

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365754	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/09/2025
NAME OF PROVIDER OR SUPPLIER Majestic Care of Columbus LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 44 S Souder Ave Columbus, OH 43222	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of a facility self-reported incident (SRI) and staff and resident interviews, the facility staff failed to ensure a resident was treated with respect/dignity. The affected one (#23) out one resident reviewed for resident rights. The facility census was 69. Findings include: Record review for Resident #23 revealed this resident was admitted to the facility on [DATE]. Diagnoses include dementia, encephalopathy, epilepsy, multiple sclerosis, bipolar disorder, major depressive disorders. Review of the comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed this resident had intact cognition evidenced by a Brief Interview for Mental Status (BIMS) score of 15. This resident was assessed to require self-care assistance due to impaired physical mobility related to Multiple Sclerosis. Review of a facility SRI for emotional/verbal abuse dated 11/30/25 revealed on 11/27/25 at 7:00 A.M. Certified Nursing Assistant, (CNA) #94 and Resident #23 had a verbal altercation in which profanity was used. The SRI further documented verbal altercation occurred at the nurses' station, where CNA #94 refused to assist Resident #23 with toileting and ostomy care and referred to the resident as a liar. CNA #94 used profanity multiple times in the resident's presence. The incident was witnessed by CNA #59, CNA #113, CNA #74 and Registered Nurse (RN) #133. During an interview on 12/03/25 at 12:15 P.M. Resident #23 confirmed that CNA #94 used profanity multiple times in front of her, though not directly to her. Resident #23 stated the incident made her feel offended at the language being used in her home. During interviews between 1:00 P.M. on 12/02/25 through 10:00 A.M. on 12/03/25 with CNA #59, CNA #113, CNA #74 and Registered Nurse (RN) #133 staff members who were present during the altercation, they all confirmed that CNA #94 was yelling and using profanity in a resident common area. The interviews all confirmed Resident #23 was present in the area during the incident. This deficiency represents non-compliance investigated under Complaint Number 2683509.		

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. Based on record review, staff interview, and review of a facility policy, the facility failed to ensure a resident's advanced directives matched in the paper and electronic health record. This affected one (#7) out of 26 residents in the initial sample. The facility census was 69. Findings include: Review of the medical record for Resident #7 revealed an admission date of 08/03/22. Diagnoses include Alzheimer's disease with late onset, dementia in other diseases classified elsewhere with mood disturbance, paranoid schizophrenia, and severe protein-calorie malnutrition. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment revealed a Brief Interview for Mental Status (BIMS) score of five out of 15 indicating severe cognitive impairment. Review of the orders for Resident #7 revealed an order that stated, FULL CODE has as Do Not Resuscitate - comfort care (DNR-CC) but POA needs to sign, remains Full Code at this time. The banner at the top of the page of the electronic health record that indicated the code status also stated the same thing. Review of the advanced directive in the paper chart revealed a signed Do Not Resuscitate (DNR) form that was signed with the Certified Nurse Practitioner's (CNP) signature and dated on 11/25/25. Additionally, the code status book at the nurses' station had the CNP-signed advanced directive stating Resident #7 was a DNR-CC. Review of the progress note dated 11/25/25 at 2:22 P.M. for Resident #7 revealed a Physician Assistant note that stated, This provider spoke to patient guardian regarding changes in code status. Approval given for code status change to DNR-CC. Paperwork completed and sent to facility for order change and document upload. Interview on 12/03/25 at 9:25 A.M. with Licensed Practical Nurse (LPN) #112 revealed the staff looked at the banner in electronic health record to determine what the code status was. Interview on 12/03/25 at 9:34 A.M. with the Director of Nursing (DON) confirmed staff looked at the banner to determine what the code status was. The DON stated she was not aware the code status book on Resident #7's floor contained the signed DNR-CC form already. The DON stated that the banner in the electronic health record is where the staff would look for the code status, but if they needed a hard copy for emergency personnel, they would look at the code status book. The DON also confirmed that the DNR-CC paperwork was placed in the electronic system. Interview on 12/03/25 at 10:42 P.M., the DON confirmed that the nurse who placed Resident #7's code status in the banner of the electronic health record was being educated and confirmed that the signed code status in electronic health record was the standing code status, and confirmed again that this did not match what the order and banner stated in electronic health record. Interview on 12/03/25 at 11:42 P.M., the DON stated Resident #7's banner in the electronic health record was changed to DNR-CC and the order was changed to match as well. Review of the facility policy titled Advanced Directives, dated 01/02/24, revealed the facility was required to support and facilitate a resident's right to request, refuse and/or discontinue medical or surgical treatment and to formulate an advance directive. Upon admission, when a resident had an executed advance directive, copies would be made and placed on the chart as well as communicated to the staff, and the facility would not discharge or transfer a resident should they refuse treatment either through an advance directive or directly unless the criteria for transfer or discharge were otherwise met.		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, review of a facility self-reported incident (SRI), staff and resident interview and facility policy review, the facility failed to ensure allegations of abuse were timely reported to the State Agency. This affected one (#23) of one resident reviewed for abuse. The facility census was 69. Findings include: Record review for Resident #23 revealed this resident was admitted to the facility on [DATE]. Diagnoses include dementia, encephalopathy, epilepsy, multiple sclerosis, bipolar disorder, major depressive disorders. Review of the comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed this resident had intact cognition evidenced by a Brief Interview for Mental Status (BIMS) score of 15. This resident was assessed to require self-care assistance due to impaired physical mobility related to Multiple Sclerosis. Review of a facility SRI for emotional/verbal abuse dated 11/30/25 revealed on 11/27/25 at 7:00 A.M. Certified Nursing Assistant, (CNA) #94 and Resident #23 had a verbal altercation in which profanity was used. The incident was witnessed by CNA #59, CNA #113, CNA #74 and Registered Nurse (RN) #133. During an interview on 12/01/25 at 4:09 P.M. Resident #23 confirmed that CNA #94 used profanity multiple times in front of her on 11/27/25. During an interview with CNA #74 on 12/03/25 at 2:16 P.M. she confirmed that she reported the incident involving CNA #94 and Resident #23 to human resources on 11/27/25. CNA #74 confirmed Regional Nurse Consultant #123 called her to discuss the incident later that morning. During an interview with Regional Nurse Consultant #123 on 12/03/2025 at 3:03 P.M. confirmed that she was the person who initiated the facility's SRI investigation involving CNA #94 and Resident #23. Regional Nurse Consultant #123 confirmed that she was informed about the incident on 11/27/25. Regional Nurse Consultant #123 states she did not open the SRI until 11/30 because that was her first day back in the office following the incident. Regional Nurse Consultant #123 confirmed the SRI involving CNS #92 and Resident #23 was not timely reported to the State Agency. Review of the facility's policy Abuse, Mistreatment, Neglect, Exploitation and Misappropriation effective 07/01/25 revealed if any form of abuse is alleged, the administrator or a designee must notify the Department of Health not later than two hours after the allegation is made.		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, review of a facility self-reported incident (SRI), review of a facility investigation, staff interview and facility policy review, the facility failed to ensure a thorough investigation was completed following a potential abuse incident. This affected one (#23) of four residents reviewed for abuse. The facility census was 69. Findings include: Record review for Resident #23 revealed this resident was admitted to the facility on [DATE]. Diagnoses dementia, encephalopathy, epilepsy, multiple sclerosis, bipolar disorder, major depressive disorders. Review of the comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed this resident had intact cognition evidenced by a Brief Interview for Mental Status (BIMS) score of 15. This resident was assessed to require self-care assistance due to impaired physical mobility related to Multiple Sclerosis. Review of a facility SRI for emotional/verbal abuse dated 11/30/25 revealed on 11/27/25 at 7:00 A.M. Certified Nursing Assistant, (CNA) #94 and Resident #23 had a verbal altercation in which profanity was used. The incident was witnessed by CNA #59, CNA #113, CNA #74 and Registered Nurse (RN) #133. Review of the facility investigation documentation pertaining to the alleged verbal abuse incident did not contain a statement from CNA #113. During an interview with CNA #113 on 12/02/2025 at 1:29 P.M. confirmed she did not witness the alleged incident between CNA #94 and Resident #23. During an interview with Regional Nurse Consultant #123 on 12/03/2025 at 3:03 P.M. confirmed that she was the person who initiated the facility's SRI and completed the investigation involving the incident between CNA #94 and Resident #23. Regional Nurse Consultant #123 confirmed that she did not obtain a statement from CNA #113. Review of the facility's policy Abuse, Mistreatment, Neglect, Exploitation and Misappropriation effective 07/01/25 revealed the person investigating the incident should interview anyone who witnessed or heard the incident.		