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	01/14/2025

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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to manage his or her financial affairs. 44070 Based on observations, staff interviews, residents interviews, and record review, facility failed to ensure residents' personal funds were available in a timely manner. This affected one resident (#7) and had the potential to affect 68 additional residents (#1, #2, #3, #5, #6, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19, #20, #21, #22, #23, #24, #26, #27, #28, #30, #31, #32, #33, #34, #35, #36, #37, #38, #39, #40, #41, #42, #46, #47, #48, #49, #50, #51, #52, #55, #56, #57, #58, #59, #60, #61, #62, #63, #64, #65, #66, #67, #69, #70, #72, #73, #74, #76, #77, #130, #180, and #182) identified to have personal fund accounts with the facility. The facility census was 74. Findings include Interview on 01/06/25 at 3:12 P.M. with Resident #7 revealed a concern related to accessing money from his personal fund account maintained by the facility. The resident shared he had tried to get money ($30.00) from his account, was told he could only get $10.00 for now and that he would need to come back for the remaining $20.00. Observations from 01/06/25 at 3:15 P.M. to 4:00 P.M. revealed Licensed Practical Nurse (LPN) #425 and Certified Nursing Aide (CNA) #416 were informed by Resident #7 that he wanted more money from his fund account. Resident#7 informed the LPN and CNA he went to the front desk and was told he would need to come back later for the rest. Interview on 01/07/25 at 9:30 A.M. with Resident #7 revealed he still had not received the additional $20.00 he requested from his resident fund account. Interviews and observation on 01/08/25 at 4:13 P.M. with Receptionist #432 and Business Office Manager (BOM) #445 revealed they had $38.00 plus coins in the resident fund box at the front desk. The Receptionist and BOM revealed they try to keep $1,000.00 in the fund box at all times and acknowledged sometimes it would get lower after residents get their money at the beginning of the month but stated staff could go to the bank to re-supply the fund box. The BOM revealed the facility had a staff member at the bank during this interview who was getting money to resupply the fund box. The BOM and Receptionist revealed residents should be able to get $50.00 each day from their account balance and facility should maintain funds for residents to obtain their balances timely upon request. The BOM revealed Resident #7 was provided the additional $20.00 this date (01/08/25) and acknowledged it was over 48 hours after the request for $20.00 was made by the resident. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview and observation on 01/09/25 at 10:00 A.M. with Receptionist #465 revealed the resident fund box at the front desk had $33.00 in it. Receptionist #465 revealed facility had $38.00 dollars at the start of her shift. She revealed at times she had to tell residents they do not have enough money available to honor their request and they would need to come back later or the next day. Review of the withdrawals from the facility fund box from 01/06/25 to 01/08/25 revealed on 01/06/25 $50.00 was withdrawn, on 01/07/25 $325.00 was withdrawn, and on 01/08/25 $175.00 was withdrawn. Review of facility policy titled, Resident/Patient Account Funds Withdrawal, dated 11/01/24 revealed request withdrawals $50.00 or less shall be dispersed in cash. The facility shall maintain a system of resident funds for withdrawal.

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F 0677

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide care and assistance to perform activities of daily living for any resident who is unable.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 51068

Based on observation, record review, policy review and interview, the facility failed to provide Resident #13 necessary supervision as per the resident's plan of care to ensure the resident maintained good nutrition and decreased risk of choking during meals. This affected one resident (#13) of three residents reviewed for nutrition. The facility census was 74.

Findings include:

Review of the medical record for Resident #13 revealed an admitted [DATE] with diagnoses including Type 2 diabetes mellitus with mild nonproliferation diabetic retinopathy and macular edema bilateral, epilepsy without status epilepticus, schizoaffective disorder bipolar type, major depressive disorder, chronic obstructive pulmonary disease, vascular dementia with agitation, anxiety disorder due to known physiological condition, gastro-esophageal reflux disease without esophagitis, hemiplegia and hemiparesis following cerebral infarction affecting left dominant side, Alzheimer's disease with early onset, hypothyroidism, age-related nuclear cataract, bilateral myopia, bilateral unspecified sequelae of cerebral infarction, other sleep disorders, hypo-osmolality and hyponatremia ataxia following cerebral infarction; iron deficiency anemia, hypotension, unspecified, hyperlipidemia, unspecified; tobacco use, other drug-induced secondary parkinsonism; history of falling; mental disorder not otherwise specified, tachycardia, and long-term (current) use of insulin.

Review of the quarterly Minimum Data Set (MDS) 3.0 assessment created on [DATE] revealed Resident #13 had a brief interview for mental status (BIMS) score of 12 indicating the resident was cognitively impaired. Resident #13 had impaired mobility and required supervision for eating.

Review of the progress notes revealed on [DATE] at 6:13 P.M. the resident was in the main dining room when staff noted she was coughing/choking on her food and the nurse was called. When the nurse arrived the Heimlich was preformed and Resident #13 became unresponsive and had no pulse. Cardiopulmonary Resuscitation (CPR) was initiated until the paramedics arrived and transported the resident to the hospital. Speech therapy was ordered to conduct an evaluation when returning to the facility.

Review of the care plan for Resident #13 revealed a focus on the resident eating quickly initiated on [DATE] with an intervention the resident was to eat only with supervision.

Review of the dietician evaluation dated [DATE] revealed the resident could eat independently, but needed extensive supervision.

Interview on [DATE] at 11:46 A.M. with the resident revealed she was switched to a mechanical soft diet due to choking and stated she hates the food and does not eat it.

Interview on [DATE] at 9:41 A.M. with the speech therapist revealed she evaluated Resident #13 after her hospitalization after she choked. The hospital stated it was a behavior eating too quickly leading to choking. She stated she knows Resident #13 does not like the mechanical soft diet and the goal was to upgrade the resident to a regular diet once they figure out alternative interventions. She stated for breakfast that morning she supervised Resident #13 for breakfast with a regular diet and the resident was still eating too fast.

(continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on [DATE] at 9:45 A.M. with Resident #13 revealed the speech therapist was in the room that morning but stated they did not explain their plan with the mechanical soft diet. Resident #13 stated she always eats on her own unsupervised either in her room or in the dining room. Resident #13 revealed at times she does not eat at all due to the mechanical soft diet. Observation on [DATE] from 12:11 P.M. revealed the food tray being passed out to Resident #13 for lunch. Resident #13 was observed eating on her own in her room with no staff present or with no assistance from staff. Interview on [DATE] at 12:42 P.M. with Resident #13, Resident #7 (roommate), and Resident #25 (roommate) confirmed no staff had come into their shared room to supervise/assist Resident #13 while eating. Additionally, Licensed Practical Nurse (LPN) #406 confirmed Resident #13 ate 50% of her lunch meal with no staff present to provide the needed supervision. Interview on [DATE] at 1:50 P.M. with the Interim Director of Nursing (IDON) and Registered Nurse (RN) #410 confirmed Resident #13 should be supervised while eating during every meal. Review of the meal supervision and assistance policy revealed the facility will utilize a systemic approach to ensure safety throughout the residents environment and among staff. Additionally, the facility would develop and implement an individualized care plan based on the resident assessment instrument (RAI) to address the residents needs and goals, and to monitor the results of the planned interventions such as adequate supervision during meal time.

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47059 Based on medical record review, hospital record review, review of the facility's incident/accident investigation, staff interview, and policy review the facility failed to develop and implement a comprehensive, individualized and effective fall management program to prevent a fall with injury for Resident #1. Actual harm occurred on 12/01/24 at approximately 12:55 P.M. when Resident #1, who had a diagnosis of dementia, fall risk with history of falls, increased lethargy and confusion sustained an avoidable unwitnessed fall out of bed resulting in head trauma/head hematoma which required hospital treatment. Prior to this fall, the resident sustained an unwitnessed fall out of bed on 12/01/24 at 1:30 A.M. with no evidence the facility implemented timely, adequate and effective interventions/measures to prevent the additional fall with injury on the same date. The resident was hospitalized until 12/09/24. Findings include: Record review revealed Resident #1 was admitted to the facility on [DATE] with diagnoses including multiple sclerosis, epilepsy, dementia, atherosclerotic heart disease, anxiety disorder, presence of a urostomy and colostomy, major depressive disorder, cardiac arrhythmia, sick sinus syndrome, bipolar disorder, and presence of cardiac pacemaker. Review of the Minimum Data Set (MDS) 3.0 assessment revealed Resident #1 had a Brief Interview of Mental Status (BIMS) score of 15 (out of 15). The MDS revealed Resident #1 had no impairment of range of motion to the upper extremities but had impairment of her lower extremities bilaterally and used a wheelchair. Review of the care plan dated 03/24/21 (and updated 12/04/24) revealed Resident #1 was at risk for falls with a history of falls. Falls interventions documented on the care plan included color tape applied to the call light to remind Resident #1 to call for help, declutter pathway in room, digital clock in room in line of site, use a self-releasing seatbelt when in the wheelchair, use of non-skid footwear, non-skid strips in front of the sink, bilateral falls mats, Dycem to wheelchair and encourage use of hipsters. Record review revealed the resident also had a plan of care related to non-compliance with an intervention to educate the resident to notify staff and ask for assistance when changing an ostomy bag. Review of a progress note revealed on 12/01/24 at 1:30 A.M. Resident #1 had an unwitnessed fall. Resident #1 was found lying beside her bed. Resident #1 stated she fell trying to change her colostomy bag. The root cause was determined to be resident the resident was known to be resistant to assistance with colostomy/urostomy bags. Current interventions in place included Dycem, skid strips, color tape to call light, signs as visual cues, and bilateral falls mats were all in place at the time of the fall. Interventions added after the fall included sign placed in room specifically reminding resident to call for assistance for cleaning area or providing direct care. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of the Incident/Accident Investigation form dated 12/01/24 at 1:30 A.M. filled out by Registered Nurse (RN) #400 revealed Resident #1 had an unobserved fall. The resident's call bell was documented to be in reach and was not activated, personal items were in reach, the bed was locked in the lowest position, bilateral floor mats were documented as in place, the floor was not wet, there was proper lighting, and assistive devices were in reach of Resident #1. Resident #1 was described as following usual routine with the comment non-compliant with the process up to change the colostomy bag. Immediate intervention listed was to keep the door open and to do every 15-minute checks until Resident #1 gets up in the morning. However, the medical record (progress note) contained no evidence 15- minute checks were completed throughout the night until the resident awoke. Post fall neurological checks were completed on 12/01/24 at 1:30 A.M., 1:45 A.M., 2:00 A.M., 2:15 A.M., 2:45 A.M., 3:15 A.M., 3:45 A.M., 4:15 A.M., 5:15 A.M., and 6:15 A.M. that were documented as normal where Resident #1 was fully conscious, moves all four extremities, grasp were equal, pupil size was equal and reactive (brisk), and the resident was documented to have had slurred speech. Follow up neurological check done at 7:15 A.M. by LPN #407 revealed all elements were the same except level of consciousness had changed to lethargic. The next neurological check completed at 11:15 A.M. again reflected the same change in the level of consciousness to now reflect the resident was lethargic. There were no additional assessments or progress note follow up to address or explain Resident #1's documented change in level of consciousness. In addition, there was no evidence of changes to the resident's supervisory and/or fall interventions as a result of the identified lethargy on the neurological assessments. The resident's plan of care was updated following the fall on 12/01/24 at 1:30 A.M. with an intervention that signs were placed in Resident #1's room to remind her to call for assistance when getting up. A progress note dated 12/01/24 at 12:10 P.M. revealed Licensed Practical Nurse (LPN) #451 noted the resident was not acting like her normal self. Resident #1's speech was slurred. Resident #1 was very lethargic and seemed confused. LPN #451 contacted the nurse practitioner (CNP) and received new orders for laboratory test of complete blood count, comprehensive metabolic panel, hepatic panel, thyroid stimulating hormone, and a chest x-ray. Resident#1's representative was made aware. However, there were no new fall risk/safety interventions implemented at this time. A progress note dated 12/01/24 at 12:55 P.M. revealed Resident #1 had another unwitnessed fall. Resident #1 was found lying beside her bed. The resident stated she was trying to get up but was unable to answer why. Resident #1 stated she was not in pain but was noted to have a large knot on the back of her head that was bleeding. The CNP was notified, and an order was received to transfer Resident #1 to the hospital for evaluation. The resident representative was notified of fall and transfer to hospital. Review of the hospital after visit summary with a visit date from 12/01/24 to 12/09/24 documented Resident #1's had a hospitalization with diagnoses of hematoma and head trauma. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 01/09/25 at 3:21 P.M. interview with the Director of Nursing (DON) revealed Resident #1 was care planned to request for staff assistance and staff continued to encourage the resident to request help. The DON confirmed Resident #1 had signs in the room to remind the resident to ask for help as a visual cue, and the resident was receiving therapy services to improve strength in her lower extremities to aid in her goal of independence. The DON revealed neurological checks were documented on a form that was included as part of the fall investigation and not in the electronic medical record, and none of the post fall assessment of neurological checks were included in the resident progress notes. The DON verified Resident #1 had a change in her neurological check completed on 12/01/24 at 7:15 A.M. when the resident was documented to be lethargic and the there was no additional neurological checks completed, or assessment of Resident #1 completed until the next routine schedule post fall neurological check at 11:15 A.M. The DON confirmed Resident #1 had progress notes included as part of the medical record dated 12/01/24 at 1:30 A.M. when the resident fell , at 12/01/24 at 12:10 P.M. when the facility notified the practitioner of the change in condition and on 12/01/24 at 12:55 P.M. when the resident had an additional fall which resulted in a hematoma, and head trauma and the need for the resident to have further treatment at the hospital. No other progress notes were part of the medical record on 12/01/24. Review of facility policy titled Fall Prevention dated 01/02/24 revealed each resident's risk factors and environment hazards would be evaluated when developing the resident's comprehensive plan of care. Interventions would be monitored for effectiveness and the plan of care would be revised as needed. When a resident experienced a fall, the facility would assess the resident, complete a post-fall assessment, complete an incident report, notify the physician and family, review the resident's care plan and update as needed, and document all assessments.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51068 Based on record review and staff interview, the facility failed timely identify and treat urinary tract infections (UTIs) for Resident #72 and Resident #59. This affected two residents (#72 and #59) of two residents reviewed for UTIs. The facility census was 74. Findings include: 1. Review of the medical record for Resident #72 revealed an admitted [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD), acute embolism and thrombosis of unspecified deep veins of the lower extremities (bilateral), chronic pulmonary embolism, diverticulosis of the intestine without perforation or abscess, hydrocele, nutritional anemia, essential hypertension, obstructive and reflux uropathy, benign prostatic hyperplasia without lower urinary tract symptoms, unspecified anemia, urinary tract infection, disorders of the left external ear, age-related cataract in the left eye, enophthalmos due to trauma or surgery in the right eye, other diseases of the pharynx, dysuria, hypo-osmolality and hyponatremia, other pulmonary embolism with acute cor pulmonale, atrophy of the globe in the right eye, aspiration risk, kidney calculus, and a personal history of transient ischemic attack (TIA) without residual deficits. Review of the entry Minimum Data Set (MDS) 3.0 assessment revealed Resident #72 was cognitively intact. Review of the progress notes revealed on 11/07/24 at 6:07 A.M. Resident #72's foley catheter was leaking and the urine draining was cloudy and pale yellow. At 7:22 A.M. the primary care provider ordered a urine analysis (UA) and culture and sensitivity (C&S). At 7:12 P.M. Resident #72 had blood in his urine and the Certified Nurse Practitioner's (CNP) instructions were to send the resident to the hospital if the bleeding persists. On 11/08/24 at 8:34 A.M. the CNP was notified of the abnormal UA and was awaiting the C&S. This C&S was reported on 11/09/24 as contaminated and to contact the laboratory within 48 hours. No additional documentation was provided in the medical record related to practitioner notification, resident assessment or actions taken by the facility related to the test not being completed. Review of the progress notes revealed on 11/19/24 at 7:30 A.M. new orders for a UA and C&S were submitted. Two days later on 11/21/24 the UA, C&S sample was collected and was picked up by the laboratory. Review of the laboratory results report from revealed the specimen was collected on 11/21/24, received on 11/21/24 but not reported for 15 days, until 12/06/24. The medical record had no documented communication from the facility to the laboratory regarding the collected UA, C&S and test results. Review of the progress note dated 12/08/24 at 1:52 P.M. revealed the urine which was obtained on 12/06/24 was not picked up by the phlebotomist due to the urine being in the refrigerator since 12/06/24. New order provided by the CNP for another UA, C&S to be completed. On 12/09/24 at 6:24 A.M. a nurse obtained a urine sample for the new UA, C&S. The medical record had no laboratory results report for this sample. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Progress note dated 12/13/24 at 12:32 P.M. revealed two UA samples were reported as contaminated, a new order for Pyridium (used to treat symptoms of UTI) was prescribed for two days with a start date of 12/13/24 and an end date of 12/15/24. On 12/16/24 at 6:59 P.M. Resident # 72 had another UA ordered. On 12/17/24 at 5:54 A.M. the urine sample was obtained for the UA, C&S. This UA was reported as contaminated on 12/20/24. Review of the progress notes revealed on 12/23/24 at 3:22 P.M. the laboratory was called by the Minimum Data Set nurse asking why the C&S was not completed. The laboratory informed the nurse there was a mistake on their behalf and the urine sample would have to be collected again due to the sample being too old to complete a C&S. The CNP ordered another UA and a sample was collected. On 12/27/24. A new order for Levofloxacin (antibiotic) was ordered for five days with a start date of 12/27/24 for a urinary tract infection (UTI). Review of the laboratory results report from revealed the sample was collected on 12/24/24, received on 12/24/24, and reported on 12/29/24 with the results of 70-99,000 Colony Forming Units per milliliter (CFU/mL) klebsiella pneumoniae, 70-99,000 CFU/mL proteus vulgaris and 70-99,000 CFU/mL enterococcus faecalis. The C&S revealed proteus vulgaris was resistant (R 4) to the ordered Levofloxacin. Review of the progress notes revealed on 12/29/24 at 10:39 P.M. Levofloxacin was discontinued and a new order for Bactrim (antibiotic) was ordered for UTI with a start date of 12/30/24 and an end date of 01/03/25. Additionally, Nitrofurantoin Macrocrystal (antibiotic) was ordered for UTI with a start date of 12/30/24 and an end date of 1/06/25. Interview on 01/09/25 at 10:42 A.M. with Interim Director of Nursing (IDON) revealed if the results of a specimen were contaminated the physician or the CNP would have the final say in ordering a new UA or ordering a treating medication. The IDON stated the reason for the delays with Resident #72's UA, C&S were due to the laboratory but confirmed the facility did not contact the laboratory during the delays and the final decision to change the laboratory companies would be up to the regional directors of the facility. She stated the time it takes for laboratory tests to return was dependent on what culture was ordered and stated it could take 24-72 hours for results but did not confirm which laboratory tests take longer. The IDON confirmed the physician did not order any medications for Resident #72 until 50 days had passed after the initial UA was collected for the suspected UTI. The IDON stated she recommended the facility start antibiotics sooner. Interview on 01/09/25 at 11:13 A.M. with the Medical Director revealed he initially ordered the UA due to Resident #72 having behaviors. He confirmed multiple UA laboratory tests came back contaminated and he did not order any other laboratory tests to confirm if there was an ongoing infection. He confirmed the resident had a UTI and medications were not ordered for 50 days after the initial UA was collected. 32654 (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of the medical record for Resident #59 revealed an initial admitted [DATE] with the latest readmission of 10/01/24. Diagnosis included but were not limited to cerebral atherosclerosis, chronic obstructive pulmonary disease (COPD), major depressive disorder, anxiety disorder, psychotic disorder with hallucinations, sleep disorders, epilepsy, dysphagia, ataxia, vascular dementia with behavioral disturbances, bilateral ocular hypertension, glaucoma, bilateral cataract, constipation, functional urinary incontinence and seasonal allergic rhinitis. Review of the resident's progress note dated 10/01/24 at 7:30 P.M. revealed the resident was admitted from the acute care hospital with a prescription for Keflex (antibiotic) 250 milligrams (mg) by mouth twice daily for seven days for infection management. Review of the progress note dated 10/02/24 at 9:13 A.M., as a late entry revealed the resident returned to the facility on [DATE] with a new order for Keflex with no diagnoses. The Certified Nurse Practitioner (CNP) was made aware and advised to stop the antibiotic and obtain a urinalysis (UA). Review of the resident's hospital discharge summary dated 10/02/24 revealed a culture and sensitivity (C&S) dated 10/01/24 revealed the resident was positive for greater than 100,000 proteus mirabilis bacteria and was ordered Keflex 250 mg by mouth twice daily for seven days. Review of the resident's urinalysis results dated 10/08/24 revealed the resident's urine was dark orange (normal yellow), clarity was extra turbid (normal clear), blood one plus (normal negative), protein one plus (normal negative), urobilinogen three plus (normal negative), leukocytes four plus (normal negative), red blood cells greater than 50 (normal less than 6), white blood cells 21-50 (normal less than six), epithelial cells few (normal negative) and bacteria to numerous to count (normal negative). The lab result indicated probable contamination. Review of the progress note dated 10/09/24 at 10:02 A.M. revealed the CNP was notified of the UA results with no new orders. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a moderate cognitive deficit. The assessment indicated the resident was always incontinent of both bowel and bladder and had not been treated for an infection in the past 30 days. Review of the medical record revealed no evidence the resident's UTI was treated. On 01/08/25 at 9:52 A.M., interview with the Interim Director of Nursing (IDON) verified the lack of treatment for the UTI and lack of follow up with the 10/08/24 contaminated urinalysis.

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

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32654 Based on medical record review, staff interview and facility policy review, the facility failed to ensure the physician provided a rationale for the decline of a pharmacy recommended gradual dose reduction (GDR) for Resident #31 and Resident #59. This affected two residents (#31 and #59) of five residents reviewed for unnecessary medications. The facility census was 74. Findings Include: 1. Review of the medical record for Resident #31 revealed an initial admitted [DATE] with the diagnoses including but not limited to Alzheimer's disease, diabetes mellitus, bipolar disorder, hypertension, anxiety disorder, hyperlipidemia, overactive bladder, sleep disorder, dementia with mood disturbance, adjustment disorder with mixed anxiety and depressed mood, and chronic pain syndrome. Review of the resident's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a severe cognitive deficit. Resident was coded to rejected care and wander. The assessment coded diagnoses of Alzheimer's, anxiety and bipolar disorder. The assessment indicated the resident received antianxiety, antidepressant and opioid medications. Review of the resident's monthly physician orders for January 2025 identified orders dated 07/19/24 for Melatonin (medication used for sleep) 10 milligrams (mg) by mouth daily at bedtime for insomnia, 08/01/24 for Zoloft (antidepressant) 100 mg by mouth daily for depression, 12/23/24 for Hydroxyzine (antihistamine) 25 mg by mouth twice daily and Ativan (antianxiety) 0.5 mg by mouth twice daily. Review of the pharmacy recommendation dated 10/02/24 revealed the pharmacist recommended a GDR for the medication Hydroxyzine 25 mg by mouth twice daily. The physician checked the box indicating past reduction attempts have resulted in problematic behavior and/or staff inability to provide care. The physician gave no further rationale for the disagreement. On 01/08/25 at 9:52 A.M., interview with the Interview Director of Nursing (IDON) verified the physician provided no rationale for the decline in the pharmacy recommended GDR. 2. Review of the medical record for Resident #59 revealed an initial admitted [DATE] with the latest readmission of 10/01/24 with the diagnoses including but not limited to cerebral atherosclerosis, chronic obstructive pulmonary disease (COPD), major depressive disorder, anxiety disorder, psychotic disorder with hallucinations, sleep disorders, epilepsy, dysphagia, ataxia, vascular dementia with behavioral disturbances, bilateral ocular hypertension, glaucoma, bilateral cataract, constipation, functional urinary incontinence and seasonal allergic rhinitis. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a moderate cognitive deficit. Resident #59 was coded to display no behaviors. The assessment coded the diagnoses of dementia, anxiety disorder, depression, psychotic disorder and sleep disorder. The assessment indicated the resident received antidepressant, opioid, antiplatelet and anticonvulsant medications. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's monthly physician orders for January 2025 identified orders dated 10/30/24 for Zoloft 100 mg by mouth daily for depression and 12/06/24 for Seroquel (antipsychotic) 25 mg by mouth twice daily for psychological disorder. Review of the pharmacy recommendation dated 11/04/24 revealed the pharmacist recommended a GDR on the medication Zoloft 100 mg daily. The physician addressed the recommendation on 11/15/24 and gave no rationale for the disagreement. On 01/08/25 at 9:52 A.M., interview with the Interview Director of Nursing (IDON) verified the physician provided no rationale for the decline in the pharmacy recommended GDR.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 47059 Based on observation, staff interview, and policy review, the facility failed to ensure medications were properly stored to include labeling that identified the date multi-use vials were first accessed/used, and medications did not exceed the expiration date on stock medication supplies. This affected two residents (#46 and #130) of two residents admitted to the third floor after 11/14/24. The facility census was 74. Findings include: Observation with Licensed Practical Nurse (LPN) #462 on 01/08/25 at 8:22 A.M. of the medication refrigerator in the third floor medication storage room revealed an opened multi-dose vial of tuberculin skin testing solution 5TU/0.1 milliliter with a manufacturer's expiration date of January 2026. The vial was opened and undated. At the time of the observation, interview with LPN #462 confirmed the vial was opened and unlabeled with either date/time opened or date/time the vial was to expire. Interview on 01/08/25 at 10:30 A.M. with LPN #462 revealed the observed tuberculin skin testing solution vial was delivered to the facility from the pharmacy on 10/22/24 and the facility policy was opened stock medications expire 30 days after opening. Review of policy Storage of Medications last revision date April 2019 revealed medications requiring refrigeration were stored in a secured location. Discontinued or outdated medications were returned to the dispensing pharmacy or destroyed.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44070 Based on observations, staff interviews, and record review the facility failed to ensure safe and sanitary storage of food and drink items in the kitchen to prevent contamination and/or spoilage. This had the potential to affect all 74 of 74 residents residing in the facility. Findings include Observation on [DATE] at 10:06 A.M. of Resident #68 revealed he had consumed chocolate milk from his breakfast tray that had a dated use by [DATE]. Observations on [DATE] beginning at 12:20 P.M. in the facility kitchen revealed the following: In the freezer there was a serving of what appeared to be fish that was unlabeled and undated, green beans were open and undated, chicken fingers were open and undated and chocolate chip cookie dough was open to air and undated. In the refrigerator there were jars of mustard and Worcestershire sauce which were undated as well as an unknown brown juice that was undated. A plastic container with cinnamon apples was undated. A large open bag of baby carrots was found to have a use by date of [DATE]. There were 14 chocolate milk containers in the walk in refrigerator that were left from breakfast service (on [DATE]) that were expired with a use by date of [DATE] and [DATE] and over 60 additional chocolate milk containers also expired with a use by date of [DATE] and [DATE]. Interview on [DATE] at 12:30 P.M. with Kitchen Manager (KM) #500 confirmed all food should be dated when the items were opened and marked with a use by date. Food should be discarded after the used by date had past. KM #500 confirmed all findings related to food being uncovered, undated and expired. He also confirmed the milk which was past the use by date from the walk in refrigerator was put out for service at breakfast on this date. Interview on [DATE] at 5:06 P.M. with Regional Kitchen Manager (RKM) #505 revealed she reviewed and audited the milk and discarded all expired milk. RKM #505 confirmed food should be dated after opening and expired milk should not be served. Observation on [DATE] at 11:25 A.M. revealed eight Trix yogurts were on trays for tray line service for the lunch meal. All eight were found to have a use by expiration date of [DATE]. Interview on [DATE] at 11:55 A.M. with Regional Kitchen Manager #505 confirmed the yogurt had a expiration use by date of [DATE]. Regional Kitchen Manager #505 stated staff checked the order and the yogurt was delivered on [DATE] and stated staff should have more than four days to serve food items. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Review of the facility provided resident diet list revealed all residents in the facility received meal trays from the kitchen. There were no residents identified with an allergy to dairy or milk, or who had a dietary preference to not receive milk, yogurt or carrots. Review of facility policy titled, Cold Foods, dated ,d+[DATE] revealed food shall be stored in wrapped or covered containers, labeled and dated.

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. 44070 Based on record review and interview, the facility failed to ensure arbitration agreements were thoroughly explained in a language the resident/representative could understand and also failed to ensure all required components and information was included in the context of the agreement. This affected three residents (#25, #27 and #55) and had the potential to affect 23 additional residents (#19, #30, #32, #46, #55, #60, #61, #66, #70, #74, #75, #76, #77, #78, #79, #130, #180, #181, #182, #183, #184, #185, and #186) who were admitted to the facility since 08/05/24. The facility census was 74. Findings include Interview on 01/06/25 at 11:33 A.M. with the Administrator during the biannual survey entrance conference revealed the facility did not have arbitration agreements and did not have any residents that had signed an arbitration agreement. Review of the admission agreement revealed an appendices Q for optional arbitration agreements without any appendix Q provided. Interview on 01/07/25 at 1:40 P.M. with Admissions #414 revealed the facility had no arbitration agreements and Admissions #414 reported the of the facility no longer did them. She confirmed it was in the table of contents of the admission agreement and stated the forms were no longer provided for resident review, but acknowledged agreements already made/signed shall be held in place and honored, and resident would be required to follow it. Review of the arbitration agreement revealed no language stating the agreement was not required and not a condition of admission. Interviews on 01/07/25 from 3:00 P.M. to 6:25 P.M. with the Administrator revealed Admissions #414 did not explain the arbitration agreements and just provided the document for the resident/family to review. The Administrator also revealed the facility had some misunderstandings on what was going on with documents as no staff could definitively state the arbitration process at the facility. The Administrator verified and acknowledged the arbitration agreement documents should be thoroughly explained. The Administrator confirmed specific language should be included in the agreement per the regulation including the agreement was not required and was not a condition of admission. Interview on 01/08/25 at 8:39 A.M. with the Administrator revealed facility was reviewing the arbitration agreements at a corporate level on this date. The Administrator revealed she had identified concerns with the agreement, but it had not been a priority from corporate and the corporate attorney to address any changes until the survey identified concerns. Interviews on 01/08/25 from 1:02 P.M. to 1:35 P.M. with Resident #25, #27, and #55 revealed none of the residents were familiar with the arbitration agreement and could not recall if they were provided or signed an arbitration agreement upon admission.

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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** 32654 Based on medical record review, staff interview and facility policy review, the facility failed to provide adequate justification for the use of antibiotics for Resident #73 and Resident ##72. This affected two residents (#73 and #72) of five residents review for unnecessary medications. The facility census was 74. Findings Include: 1. Review of the closed medical record for Resident #73 revealed an initial admitted [DATE] with the latest readmission of 06/27/24. Diagnoses included but were not limited to diabetes mellitus with diabetic retinopathy with macular edema, hypothyroidism, peripheral vascular disease, bipolar disorder, chronic kidney disease, sleep disorders, cirrhosis of liver, major depressive disorder, gastro-esophageal reflux disease, enterocolitis due to clostridium difficile (c-diff), anxiety disorder, hyperlipidemia, severe morbid obesity, hypertension, congestive heart failure, arthropathic psoriasis, lymphedema, anemia, factitious disorder imposed on self combined with psychological and physical signs and symptoms, post traumatic stress disorder, obstructive and reflux uropathy, constipation and cerebral ischemia. Review of the progress note dated 10/30/24 at 7:12 P.M. revealed the resident complained of dysuria. The Certified Nurse Practitioner (CNP) was notified and a new order for urinalysis (UA) was placed. Review of the progress note dated 10/31/24 at 4:44 P.M. revealed the urine specimen was collected and picked up by the facility's contracted laboratory company. Review of the UA results dated 11/04/24 revealed the resident's clarity was abnormal at extra turbid, glucose abnormal at three plus, blood (RBC) abnormal at 21 to 50, white blood cells (WBC) abnormal at greater than 50, epithelial cell abnormal at few, bacteria abnormal at few. Review of the progress note dated 11/05/23 at 6:48 A.M. revealed the laboratory result was received and was sent to the CNP with no new orders. Review of the progress note dated 11/06/24 at 11:55 A.M. awaiting culture and sensitivity (C&S) results. Review of the resident's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had no cognitive deficit. The assessment indicated the resident was not treated for an infection in the past 30 days. Review of the situational background assessment recommendation (SBAR) dated 11/07/24 revealed the resident was placed on Cipro (antibiotic) 500 milligrams (mg) by mouth twice daily for seven days for a urinary tract infection (UTI). (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 the resident's C&S results dated 11/08/24 revealed the urine was found to have 70,000 to 99,000 escherichia coli. Further review revealed the antibiotic Cipro was resistant to the identified bacteria and sensitive to the antibiotic to Keflex. Review of the progress note dated 11/08/24 at 8:40 A.M. revealed the physician reviewed the lab results. The antibiotic Cipro 500 mg was discontinued due to being resistant to the bacteria. A new order was given for Keflex 250 mg twice daily for seven days. On 01/09/25 at 4:30 P.M., interview with Registered Nurse (RN) #450 verified the antibiotic Cipro was ordered prior to the C&S result returned and the lack of follow up for the contaminated UA results. 2. Review of the medical record for Resident #72 revealed an initial admitted [DATE] with the latest readmission of 02/01/24. Diagnoses included but were not limited to chronic obstructive pulmonary disease (COPD), chronic pulmonary embolism, diverticulosis of intestine, hydrocele, anemia, hypertension, obstructive and reflux uropathy, benign prostatic hyperplasia, UTI, dysuria and calculus of kidney. Review of the plan of care dated 02/02/24 revealed the resident had occasional hematuria, dysuria and pain in urethra related to Foley catheter and was at risk for infection related to diagnoses hydrocele, BPH and kidney calculus. Interventions included administer medication as ordered, observe for side effects, notify physician of any abnormal findings, encourage fluids, observe for continued symptoms of infection and assist with routine toileting and assist with incontinent and peri-care as needed. Review of the resident's significant change Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had no cognitive deficit. The assessment indicated the resident had an indwelling urinary catheter and was not treated for an infection in the past 30 days. Review of the progress note dated 11/10/24 at 6:34 A.M. revealed the resident reported his indwelling urinary catheter was leaking and the nurse observed the resident urinate around the catheter. The urine was noted to be blood tinged with a foul odor and a large amount of mucous. The nurse changed the resident's indwelling urinary catheter and was draining hazy colored urine with some bleeding in the tubing. Review of the progress note dated 11/11/24 at 10:02 A.M. a new order was obtained for a UA. Review of the progress note dated 11/19/24 at 12:08 A.M. revealed the urine for the UA was obtained. Review of the progress note dated 11/21/24 at 5:27 P.M. revealed the urine for the UA/S&S STAT was collected and waiting to be picked up by the lab. Review of the progress note dated 11/29/24 at 6:38 P.M. revealed the UA/C&S results were received and the CNP was notified and gave no new orders. Review of the progress note dated 12/08/24 at 3:52 P.M. revealed the resident's urine was not picked up by the facility contracted lab due to urine being in the refrigerator since 12/06/24. (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 the progress note dated 12/09/24 at 6:24 A.M. revealed the resident had no urine output for the shift and the resident's indwelling urinary catheter was changed. The urine for the UA/C&S was obtained. Review of the progress note dated 12/13/24 at 12:32 P.M. revealed the resident's urine had been obtained twice and resulted as contaminated. The resident continued to complain of dysuria. New orders were obtained for Pyridium (medication to treat UTI symptoms) three times daily for two days. Review of the SBAR dated 12/16/24 at 9:31 A.M. revealed a new order was obtained for a UA/C&S. Review of the progress note dated 12/17/24 at 5:54 A.M. revealed the urine for the UA/C&S was obtained. Review of the progress note dated 12/19/24 at 6:23 A.M. revealed the UA results were faxed to the CNP with no new orders at that time. Review of the progress note dated 12/23/24 at 3:22 P.M. revealed the facility called the facility contracted laboratory and questioned why the C&S had not been completed. The laboratory revealed it was a mistake on their part and the laboratory specimen would have to be obtained again. The CNP was notified and ordered to obtain urine for C&S. Review of the progress note dated 12/27/24 at 5:43 P.M. revealed a new order was obtained for Levaquin (antibiotic) 500 mg by mouth daily for five days for UTI. Review of the progress note dated 12/29/24 at 10:39 P.M. revealed the C&S results returned and new orders were obtained to discontinue the Levaquin and start Macrobid 1(antibiotic) 00 mg by mouth twice daily for seven days for UTI. Review of the progress note dated 12/29/24 at 10:43 P.M. revealed the CNP returned call and also ordered Bactrim Double Strength (DS) (antibiotic) 800/160 mg by mouth twice daily for five days for UTI. On 01/09/25 at 4:30 P.M., interview with Registered Nurse (RN) #450 verified the antibiotic Levaquin was ordered prior to the C&S result return. Review of the facility policy titled, Antibiotic Stewardship, dated 2001 and last revised 2016 revealed antibiotics will be prescribed and administered to residents under the guidance of the facility's antibiotic stewardship program. When a resident was admitted from an emergency department, acute care facility, or other facility, the admitting nurse would review discharge and transfer paperwork for current antibiotic/anti-infective orders. When a C&S was ordered lab results and the current clinical situation would be communicated to the prescribe as soon as available to determine if antibiotic therapy should be started, continued, modified or discontinued.

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F 0922 Level of Harm - Potential for minimal harm Residents Affected - Many	Have enough backup water supply for essential areas of the nursing home. 44070 Based on observations, record review and interview, the facility failed to ensure an adequate water supply was maintained in case of emergency. The facility emergency water supply policy did not include provisions for how emergency water would be stored including potable and non-potable water, method for distributing water and details for how the facility shall estimate the needed volume of water. This had potential to affect all facility residents. Facility census was 74. Findings include On 01/06/25 at 11:33 A.M. interview with the Administrator revealed the facility emergency water plan was in the survey readiness binder. Review the emergency water plan revealed it included steps to take in case of a short term water shut off including boiling water and flushing water systems. A contract was later provided for Water Company (WC) #1050, the emergency water supplier. Review of the policy from WC #1050 dated 01/01/25 revealed in the event of a water emergency, WC #1050 would provide gallons of drinking water within 24 to 48 hours. The contract included, if the emergency water company was also impacted in water outage, they could not be held responsible for not fulfilling the contract timeline. It also indicated they would fulfill this timeline as long as their personnel were not placed in harms way or violated Department of Transportation rules and regulations. On 01/07/25 at 4:25 P.M. observation with Kitchen Manager #500 revealed emergency water was not stored in the kitchen and staff had to go searching for the emergency water being stored by facility. After 10 minutes of searching including management staff, maintenance, and Administrator the water supply was found in a small supply closet in the human resources office behind several boxes of paper which had to be moved to visualize the boxes of water. A total of 31 boxes with three gallons per box for a total of 93 gallons of water was noted. The amount was confirmed via interview by Kitchen Manager #500 who stated typically there should be at least 150 gallons stored or enough for a week supply. He stated some must have been destroyed when they moved the water from the therapy gym to the human resource closet. Kitchen Manager #500 stated he last ordered emergency water a few months ago. However, the facility was unable to provide evidence of when this order occurred and revealed his emergency water supplier was Food Company #1060. At the time of the interview Kitchen Manager #500 revealed the supply was way less than it should be. Review of facility policy titled, Water Supply - Disruption Due to Repairs or Emergencies, dated 02/2018 revealed the facility shall respond to contamination of water supply and prevent the spread of waterborne microorganisms. Facility estimated the water needs for the entire facility for three days shall include one to three liters per resident per day plus 50 gallons per day per 100 residents. (continued on next page)

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F 0922 Level of Harm - Potential for minimal harm Residents Affected - Many	For a census of 74 residents for one liter per resident per day revealed 74 liters divided by 3.785 liters in a gallon equaled 19.55. Three liters per resident per day equaled 74 liters times three (222) divided by 3.785 liters in a gallon equaling 58.65. In addition, the facility reported needs of 50 gallons for every 100 residents (0.5 gallon per resident calculation) daily. With a census of 74 this would add 37 gallons to the totals. Therefore, the facility estimated needs ranged from 56.55 to 95.65 gallons needed for one day. For a three day supply as the policy suggested, the facility should maintain a supply of water of 169.65 to 286.95 gallon supply. For a week long supply as the Kitchen Manager suggested, the facility should maintain a supply of water of 395.85 to 669.55 gallon supply.