STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365834	A. Building B. Wing	03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Majestic Care of Kent	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)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review and review of facility policy, the facility failed to provide advanced, written notification of room changes that were signed by the resident and/ or the resident's representative for Residents #16, #30, and #56. This affected three (Residents #16, #30, and #56) of three residents reviewed for room changes.Findings include:1. Review of the medical record for Resident #16 revealed an admission date of 01/20/26. Diagnoses included chronic obstructive pulmonary disease, chronic respiratory failure, and obesity.Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #16 had intact cognition and required extensive assistance for all activities of daily living.Review of the progress note dated 02/11/26 revealed staff talked with Resident #16 and her daughter on 02/10/26 regarding a room move. The family and resident were agreeable.Review of the intra facility room change form dated 02/11/26 revealed Resident #16 was transferring rooms but was not signed by Resident #16 or her representative.2. Review of the medical record for Resident #30 revealed an admission date of 05/23/16. Diagnoses included hypertensive chronic kidney disease, gastroesophageal reflux disease, and obesity.Review of the annual MDS dated [DATE] revealed Resident #30 had moderate cognitive impairment and required extensive assistance with all activities of daily living.Review of the progress note dated 02/10/26 revealed Resident #30 was spoken to regarding a room move. Resident #30 was in agreement and observed throughout the facility telling everyone about the move.Review of the intra facility room change form dated 02/11/26 revealed Resident #30 was moving rooms. The form was not signed by Resident #30 or her representative.3. Review of the medical record for Resident #56 revealed an admission date of 02/08/25 and a discharge date of 02/26/26. Diagnoses included limb girdle muscular dystrophy, neuromuscular bladder, and osteoarthritis.Review of the annual MDS dated [DATE] revealed Resident #56 had intact cognition and required extensive assistance for all activities of daily living.Review of the progress notes revealed no notes observed about a room change on 02/11/26.Review of the facility intra facility room change form dated 02/11/26 revealed Resident #56 was to change rooms, but it was not signed by Resident #56 or her representative.Interview on 03/11/26 at 11:10 A.M. with Social Worker #503 and the Administrator confirmed there were room changes for Residents #16, #30, and #56. They confirmed there was no written notice of the transfer given to the residents or their representatives. They reported Residents #16 and #30 were notified of the room change on 02/10/26, and their rooms were moved on 02/11/26. They provided documentation to support that. No documentation was available for Resident #56, but they reported they spoke with Resident #56 and her brother on 02/10/26, and her room was moved 02/11/26. During that conversation with her brother was when Social Worker #503 was notified to look into transferring Resident #56, and she began that process. The Administrator and Social Worker #503 reported 24-hour notice they felt was appropriate for timely notice.Review of the facility policy Room or Roommate Change, original date 01/02/24, revealed prior to making a room change or roommate assignment, all persons involved in the change assignment, such as residents and their representatives, will be given advance notice of such a change is possible. The notice of a change in room or roommate will be provided in writing; in a (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	language and manner the residents and the representatives understand and will include the reasons why the move or change is required.This deficiency represents non-compliance investigated under Complaint Number 274269.

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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 - Some	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 record review, interview and review of the facility self-reported investigation (SRI) investigation, the facility failed to administer evening medications on 02/21/26 as ordered by the physician to Residents #33, #36, #37, #38, #39, #40, #43, #44, #45, #46, #47, #49, #50, #52, #54, and #57. This affected 16 (Residents #33, #36, #37, #38, #39, #40, #43, #44, #45, #46, #47, #49, #50, #52, #54, and #57) of 24 residents reviewed for medication administration on 02/21/26. The facility census was 53.Findings include:1. Review of the medical record for Resident #33 revealed an admission date of 05/29/25. Diagnoses included cellulitis of left lower limb, hypothyroidism, and obesity.Review of the Medication Administration Record (MAR) for February 2026 revealed Resident #33 did not receive lactobacillus capsule (probiotic), desmopressin acetate (antidiuretic hormone) 0.1 milligrams (mg), levothyroxine (thyroid hormone) 25 micrograms (mcg) 2 tablets, expedite (liquid collagen) 60 milliliters (ml), ProStat (protein supplement) 30 ml, and loratadine (antihistamine) 10 mg on the evening of 02/21/26.2. Review of the medical record for Resident #36 revealed an admission date of 08/11/22. Diagnoses included type two diabetes mellitus, morbid obesity, and depression.Review of the MAR for February 2026 revealed Resident #36 did not receive his colchicine (anti-inflammatory) 0.5 mg on the evening of 02/21/26.3. Review of the medical record for Resident #37 revealed an admission date of 11/15/24. Diagnoses included congestive heart failure, lymphedema, and diabetes insipidus.Review of the MAR from February 2026 revealed Resident #37 did not receive his ezetimibe (cholesterol reducing medication) 10 mg, metformin (medication to treat diabetes) 500 mg, expedite 60 ml, acetaminophen (analgesic) 500 mg two tablets, gabapentin (anticonvulsant and nerve pain medication) 400 mg, and ProStat 30 ml on the evening of 02/21/26.4. Review of the medical record for Resident #38 revealed an admission date of 06/24/24. Diagnoses included chronic obstructive pulmonary disease (COPD), emphysema, and atrial fibrillation.Review of the MAR from February 2026 revealed Resident #38 did not receive his melatonin (hormone to aid in sleep) 5 mg, montelukast (asthma medication) 10 mg, Protonix (stomach acid reducer) 40 mg, trazadone (antidepressant) 50 mg, apixaban (blood thinner) 5 mg, metoprolol tartrate (medication to treat high blood pressure, angina, and heart failure) 50 mg, omega 3 capsule (supplement), Pulmicort (corticosteroid inhaler) two puffs, senna (laxative) 8.6 mg, Combivent (bronchodilator) one puff, Haldol (antipsychotic) 2 mg, and Tylenol (analgesic) 325 mg two tablets, on the evening of 02/21/26.5. Review of the medical record for Resident #39 revealed an admission date of 02/19/26. Diagnoses included necrotizing fasciitis, acute respiratory failure, and diabetes mellitus.Review of the MAR from February 2026 revealed Resident #39 did not receive his atorvastatin calcium (cholesterol reducing medication) 40 mg on the evening of 02/21/26.6. Review of the medical record for Resident #40 revealed an admission date of 03/27/25. Diagnoses included COPD, schizophrenia, and depression.Review of the MAR from February 2026 revealed Resident #40 did not receive his divalproex sodium ER (mood stabilizer) 500 mg, melatonin 3 mg, trazadone 50 mg, Zyprexa (antipsychotic) 20 mg, Seroquel (antipsychotic) 75 mg, Ativan (antianxiety) 0.5 mg, and Ativan 0.5 mg on the evening of 02/21/26.7. Review of the medical record for Resident #43 revealed an admission date of 04/25/24. Diagnoses included Alzheimer's Disease, type two diabetes mellitus, and COPD.Review of the MAR from February 2026 revealed Resident #43 did not receive his atorvastatin calcium 80mg, Flomax (treats benign prostatic hypertrophy) 0.4 mg, gabapentin 100 mg, Keppra (anti-epileptic) 5 ml, magnesium oxide (supplement) 400 mg, memantine (treats Alzheimer's disease) 5 mg, metformin 500 mg, and Prilosec (reduces stomach acid) 20 mg on the evening of 02/21/26.8. Review of the medical record for Resident #44 revealed an admission date of 05/09/24. Diagnoses included dementia, depression, and malignant neoplasm of bone marrow.Review of the MAR from February 2026 revealed Resident #44 did not receive her donepezil (medication to improve cognitive function) 10 mg on the evening of 02/21/26.9. Review of the medical record for Resident #45 revealed an admission date of 05/09/24. Diagnoses (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	included vascular dementia, atrial fibrillation, and hypertension.Review of the MAR from February 2026 revealed Resident #45 did not receive his donepezil 10 mg on the evening of 02/21/26.10. Review of the medical record for Resident #46 revealed an admission date of 04/23/22. Diagnoses included atrial fibrillation, COPD, and senile degeneration of the brain.Review of the MAR from February 2026 revealed Resident #46 did not receive his Remeron (antidepressant) 15 mg, rivaroxaban (anticoagulant) 20 mg, trazadone 25 mg, hydroxyzine (antihistamine) 25 mg, Symbicort (asthma medication) two puffs, and a Magic Cup (nutritional supplement) on the evening of 02/21/26.11. Review of the medical record for Resident #47 revealed an admission date of 02/27/19. Diagnoses included schizophrenia, hypertension, and insomnia.Review of the MAR from February 2026 revealed Resident #47 did not receive her divalproex sodium (mood stabilizer) 125 mg, fluphenazine decanoate (antipsychotic) 25 mg/ml 0.5 ml intramuscular, melatonin 10 mg, quetiapine fumarate (antipsychotic) 50 mg, aspirin (blood thinner) 81 mg, Zyprexa 5 ml, and Ensure Plus 4-ounces (nutritional supplement) on the evening of 02/21/26.12. Review of the medical record for Resident #49 revealed an admission date of 02/20/23. Diagnoses included catatonic schizophrenia, insomnia, and intermittent explosive disorder.Review of the MAR from February 2026 revealed Resident #49 did not receive his melatonin 10 mg, trazadone 75 mg, benztropine mesylate (anticholinergic) 0.5 mg, Keppra 50 0mg, risperidone (antipsychotic) 1 mg, senna 8.6 mg, clonazepam (benzodiazepine) 0.25 mg, and thiamine (supplement) 100 mg on the evening of 02/21/26.13. Review of the medical record for Resident #50 revealed an admission date of 06/20/25. Diagnoses included seizures, visual hallucinations, and dementia.Review of the MAR from February 2026 revealed Resident #50 did not receive his atorvastatin calcium 10 mg, Lantus (insulin) 24 units, Remeron 30 mg, Ativan 0.5 mg, Eliquis 5 mg, Glucerna 8 ounces (nutritional supplement), Keppra 500 mg, metoprolol tartrate 12.5 mg, Humalog (insulin) 4 units, and Seroquel 50 mg on the evening of 02/21/26.14. Review of the medical record for Resident #52 revealed an admission date of 12/31/25. Diagnoses included type two diabetes mellitus, dementia, and overactive bladder.Review of the MAR from February 2026 revealed Resident #52 did not receive her Protonix 40 mg, Ensure Plus 8 ounces, and Remeron 7.5 mg on the evening of 02/21/26.15. Review of the medical record for Resident #54 revealed an admission date of 12/09/23. Diagnoses included Alzheimer's disease, convulsions, and insomnia.Review of the MAR from February 2026 revealed Resident #54 did not receive her melatonin 10 mg and Keppra 500 mg on the evening of 02/21/26.16. Review of the medical record for Resident #57 revealed an admission date of 08/29/24. Diagnoses included Alzheimer's disease, dementia, and anxiety disorder.Review of the MAR from February 2026 revealed Resident #57 did not receive her Buspar 9antianxiety) 5 mg, Ensure Plus 8 ounces, and Ativan 0.5 mg on the evening of 02/21/26.Interview on 03/12/26 at 9:05 A.M. with the Administrator and the Director of Nursing (DON) confirmed on 02/21/26 the Assistant Director of Nursing (ADON) was called in to work the day shift and when her shift ended at 7:00 P.M., her replacement never showed up. The ADON abandoned her shift and called the Administrator and quit her job. The ADON dropped her keys for the medication cart off at the Administrators home. There was still a nurse in the facility during that shift and there were extra keys available in the Administrators' office which the nurse on duty had access to. The nurse working refused to take the keys to the medication cart since they were not signed off to her. The nurse working at the facility that night did not administer nighttime medications to the residents on the 300 and 400 halls. All residents were assessed that night, and pain medications were administered as needed to those residents. The facility started an SRI for the event and assessed all residents affected. No adverse outcomes were found as each resident was assessed by the nurse practitioner, and the pharmacist reviewed all the medications to ensure no concerns. No outcomes were found. Resident #57, on the 300 units, who did have a seizure the next day, but after review of her medical record revealed no diagnoses of seizure disorders, and she was not on any seizure medications.Review of the facility SRI tracking number 2713454 dated 02/21/26 revealed a nurse left the faciity on [DATE] at around 7:30 P.M. taking the medication cart keys and not signing them off to the other nurse. The nurse left because her replacement did not show up, and (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	she quit her job. The nurse dropped her keys off at the Administrators home who promptly returned them the next day. The Administrator informed the nurse in the facility that there were extra keys available to her, but she would not accept them because they were not signed out to her. No residents on the 300 or 400 halls received their nighttime medications as prescribed. The next morning two nurses showed up for their shifts and all residents were assessed and interviewed if able. The residents on the 300 and 400 halls were assessed by the nurse on duty during the night, wound care treatments were provided as ordered, and as needed pain medications were administered. After thorough review of the facility along with collaboration with the physician's assistant and pharmacist no adverse outcomes were identified. All staff were reeducated on the attendance policy, and the Administrator and the DON have been monitoring staffing since the incident.This deficiency represents non-compliance investigated under Master Complaint Number 279187.