

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365834	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/29/2026
NAME OF PROVIDER OR SUPPLIER Majestic Care of Kent		STREET ADDRESS, CITY, STATE, ZIP CODE 1290 Fairchild Avenue Kent, OH 44240	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observation, interviews, and review of facility policy, the facility failed to maintain a safe, clean and sanitary kitchen, and store frozen foods in accordance with professional standards of food safety. This had the potential to affect all 51 residents who received food prepared in the kitchen. The facility census was 51. Findings include: Observations on 01/28/26 at 8:35 A.M. during a tour of the kitchen revealed the walk-in freezer revealed one large bag of beef patties, one large bag of chicken breasts, one large bag of breaded chicken tenderloins and one large bag of peppers and onions, all opened and undated. Interview at the time of the observation with Kitchen Aide #506 and Facility [NAME] #531 confirmed the findings and stated all opened frozen foods should be sealed and dated to prevent freezer burn. The dishwasher sanitization area had a large amount of black mold-like substance covering the walls below the rinse shelf where the automatic dishwasher was placed. There was also an open wall area approximately six by six inches with exposed wires which were also covered in a black mold-like substance and a notable amount of dirt and debris on top of the wires and wire casing unit. Interview at the time of the observation with Kitchen Aide #506 verified the findings and stated she was not aware of the black mold-like substance on the walls and under the dishwasher shelf. Interview with Maintenance Director #536 on 01/28/26 at 10:50 A.M. confirmed the black mold-like substance and the dirt and debris on the walls under the dishwasher shelf including the approximately six by six inch hole in the wall that was used for the installation of the new automatic dishwasher unit; however, the wall opening was never closed which exposed it to the black mold-like substance and a notable amount of dirt and debris inside the drywall and on the wiring. Review of the facility policy labeled, Label and Dating, revised 10/06/25, revealed all food items prepared, opened, or stored in the facility kitchen must be clearly labeled and dated to maintain food safety, prevent spoilage, and ensure compliance with state health regulations and local health department requirements. Review of facility policy labeled, Kitchen Sanitation, revised 10/06/25, revealed sanitary conditions were maintained in the storage, preparation, and serving areas at all times. Equipment was to be clean, organized, and free of spills, mold, or build up. This deficiency represents non-compliance investigated under Master Complaint Number 2689815 and Complaint Number 2687104.</p>		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 365834	If continuation sheet Page 1 of 1