonary disease, vascular dementia, anxiety, hemiplegia and hemiparesis, and Alzheimer's disease. Review of the medical record for Resident #30 revealed an admitted [DATE]. Diagnoses included epilepsy, malnutrition, cirrhosis, heart failure, anxiety, hemiplegia, depression, chronic obstructive pulmonary disease, dementia, psychotic disorder, cerebral infarct and mild cognitive impairment. Review of the medical record for Resident #65 revealed an admitted [DATE]. Diagnoses included cerebral infarct, chronic obstructive pulmonary disease, depression, anxiety, psychotic disorder, epilepsy, vascular dementia and dysphasia. Review of the medical record for Resident #69 revealed an admitted [DATE]. Diagnoses included paranoid schizophrenia, hepatitis, Alzheimer's disease, dementia, and chronic obstructive pulmonary disease. Observation on 07/30/24 at 10:40 A.M. revealed Resident #17, #30, #65 and #69 shared a room and shared a sink in the common area of the room. Around the left side of the sink, the drywall was damaged where the sink connected to the wall. The sink was bracketed to the wall and did not have a base and the sink would move slightly if it was pressed on. The drywall was noted to be discolored. Observation on 07/31/24 at 12:30 P.M. revealed the drywall remained missing/damaged. Observation and interview on 07/31/24 at 5:00 P.M. with Housekeeping Manager #305 revealed housekeeping manager confirmed the drywall was damaged on the left side of the sink and also confirmed the sink moved slightly when pressed on. She took photographs to show the Maintenance team the damage. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of facility policy titled, Safe and Homelike Environment, dated 01/02/24 revealed the facility would provide a safe, clean, comfortable and homelike environment, which included resident receiving care and services safely. This included adequate lighting and Maintenance Director would complete periodic rounds checking lights. The policy revealed housekeeping and maintenance services would be provided as necessary to maintain sanitation and a comfortable environment. Facility shall maintain bed linens that were clean and in good condition. This deficiency represents non-compliance investigated under Complaint Number OH00155526.