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	06/12/2025

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 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of resident funds, and interview, the facility failed to notify each resident, who received Medicaid benefits, when the amount in the resident's account reached $200 less than the Social Security Income resource limit for one person. This affected two residents (#6 and #48) out of four residents reviewed for personal funds. Findings include: 1. Review of the medical record for Resident #6 revealed an admission date of 12/09/18. Diagnoses include hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, type two diabetes, chronic combined systolic and diastolic heart failure, vascular dementia, hypothyroidism, schizoaffective disorder bipolar type, bipolar disorder, hyperlipidemia, chronic pulmonary edema, spinal stenosis, anxiety disorder, chronic respiratory failure, blindness left eye category four, muscle weakness, major depressive disorder, and chronic pain syndrome. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #6 was cognitively impaired. Review of the plan of care dated 04/10/25 revealed Resident #6 had a communication problem related to cognitive deficit, cognitive deficits demonstrated by decreased safety awareness, impaired decision making, self-care deficit, and short and long term memory deficits. Review of Resident #6's Resident Statement Landscape revealed the residents funds were within $200 of the Social Security Income resource limit during the months of February 2025, March 2025, April 2025, May 2025, and June 2025. There was no documented evidence of a notification to the resident and/or their representative regarding the funds balance. Interview on 06/12/25 at 11:25 A.M. with Business Office Manager #192 confirmed that notifications of being within the $200 dollars of the Social Security Income resource limit were not sent to Resident #6 or their representative for the months of February 2025, March 2025, April 2025, May 2025, and June 2025. (continued on next page)

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

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

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F 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of the medical record for Resident #48 revealed an admission date of 09/12/19. Diagnoses included anxiety disorder, bilateral primary osteoarthritis of knee, sleep disorder, irritable bowel syndrome, chronic obstructive pulmonary disease, hypertension, major depressive disorder, myopia, presbyopia, tobacco use, difficulty walking, and chronic or unspecified gastric ulcer with perforation. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #48 was cognitively intact. Review of Resident #48's Resident Statement Landscape revealed the residents funds were within $200 of the Social Security Income resource limit during the months of March 2025, April 2025, and May 2025. There was no documented evidence of a notification to the resident and/or their representative regarding the funds balance. Interview on 06/12/25 at 11:25 A.M. with Business Office Manager #192 confirmed that notifications of being within the $200 dollars of the Social Security Income resource limit were not sent to Resident #48 or their representative for the months of March 2025, April 2025, and May 2025.

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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 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** Based on observation, record review, and interview, the facility failed to ensure appropriate care and services were provided, including dignity and proper technique, during routine suprapubic catheter care. This affected one (Resident #29) out of one resident reviewed for catheter care. The facility identified six residents with indwelling catheters. The facility census was 75. Findings include: Review of the medical record for Resident #29 revealed an admission date of 01/29/25 with diagnoses of obstructive and reflux uropathy, major depressive disorder, insomnia, chronic pain syndrome and history of transient ischemic attack and cerebral infarction. Review of the care plan dated 01/30/25 revealed Resident #29 was at risk for infection/complications related to the use of a suprapubic catheter with the diagnosis of obstructive uropathy. Interventions included to document catheter output every shift, anchor the catheter to gravity drainage as ordered, catheter/peri-care at least every shift and as needed, and educate resident on risks of infection and safe practices. Review of Resident #29's physician orders dated 02/03/25 revealed orders to cleanse the supra-pubic site every shift with soap and water and cover with split gauze. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #29 was cognitively intact, was dependent on staff for toileting, required an indwelling catheter for urinary needs and was incontinent of bowel. Observation on 06/12/25 at 7:50 A.M., Certified Nursing Assistant (CNA) #161 was observed performing catheter care for Resident #29, assisted by Assistant Director of Nursing (ADON) #135 and Registered Nurse (RN) #136. CNA #161 began by explaining the procedure to the resident. She prepared two containers, one with soapy water and one with rinse water, which were placed on the right side of the table with assistance from ADON #135. In addition, washcloths and bath towels were available for usage. The resident was positioned flat in a Trendelenburg position. CNA #161 asked to remove the resident's pants and rolled the resident from side to side, leaving the residents brief around the knees and fully exposing the resident throughout the procedure. CNA #161 cleansed the catheter insertion site using a washcloth dipped in soapy water. While cleaning, she held the catheter approximately three inches below the insertion point, causing tension on the catheter tubing. Approximately three cleansing passes were completed. The same cleaning process was repeated using rinse water. Interview on 06/11/25 at 11:55 A.M. with the Assistant Director of Nursing (ADON) #135 confirmed proper technique for securing the catheter during cleansing included securing the line at the insertion point and wiping from the insertion site outward. ADON #135 confirmed proper technique was not preformed during supra-pubic catheter care. She further confirmed that the resident should have been covered during catheter care to maintain dignity. Interview on 06/12/25 at 9:39 A.M. CNA #161 confirmed she was taught to secure the catheter at the top and to wipe downward during catheter care. Additionally, CNA #161 stated that Resident #29 should have been kept covered except during the actual peri-care, to maintain dignity. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview 06/12/25 at 9:42 A.M. with Registered Nurse (RN) #136 confirmed the catheter was not properly secured during cleaning, resulting in tugging on the catheter tubing. Additionally, RN #136 observed the resident was not covered while catheter care was being completed.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, medical record review, staff interview, and facility policy review, the facility failed to ensure pressure reducing devices were in place as ordered. This affected one (Resident #61) of three residents reviewed for pressure ulcers. The census was 75. Findings Include: Review of the medical record revealed Resident #61 was admitted to the facility on [DATE]. His diagnoses were cerebral atherosclerosis, bipolar disorder, benign prostatic hyperplasia, dementia, moderate protein calorie malnutrition, hypertension, delusional disorder, anxiety disorder, insomnia, depression, violent behavior, psychosis, visual hallucinations, and Parkinsonism. The record revealed the resident did not have any active wounds. Review of Resident #61's Minimum Data Set (MDS) assessment, dated 03/05/25, revealed he was cognitively intact. Review of Resident #61's care plan dated 06/03/25 revealed a care area related to refusal of care and skin breakdown. The care plan stated he would refuse to allow preventative boots and float heels at times. Review of Resident #61 physician orders, dated 06/09/25, revealed he was to have bilateral heel protectors when in bed for wound prevention. Review of Resident #61's behavior logs, dated June 2025, revealed no documentation of refusal of care, especially no documented refusals of putting on his offloading boots. Review of Resident #61's Treatment Administration Record (TAR), dated June 2025, revealed documentation to support his offloading boots were in place twice daily from 06/09/25 to 06/11/25, and during the morning shift of 06/12/25. Observation on 06/09/25 at 1:57 P.M. revealed Resident #61 was awake, lying in bed, and only had his right offloading boot on. His left foot/heel did not have a boot on it and it was not offloaded in any manner. Observation on 06/11/25 at 2:45 P.M. revealed Resident #61 lying in bed asleep. He had a pillow underneath his calves, which offloaded his heels, but he did not have any offloading boots on either feet. Observation on 06/12/25 at 9:30 A.M. and 11:05 A.M. revealed he was transferred from his bed to his wheelchair. Then he was seen in the dining room, sitting in his wheelchair. At no point did he have his offloading boots on his feet. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Certified Nursing Aide (CNA) #300 on 06/12/25 at 11:06 A.M. stated the aides did not document whether the resident refused care/treatments or not, they would report it to the nurse, and the nurse would document it. She confirmed Resident #61 did not wear his boots today (06/12/25), even while he was in bed. She confirmed she did not know why it would be documented in his medical record that his boots were on. Interview with Registered Nurse (RN) #138 on 06/12/25 at 11:13 A.M. stated they would document twice daily in the medical record as to whether a resident had completed their tasks/treatments or used a device as ordered. She confirmed they had documented Resident #61 was using his offloading boots, but confirmed he was in his wheelchair and in therapy during that morning, which he wouldn't use his boots during those times. She confirmed she documented the order was completed without verifying it was. She confirmed if the resident refused his offloading boots, they would document that in the behavior logs. Review of the facility Wound Management policy, dated 05/30/24, revealed it is the policy of the facility that those residents with impaired skin integrity are recognized by the care team, treated timely, and interventions to heal are not exhausted until the skin is healed. The facility will have a system in place to identify impaired skin integrity development early to prevent further damage and treat the condition as soon as it's identified.

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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** 2. Review of Resident #59's medical record revealed an admission date of 01/17/25 with diagnoses including bipolar disorder, emphysema, fusion of cervical spine, spinal stenosis, other chronic pain, lumbago with sciatica, and type two diabetes mellitus, Review of Resident #59's comprehensive Minimum Data Set (MDS) dated [DATE] revealed the resident had intact cognition and the resident received scheduled and as needed pain medications. Review of Resident #59's physician order dated 05/19/25 revealed an order for Percocet Oral tablet 325 milligrams (mg) one tablet by mouth every six hours as needed for pain. Review of Resident #59's plan of care revised 06/10/25 revealed the resident had pain related to sciatica pain radiating to legs and a chronic pain diagnosis. Interventions included administering medication as ordered, notifying the physician of unrelieved pain, observing for side effects of pain medications, observing for symptoms of non-verbal pain, offering nonpharmacological interventions, and reporting to the nurse any changes in usual activity. Review of Resident #59's Medication Administration Record (MAR) from 06/01/25 to 06/09/25 revealed Percocet was administered three times on 06/01/25 and 06/02/25, and administered twice on 06/03/25 through 06/09/25. On 06/05/25 Percocet was administered two times for a pain scale of zero out of ten, ten being the worst. Review of Resident #59's progress notes revealed nonpharmacological interventions were not attempted and descriptions of pain were not given for one administration on 06/01/25, one administration on 06/03/25, two administrations on 06/05/25, one administration on 06/07/25, and two administrations on 06/08/25. Nonpharmacological interventions were not documented for one administration on 06/02/25, one administration on 06/03/25, one administration on 06/04/25, two administrations on 06/06/25, and one administration on 06/07/25. Interview on 06/10/25 at 2:28 P.M. with the Director of Nursing (DON) revealed that 'as needed' pain medications should not be given for a pain level of zero. She stated with every administration they should be documenting nonpharmacological interventions and a description of the pain. Review of the policy titled 'Pain Management' revealed documentation of the administration of ordered 'as needed' pain medication were to be initialed in the electronic medication administration record. Additional information including, but not limited to, reasons for administration, and effectiveness of pain medication were to be documented in the medical record. Based on observation, interview, record review, and review of facility policy, the facility failed to establish a pain goal regimen and document effectiveness of pain medication administration for Resident #25. Additionally, the facility failed to administer and document nonpharmacological pain interventions for Resident #59's as-needed pain medication orders. This affected two residents (#25 and #59) of five residents reviewed for unnecessary medications. The facility census was 75. Findings include: (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 medical record for Resident #26 revealed an initial admission date of 04/17/14. Medical diagnoses included schizoaffective disorder- bipolar type, diabetes mellitus (DM) type two with diabetic polyneuropathy, hypertensive heart disease with heart failure, irritable bowel syndrome, and chronic pain syndrome. Review of Resident #26's comprehensive Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed she had intact cognition, no impairment of range of motion, utilized a walker, and required set-up assistance or supervision for self-care and mobility. Review of Resident #26's physician order dated 02/22/24 revealed an order for Oxycodone oral capsule 5 milligrams (mg) with instructions to give one capsule by mouth two times a day for pain, Lidocaine External Patch 4 percent (%) with instructions to apply it to the lower back topically one time a day, Gabapentin 100 mg with instructions to administer one capsule by mouth two times a day for pain, and Acetaminophen 500 mg with instructions to administer one tablet by mouth every eight hours as needed for mild to moderate pain. Review of Resident #26's care plan dated 03/07/19 addressed chronic pain in bilateral lower extremities (BLE) with a goal that the resident would not have discomfort related to side effects of analgesia through the review date. Interventions included administer analgesic medications per orders, evaluate the effectiveness of pain interventions, review for compliance, alleviating of symptoms, dosing schedules, resident satisfaction with results, impact on functional ability and impact on cognition. The care plan dated 02/19/24 revealed the resident was at risk for pain due to depression and DM with the goal that resident will verbalize adequate pain relief. Interventions included notifying the medical doctor (MD) of unrelieved or worsening pain, and therapy to screen quarterly and as needed. Review of Resident #26's last quarterly pain evaluation dated 04/07/25 revealed Resident #26 had pain in the last five days and rated the frequency of the pain as occasionally. Review of Resident #26's Medication Administration Record (MAR) from 01/01/25 through 06/12/25 revealed Oxycodone was administered as ordered and a pain level rating for each administration was also documented; However, there was no evaluation of the effectiveness of the medication after administration. Interview with Resident #26 on 06/12/25 at 11:12 A.M. reported persistent back and hip pain, stating the 5 mg Oxycodone was ineffective. She stated she used therapy techniques such as riding a stationary bike and using her rollator helped with reduction of the pain and she utilized the occasional PRN (as needed) medications during the morning and evening, but she did not consistently notify nursing staff of the ineffective pain management or note a significant concern with her prescribed regimen. Interview with Unit Manager (UM) #197 on 06/12/25 at 11:36 A.M. stated that scheduled pain medication effectiveness was evaluated on the quarterly pain assessment reviews, and she confirmed the pain medication effectiveness was not evaluated after administration of the pain medication. UM #197 stated that staff relied on the residents to tell them if their scheduled pain medications were effective or not. UM #197 stated that if a resident reported continued pain with a scheduled pain medication regimen that staff would conduct a pain assessment and notify the provider. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Director of Nursing (DON) on 06/12/25 at 1:35 P.M. confirmed the facility did not have a pain rating goal for Resident #26 related to what an acceptable level of pain was. Review of the facility policy titled Pain Management dated January 2020 stated the reasons for administration and effectiveness of pain medication will be documented in the electronic medical record. The licensed nurse will monitor the efficacy of the medication and notify the physician as needed.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure infection control practices were implemented during routine suprapubic catheter care. This affected one (Resident #29) out of one resident reviewed for catheter care. The facility identified six residents with indwelling catheters. The facility census was 75. Findings include: Review of the medical record for Resident #29 revealed an admission date of 01/29/25 with diagnoses of obstructive and reflux uropathy, major depressive disorder, insomnia, chronic pain syndrome and history of transient ischemic attack and cerebral infarction. Review of the care plan dated 01/30/25 revealed Resident #29 was at risk for infection/complications related to the use of a suprapubic catheter with the diagnosis of obstructive uropathy. Interventions included to document catheter output every shift, anchor the catheter to gravity drainage as ordered, catheter/peri-care at least every shift and as needed, and educate resident on risks of infection and safe practices. Review of Resident #29's physician orders dated 02/03/25 revealed orders to cleanse the supra-pubic site every shift with soap and water and cover with split gauze. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #29 was cognitively intact, was dependent on staff for toileting, required an indwelling catheter for urinary needs and was incontinent of bowel. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 06/12/25 at 7:50 A.M., Certified Nursing Assistant (CNA) #161 was observed performing catheter care for Resident #29, assisted by Assistant Director of Nursing (ADON) #135 and Registered Nurse (RN) #136. CNA #161 began by explaining the procedure to the resident and performing hand hygiene. She prepared two containers, one with soapy water and one with rinse water, which were placed on the right side of the table with assistance from ADON #135. In addition, washcloths and bath towels were available for usage. The resident was positioned flat in a Trendelenburg position. CNA #161 asked to remove the resident's pants and rolled the resident from side to side, leaving the residents brief around the knees and fully exposing the resident throughout the procedure. CNA #161 cleansed the catheter insertion site using a washcloth dipped in soapy water. While cleaning, she held the catheter approximately three inches below the insertion point, causing tension on the catheter tubing. Approximately three cleansing passes were completed. The soiled washcloth was then placed back into the container of clean soapy water. The same cleaning process was repeated using rinse water, and the used rinse cloth was disposed of in a trash bag located at the foot of the bed. CNA #161 then retrieved the previously used washcloth that had been left in the soapy water basin and disposed of it in the trash bag. However, she did not replace the soapy water. Instead, she continued catheter care using a clean washcloth dipped into the now-contaminated soapy water and proceeded to cleanse the area around the catheter site. After catheter care was completed, the resident was covered with his own bed blanket which was noted with numerous hairs on it. CNA #161 and ADON #135 obtained fresh water in preparation for perineal care. CNA #161 then uncovered the resident, cleansed the perineal area with a soapy washcloth, and placed the soiled cloth into the clean soapy water basin. She completed a final cleanse using a clean washcloth dipped in rinse water, disposing the cloth in the trash bag at the foot of the bed. CNA #161 then grabbed the washcloth from the soapy water bin and placed it into the trash bag and the resident was re-gowned. Interview on 06/11/25 at 11:55 A.M. with the Assistant Director of Nursing (ADON) #135 confirmed staff should not place soiled washcloths back into the clean wash basin, stating that once used, these cloths should have been placed into soiled laundry or waste containers. Interview on 06/12/25 at 9:39 A.M. CNA #161 acknowledged that she was not supposed to place a soiled washcloth back into the container of clean water, but could not recall whether she did so during this procedure. Interview 06/12/25 at 9:42 A.M. with Registered Nurse (RN) #136 confirmed she observed CNA #161 placed the soiled washcloth into the bucket containing clean soapy water, contaminating the water used for further cleansing of the catheter and insertion site.