

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366120	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/04/2025
NAME OF PROVIDER OR SUPPLIER Majestic Care of Cedar Village.		STREET ADDRESS, CITY, STATE, ZIP CODE 5467 Cedar Village Drive Mason, OH 45040	

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 0728</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure that nurse aides who have worked more than 4 months, are trained and competent; and nurse aides who have worked less than 4 months are enrolled in appropriate training.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to ensure staff was qualified to complete resident care. This had the potential to affect all 142 residents residing in the facility. The facility census was 142. Findings include: Review of the employee record for Nursing Assistant (NA) #540 revealed a hire date of 11/23/24 as a NA. Further review of NA #540's employee record revealed the staff member had not completed the state test to be a Certified Nursing Assistant (CNA). Review of the Detailed Hours Report with Training Category and Pay Category dated 08/14/25 revealed CNA #540 worked 11/28/25 through 04/18/25 as a CNA. Interview on 08/14/25 at 11:54 A.M. with Human Resource #434 confirmed NA #540 was hired on 01/23/24 as a NA for both assisted living and long-term care. Interview also confirmed when NA #540 was hired, she had completed the course for the CNA program but had not passed her state test. Interview also confirmed NA #540 worked for [NAME] Care of Cedar Village on 11/28/24 and was eligible to work for a total of four months with her nursing certificate. Interview also confirmed NA #540 should not have worked as a NA past 03/27/25. Interview confirmed NA #540 worked through 04/18/25. This deficiency represents non-compliance investigated under Complaint Numbers 1359585 (OH00162141) and 1359585 (OH00162141) .</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
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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation and staff interview, the facility failed to ensure medication was available and administered according to physicians' orders. This affected one resident (#3) of four residents reviewed for medication administration. The facility census was 142. Findings include: Review of the medical record for Resident #3 revealed an admission on [DATE] with diagnoses including but not limited to irritable bowel syndrome, hypothyroidism, chronic kidney disease and chronic congestive heart failure. Review of the plan of care for Resident #3 dated 07/19/24 revealed resident has potential nutritional risk related to congestive heart failure, congestive obstructive pulmonary disease, hypothyroidism, anemia and abnormal labs. Interventions include laboratory tests as ordered, medications as ordered, registered dietician to evaluate and make diet recommendations as needed. Review of the physician orders for Resident #3 revealed an order dated folic acid, vitamin B6, vitamin B12, 4-50-2 milligrams (mg) tablet give one tablet two times a day for vitamin dated 07/12/24. Review of the Medication Administration Record (MAR) for the month of July 2025 for Resident #3 revealed the resident did not receive the ordered medication folic acid, vitamin B6, vitamin B12, 4-50-2 milligrams (mg) tablet give one tablet two times a day on the following dates: 07/01/25, 07/02/25, 07/03/25, 07/04/25, 07/05/25, 07/06/25, 07/07/25, 07/08/25, 07/09/25, 07/10/25, 07/12/25, 07/13/25, 07/14/25, 07/17/25, 07/20/25, 07/21/25, 07/22/25, 07/23/25, 07/24/25, 07/25/25, 07/26/25, 07/27/25, 07/28/25, 07/29/25, 07/30/25 and 07/31/25. Further review of the MAR for the month of July 2025 for Resident #3 revealed facility staff signed the MAR for folic acid, vitamin B6, vitamin B12, 4-50-2 milligrams (mg) tablet give one tablet two times a day at that the 5:00 P.M. only dose was administered on 07/01/25 through 07/31/25. Review of the MAR for the month of August 2025 for Resident #3 revealed resident did not receive the ordered medication folic acid, vitamin B6, vitamin B12, 4-50-2 milligrams (mg) tablet give one tablet two times a day on the following dates at the 7:00 A.M. dose: 08/01/25, 08/02/25, 08/03/25, 08/04/25, 08/07/25, 08/07/25, 08/08/25, 08/09/25, 08/11/25, 08/12/25, 08/14/25, 08/15/25, 08/16/25, 08/17/25. Further review of the MAR for August 2025 revealed Resident #3 was administered folic acid, vitamin B6, vitamin B12, 4-50-2 milligrams (mg) tablet give one tablet two times a day at the 5:00 P.M. only dose on 08/01/25, 08/02/25, 08/03/25, 08/04/25, 08/05/25, 08/06/25, 08/07/25, 08/08/25, 08/09/25, 08/10/25, 08/11/25, 08/12/25, 08/13/25, 08/14/25, 08/15/25, 08/16/25 and 08/17/25. Interview on 08/18/25 at 9:49 A.M. with Licensed Practical Nurse (LPN) #238 stated Resident #3 did not have the prescribed folic acid, vitamin B6, vitamin B12, 4-50-2 milligrams (mg) tablet available to administer. LPN #238 stated the over-the-counter medication available did not have the correct amounts of vitamins and she did not administer it. LPN #238 was unable to recall if the physician or the pharmacy was notified that the medication was not available as prescribed. Interview on 08/18/25 at 1:30 P.M. with Pharmacist #153 verified the pharmacy did not supply the facility with folic acid, vitamin B6, vitamin B12, 4-50-2 milligrams (mg) tablet give one tablet two times a day medication. Interview on 08/19/25 at 10:19 A.M. with Director of Nursing (DON) verified the medication was not administered as ordered and should have been. DON stated the facility changed pharmacy's on 07/01/25 and there was no communication documented in Resident #3 medical record or internal communication that the physician was notified of medication not being available for administration or that the pharmacy was notified of the need for refills. DON stated she can not confirm what the medication was that the facility staff was administering as the prescribed formula was not sent from the pharmacy. This deficiency represents non-compliance investigated under Complaint Number 1359585 (OH00162141).</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observations, staff interviews and policy reviews, the facility failed to ensure staff completed hand hygiene after removing soiled incontinent brief and before donning new gloves. This affected one (#104) out of three residents observed for incontinence care. Additionally, the facility failed to ensure medications were administered in a way to avoid transmission of communicable diseases. Specifically, the facility staff touched resident medications with their bare hands when administering medications and failed to clean a multi resident blood glucometer between residents. This affected three (#125, #139, and #140) out of three residents observed for medications/glucometer checks. Lastly, the facility failed to provide a sanitary environment for resident dining and storage of medications in the medication cart. This had the potential to affect the 26 residents residing on the Peach Unit. The facility census was 142.</p> <p>Findings include:</p> <p>1. Medical record review for Resident #104 revealed an admission on [DATE] with diagnoses including but not including type two diabetes mellitus, ulcerative colitis, morbid obesity, venous insufficiency and hypertensive heart disease.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] for Resident #104 revealed an intact cognition. Resident #104 required maximum assistance with toileting tasks, transfers and bed mobility. Resident #104 was incontinent of bowel and bladder.</p> <p>Review of the plan of care for Resident #104 dated 02/04/25 revealed resident required assistance with activities of daily living (ADL) related to impaired mobility, weakness and disease progression. Interventions included mechanical lift for transfers from two staff members and a geriatric chair for locomotion.</p> <p>Observation on 08/18/25 at 10:35 A.M. of Resident #104 incontinent care by Certified Nurse Assistant (CNA) #374 and Licensed Practical Nurse (LPN) #455 revealed CNA #374 advised resident of task to be completed in preparation of transportation to the shower room. CNA #374 donned gloves and provided incontinent care to Resident #104 who was incontinent of both bladder and bowel without concerns. CNA #374 removed the incontinent brief and discarded the item into the trash can. CNA #374 applied clean gloves from box located on the resident's nightstand and applied them without completing hand hygiene. CNA #374 then assisted Resident #104 to roll from one side to side to position resident onto Hoyer sling pad. CNA #374 retrieved the Hoyer lift positioning the lift arms over Resident #104 and proceeded to attach Hoyer Sling pad to Hoyer lift with LPN #455 assisting. CNA #374 using the lift controller hanging on the hoyer lift bar to lift and transfer Resident #104 to a shower chair. LPN #455 and CNA #374 then disconnected the Hoyer lift arms from the Sling pad and moving the lift into the resident's bathroom. CNA #374 covered Resident #104 with shower sheet, removed gloves discarding them into the trash can in Resident #104's room, opening the door to the hallway and exited to room without completing hand hygiene. CNA #374 pushed Resident #104 to the shower room, unlocked the door with a keypad code and assisted the resident into the shower room.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview on 08/18/25 at 10:55 A.M. with LPN #455 verified the CNA #374 removed gloves after completing incontinent care and did not complete hand hygiene prior to donning new gloves. Additionally, LPN #455 verified CNA #455 did not complete hand hygiene after removing gloves a second time and exiting the room to provide Resident #104 a shower.</p> <p>Review of the facility policy titled &ldquo;Handwashing-Hand Hygiene&rdquo;, dated 03/01/25 states care team members must wash their hands for twenty seconds using antimicrobial or non-antimicrobial soap before and after direct contact with residents/patients and after removing gloves.</p> <p>2. Observation on 08/18/25 at 12:24 P.M. of medication cart located on the Peach Unit with LPN #455 revealed medications were provided to the facility from the pharmacy in a numbered card style unit dose package sealed with a foil type backing. The medication cart stored all medication for the 26 residents residing on the unit. Further observation revealed each section storing the medication cards had loose and broken tablets with a heavy accumulation of multiple colors of sand sized material under the medication cards.</p> <p>Interview on 08/18/25 at 12:30 P.M. with LPN #455 verified the medication carts were not clean and the number of medications in pill and capsule form in the bottom of the drawers in direct contact with the resident's medication cards exceeded one hundred in number. LPN #455 stated the facility has cleaning tasks assigned to each shift and night shift was assigned to clean the cart at regular frequency.</p> <p>Interview on 08/18/25 at 1:45 P.M. with the Director of Nursing (DON) verified the unit managers are supposed to conduct observations to ensure cleaning tasks are completed. DON verified the medication carts are to be cleaned on a routine basis and should not have any accumulation or loose tablets in the bottom of the drawers.</p> <p>Review of the facility policy titled &ldquo;Medication Storage&rdquo;, dated 01/02/24 stated it is the policy of this facility to ensure all medications housed on our premises will be stored in the pharmacy and or medication rooms according to the manufacturers recommendations and sufficient to ensure proper sanitation.</p> <p>3. Review of the medical record for Resident #125 revealed an admission date of 01/06/24 with diagnoses of malignant neoplasm of unspecified part of unspecified bronchus r lung, neoplasm of uncertain behavior of spinal cord, anxiety, chronic obstructive pulmonary disease, and panic disorder.</p> <p>Review of the physician orders revealed an order for Drizama 60 mg 1 tablet (tab), Gabapentin 600 mg 1 tab, Tamsulosin 0.4 mg 1 cap, Oxycodone 30 mg 1 tab as needed, Trazadone 50 mg 1 tab, and Finasteride 6 mg 1 tab by mouth.</p> <p>Observation on 08/14/25 8:10 A.M. with Licensed Practical Nurse (LPN) #336 revealed LPN #336 removed Drizama 60 mg 1 tab, Gabapentin 600 mg 1 tab, Tamsulosin 0.4 mg 1 cap, Oxycodone 30 mg 1 tab as needed, Trazadone 50 mg 1 tab, and Finasteride 6 mg 1 tab from the pill cards with her bare hands, physically touching each pill. LPN #336 administered the medication to Resident #125.</p> <p>Interview on 08/14/25 at 8:38 A.M. with LPN #336 confirmed she touch each pill she pulled, she touched with her bare hands.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>4. Review of the medical record for Resident #139 revealed an admission date of 05/19/22 with diagnoses of chronic venous hypertension (idiopathic) with ulcer of right lower extremity, type 2 diabetes mellitus without complications polyneuropathy, peripheral vascular disease, and generalized anxiety disorder.</p> <p>Review of the physician orders revealed an order for Aspirin 81 mg Chewable 1tab, Escitalopram 10 mg 1 tab, Carvedilol 3.125 mg 1 tab, Allopurinol 100 mg 1 tab, Furosemide 20 mg 3 tabs, Januvia 25 mg 1 tab, Levothyroxine 100 mcg 1 tab, Potassium Cl Micro 20 meq 200 mg ER 1 tab, Mag Ox 400 mg 1 tab, Ferrous Sulfate 325 mg 1 tab, Multi-Vitamin 1 tab, Vitamin B-12 1000 mcg 1 tab, Vitamin D 25 mcg 2 tabs, and finger stick blood sugar (FSBS).</p> <p>Observation on 08/14/25 at 7:53 A.M. with Licensed Practical Nurse (LPN) #336 revealed LPN #336 removed Aspirin 81 mg Chewable 1tab, Escitalopram 10 mg 1 tab, Carvedilol 3.125 mg 1 tab, Allopurinol 100 mg 1 tab, Furosemide 20 mg 3 tabs, Januvia 25 mg 1 tab, Levothyroxine 100 mcg 1 tab, Potassium Cl Micro 20 meq 200 mg ER 1 tab, Mag Ox 400 mg 1 tab, Ferrous Sulfate 325 mg 1 tab, Multi-Vitamin 1 tab, Vitamin B-12 1000 mcg 1 tab, Vitamin D 25 mcg 2 tabs from the pill cards with her bare hands, physically touching each pill. Observation also revealed LPN #336 administered the medication the Resident #139, then washed her hands, applied gloves, and checked the residents FSB with a glucometer, then placed the glucometer back in the case. LPN #336 removed her gloves, washed her hands, then picked up the glucometer case and placed it in the medication cart.</p> <p>Interview on 08/14/25 at 8:38 A.M. with LPN #336 confirmed on 08/14/25 at 8:38 A.M. confirmed she touched each pill she pulled; she touched with her bare hands. Interview also confirmed LPN #336 did not clean the glucometer between using on multiple residents. Interview also confirmed she is supposed to clean the glucometer after each resident use with a sanitizing wipe.</p> <p>5. Review of the medical record for Resident #140 revealed an admission date of 04/17/25 with diagnoses of type 2 diabetes mellitus with diabetic neuropathy, hypertensive heart and chronic kidney disease without heart failure, with stage 1 through stage 4, major depressive disorder, anxiety disorders, chronic pain syndrome, anemia, and primary osteoarthritis, right shoulder.</p> <p>Review of the physician orders revealed an order for Aspirin 81 mg chewable 1 tab, Sodium Bicarb 5.02 gr 1 tab, Bisacodyl 5 mg 2 tabs, Senna Plus 8.6mg &ndash; 50 mg 2 tabs, Buspirone 7.5 mg 1 tab, Amlodipine 19 mg 1 tab, Duloxetine 30mg 1 tab, Multi-Vitamin 1 tab, Duloxetine DR 60 mg 1 tab, Cetirizine 10 mg 1 tab, Gabapentin 100 mg 1 tab, and Propranolol 80 mg 1 tab.</p> <p>Observation on 08/14/25 at 8:21 A.M. with LPN #336 revealed Aspirin 81 mg chewable 1 tab, Sodium Bicarb 5.02 gr 1 tab, Bisacodyl 5 mg 2 tabs, Senna Plus 8.6mg &ndash; 50 mg 2 tabs, Buspirone 7.5 mg 1 tab, Amlodipine 19 mg 1 tab, Duloxetine 30mg 1 tab, Multi-Vitamin 1 tab, Duloxetine DR 60 mg 1 tab, Cetirizine 10 mg 1 tab, Gabapentin 100 mg 1 tab, and Propranolol 80 mg 1 tab was pulled from the pill cards with her bare hands, physically touching each pill. LPN #336 administered the medication to Resident #140, then washed her hands, applied gloves, and checked the residents FSB with a glucometer, then placed the glucometer back in the case. LPN #336 removed her gloves, washed her hands, then picked up the glucometer case and placed it in the medication cart.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview on 08/14/25 at 8:38 A.M. with LPN #336 confirmed on 08/14/25 at 8:38 A.M. confirmed she touch each pill she pulled; she touched with her bare hands. Interview also confirmed LPN #336 did not clean the glucometer between using on multiple residents. Interview also confirmed she is supposed to clean the glucometer after each resident use with a sanitizing wipe.</p> <p>This deficiency represents non-compliance investigated under Complaint Number 1359585 (OH00162141).</p>		

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.</p> <p>Based on observation, staff and resident interviews and record review, the facility failed to ensure the facility was free from pests. This had the potential to affect all 142 residents residing in the facility. The facility census was 142. Findings include: Initial tour completed on 08/13/25 from 8:28 A.M. through 8:50 A.M. with the Director of Nursing (DON) revealed four dinner trays dated 08/12/25 were setting on the tables in the Gardenia dining area. Gnats were present on the trays and flying around the trays. There was two trays located on the windowsill in the Gardenia dining area. One of the trays had a couple gnats on the food, the other tray had approximately twenty ants on the plate and food. Observation of the Apple unit dining area had three dinner trays dated 08/12/25 with gnats on the food and gnats flying above the food. Observation on the Peach unit dining area had two trays dated 08/12/25 with gnats on the food of one of the trays. The DON was present during observation and confirmed the presence of gnats and ants on food and food dishes in the dining areas on Gardenia Unit, Apple Unit, and Peach Unit. Observation and interview on 08/13/25 at 10:15 A.M. with Resident #80 in dining room of Gardenia. Observations revealed gnats present on tray while resident is eating breakfast. Resident #80 reports they are there often. Interview on 08/13/25 at 10:16 A.M. with Licensed Practical Nurse (LPN) #414 confirmed the gnats were present on Resident #80's meal tray while eating and confirmed there are gnats present often. Observation on 08/14/25 at 6:09 A.M. with LPN #305 revealed the juice machine on Peach unit had multiple gnats on all four of the spouts on the machine. Interview on 08/14/25 at 6:09 A.M. with LPN #305 present during the observation and confirmed the presence of gnats on all four of the spouts on the machine. Review of the Pest Control #09's work order dated 08/04/25 revealed treated deli for gnats, and treated for ants didn't see any ant activity, light gnats. Review of the Cleaning Schedules, undated revealed all dining rooms are cleaned after each meal and dining aides are to take trays to the kitchen after each meal. Review of the Pest Control Program, dated 12/12/23 revealed it is the policy of this facility to maintain an effective pest control program that eradicates and contains common household pests and rodents. This deficiency represents non-compliance investigated under Complaint Numbers 2580789, 1359585 (OH00162141) and 1359582 (OH00162827).</p>		