STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366120	A. Building B. Wing	06/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Majestic Care of Cedar Village.	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)
F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on record review and staff interview, the facility failed to consider and timely resolve resident concerns. This affected twelve residents who regularly attended resident council meetings. The facility census was 151. Findings include: During the Resident Council discussion task on 06/10/2026 at 10:30 A.M., with three residents (#01, #62 and #79) revealed the Administrator attended and ran the Resident Council meetings and the residents felt their concerns were not addressed. The residents reported there was no follow-up to the concerns and issues brought up in the meetings were never included in the following meetings with information on resolution. Review of the Resident Council meeting minutes for the from May 2025 through May 2026, revealed no documented old business and no documented evidence of discussion or resolutions to concerns which had been brought up. During an interview on 06/11/26 at 9:28 A.M., Activity Director (AD) #315 stated the Administrator ran the meetings and documented the minutes. AD #315 stated there should be documented evidence of the residents' concerns and resolution in the minutes. AD #315 verified there was no old business documented and there was no documented resolution of the residents' concerns. During an interview on 06/11/26 at 1:14 P.M., the Administrator stated he attended the Resident Council Meetings and compiled the minutes of the meetings. The Administrator verified there was no documented evidence of resolutions from the resident concerns brought up in the meetings. This deficiency represents non-compliance investigated under Complaint Number 2674967.

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, interview, and policy review, the facility failed to maintain environmental temperature at a comfortable level on the Apple nursing unit. This affected six residents (#1, #71, #108, #114, #130, and #6) and had the potential to affect all 24 residents residing on the Apple nursing unit. The facility census was 151.Observation during facility tour on 06/11/26 between 5:46 P.M. and 6:20 P.M. with Maintenance Director #200 revealed the Apple nursing unit main corridor was 84.9 degrees Fahrenheit, Apple dining room was 89.8 degrees Fahrenheit, resident room for Resident #1 was 84.7 degrees Fahrenheit, Resident # 71 was 85.6 degrees Fahrenheit, Resident #108 was 83.3 degrees Fahrenheit, Residents #114 and #130 was 84.4 degrees Fahrenheit, and Resident #6 was 84.4 degrees Fahrenheit. All temperatures were taken and verified by Maintenance Director #200 who utilized the facility's infrared thermometer. Interviews on 06/11/26 between 5:46 P.M. and 6:14 P.M. with Residents #6, #108 and #114 revealed it was terribly hot.Interview on 06/11/26 at 6:14 P.M. with Maintenance Director #200 verified environmental temperature for the Apple nursing unit and the room temperatures for Residents #1, #6, #71, #108, #114 and #130 was not homelike or comfortable for the residents. Maintenance Director #200 also verified the ambient air temperatures had not been documented on the Apple nursing unit or the other four potentially affected nursing units.Interview on 06/12/26 at 3:14 P.M. with the Administrator revealed Apple nursing unit temperature concerns started on 06/07/26 at 2:00 P.M. when he was notified by the facility that the air conditioning was not operating. The Administrator stated he requested Maintenance Director #200 to assess the situation. On 06/08/26 portable air conditioning units were brought in along with some fans to circulate air. The Administrator stated Maintenance Director #200 did not monitor and document environmental temperatures, which was an integral part of the Extreme Temperature response plan. The Administrator also stated he did not report the situation in the facility to the Regional [NAME] President of Operations until 06/10/26 at 5:00 P.M. Review of the facility's Extreme Temperature Emergency Response Action Plan revealed ambient air temperatures will be monitored and documented on all impacted units/areas Review of the policy titled, Physical Environment, dated 01/01/26, revealed a purpose to ensure our facilities are designed, constructed, equipped, and maintained in a manner that provides a safe, functional, sanitary, and comfortable environment for residents/patients, Care Team Members, and the public. Resident/patient rooms and activity areas must be maintained at a temperature comfortable for residents/patients not Care Team Members. Review of the policy titled, Safe and Homelike Environment, dated 01/01/26, revealed a purpose to provide a safe, clean, comfortable, and homelike environment that supports resident/patient independence, enables the use of personal belongings, and ensures the delivery of care and services in a manner that minimizes safety risks and promotes well-being. The facility will strive to maintain comfortable and safe temperature levels in common resident/patient areas between 71 and 81 degrees Fahrenheit.This deficiency represents non-compliance investigated under Complaint Number 3043920 and Complaint Number 2731043.

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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 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, resident interviews, staff interviews, facility investigation review, and facility policy review, the facility failed to report concerns for misappropriation to the State Agency in a timely manner. This affected one (Resident #55) of three residents sampled for abuse. The facility census was 151. Findings include:Review of the medical record revealed Resident #55 was admitted to the facility on [DATE]. Diagnoses included Type II Diabetes, peripheral vascular disease, unspecified kidney disease, chronic pain syndrome, and unspecified anxiety disorder. Review of the most recent Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #55 was cognitively intact, had verbal behaviors, did not wander, and occasionally rejected care. Review of document titled (Resident #55)- Interview/Investigation, Missing $30, not dated, revealed Resident #55 informed the Administrator that $30.00 was missing from under the lamp in his room. The resident stated he had 25 one-dollar bills and one five dollar bill in a wad under his lamp. Resident #55 stated his friend outside the facility knew about the money, but this could not be confirmed. The Administrator offered a safe alternative for storing his personal belongings, but the resident refused. The Administrator stated explained he could not replace the $30.00 because he could not confirm Resident #55 had it. The Administrator offered to purchase some of the resident's favorite snacks along with some healthier snack alternatives in the equivalent of $30.00, and the resident agreed. The Administrator purchased and delivered the snacks to Resident #55. Additional review revealed the facility interviewed staff, and none were aware of the missing money. During an interview on 06/08/2026 at 3:33 P.M. Resident #55 stated he reported concerns, date not specified, to the Administrator and Social Service Designee when he discovered upon return from the hospital in either July or August 2025 that the $30.00 he had stored under the lamp in his room was missing. Resident #55 stated he had one $5.00 bill and 25-$1.00 bills for the vending machine. Resident #55 stated he a had a meeting with the social service designee and three other unidentified staff, during which staff stated they would refund him his money. The administrator asked Resident #55 what kind of snacks he liked and provided snacks in place of refunding the money. During an interview on 06/10/2026 at 1:46 P.M. the Administrator stated Resident #55's allegation of missing money was brought to his attention much later than the date of the incident. The Ombudsman sent an email in February 2026 asking the Administrator to address it. Prior to her notification, date not specified, the resident had not made any complaints about missing money. Resident #55 was hospitalized in October 2025, but the Administrator did not become aware of the incident until February 2026. The Administrator stated he did not report it because the Ombudsman asked him to report directly to her. The Administrator verified he did not file an SRI because it had been so long since the alleged event had occurred. The administrator stated he purchased and delivered snacks on 02/06/26 to replace the $30 that was allegedly missing. Review of policy titled Abuse, Mistreatment, Neglect, Exploitation, and Misappropriation dated 06/05/25 revealed the facility investigated and reported all alleged violations involving misappropriation to the Department of Health with 24 hours of the care team being notified of the allegation. This deficiency represents noncompliance investigated under Complaint Number 2993750.

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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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, resident interviews, staff interviews, and facility policy review, the facility failed to ensure residents received routine dental services. This affected two (Resident #12 and Resident #55) of two residents sampled for dental services. The facility census was 151. Findings include: 1.Review of the medical record revealed Resident #12 was admitted to the facility on [DATE]. Diagnoses included unspecified cerebrovascular disease, chronic pulmonary embolism, paranoid schizophrenia, mild vascular dementia with psychotic disturbance, and unspecified seizures. Review of the most recent Minimum Data Set (MDS) dated [DATE] revealed Resident #12 had moderately impaired cognition, had no behaviors, did not wander, and did not reject care. Resident #12 had adequate vision and did not use corrective lenses. Review of care plan dated 02/03/25 revealed Resident #12 has oral/dental health problems due to missing teeth and history of mouth pain. Interventions included administering medications as ordered, coordinating arrangements for dental care and transportation needs, observe and report dental problems, and encourage mouth care twice daily. Review of the medical record revealed Resident #12 revealed the resident had no progress notes regarding dental visits in last 12 months. Review of dental health services treatment record revealed Resident #12 had records for dental examinations provided on 07/20/22, 01/31/23, and 03/20/24. During an interview on 06/08/2026 at 11:35 A.M. Resident #12 stated she can't remember the last time she saw a dentist. Resident #12 denied dental pain but stated she had difficulty chewing. During an interview on 06/10/2026 10:18 at A.M. the Director of Nursing (DON) verified Resident #12 had not had dental services since 03/20/24. 2. Review of the medical record revealed Resident #55 was admitted to the facility on [DATE]. Diagnoses included Type II Diabetes, peripheral vascular disease, unspecified kidney disease, chronic pain syndrome, and unspecified anxiety disorder. Review of the most recent Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #55 was cognitively intact, had verbal behaviors, did not wander, and occasionally rejected care. Review of care plan dated 04/17/25 revealed Resident #55 had oral/dental problems due to missing teeth. Interventions included coordinating appointments and transportation for dental care, observe/report dental concerns, and encouraging mouth care twice daily. Review of the medical record revealed Resident #55 had a dental examination through the facility clinic on 11/05/25. At the time, the resident reported no dental pain, had multiple missing teeth, existing restorations, and moderate bone loss. Recommendations for care were illegible. On 04/02/26, Resident #55 refused dental services through the clinic at the facility, and there were no additional notes regarding attempts to schedule dental services. During an interview on 06/08/2026 at 3:50 P.M. Resident #55 stated he did not want dental services provided through the facility and had been trying to get an appointment at an outside dental provider for months. Staff told him the only dentist in the area who accepted Medicaid was all booked up for five months. During an interview on 06/10/2026 at 2:37 P.M. Licensed Practical Nurse (LPN) #419 stated Resident #55 refused to come down to the clinic because he did not like the dentist that provided services at the facility. She called the dentist's office and found out the dentist he did not like was not with the dental service anymore and a different dentist came last week. He said he did not want to see any dentist in the facility clinic. LPN #419 stated Medical Records #311 made appointments with outside providers. 06/11/2026 1:52 PM Medical Records #311 confirmed she had not become aware that Resident #55 needed a dental appointment scheduled with an outside provider until Resident #55 approached her at the beginning of the June 2026 and asked to have a dental appointment scheduled. The provider she contacted did not have an appointment available in June, and the provider said they would call the facility if they had any cancellations. Medical Records #311 confirmed she did not schedule an appointment for the first-available time while she had the opportunity. Resident #55 was upset there were no appointments available in June 2026. Medical Records #311 stated she had since called the provider (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	multiple time to schedule the next available appointment, but the provider did not answer. She left messages requesting a return call. Review of policy titled Dental Services dated 11/17/25 revealed the facility ensured residents received timely, appropriate, and safe dental care to maintain oral health, prevent complications, and support overall well-being. This deficiency represents noncompliance investigated under Complaint Number 2993750.

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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, resident interview, and staff interview, the facility failed to ensure food was served at appropriate and safe temperatures. This had the potential to affect 149 residents who received food from the kitchen. The facility identified two residents (#02 and #03) who did not receive food from the kitchen. The facility census was 151. Findings include: Observation on 06/10/26 at 7:49 A.M. revealed a large pan of individually scooped and covered plastic cups sitting on the counter in the tray line area. There was no ice nor any other method used to keep the contents cold. Further observation revealed the pan of plastic cups remained in the tray line area through the entire tray line service. Interview at the same time, Dietary Aid (DA) #690 stated the plastic cups contained yogurt. Review of a test tray on 06/10/26 at 9:32 A.M., after all residents had been served, revealed the eggs were 110 degrees Fahrenheit (F) and the yogurt was 64 degrees F. Interview at the time of the observation Director of Nutrition and Food Service (DNFS) #605 verified the eggs were 110 degrees F and the yogurt was 64 degrees F. DNFS #605 stated his expectation was for the eggs to be a minimum of 135-140 degrees F and the yogurt to be 45 degrees F or less at the time it reached the residents. Interview on 06/10/26 at 11:44 A.M., Resident #39 stated her eggs at breakfast were not hot enough and the food tends to not be served very hot. Review of the facility policy titled, Food Production, dated 10/06/25, revealed food would be served at the appropriate temperatures. This deficiency represents non-compliance investigated under Complaint Number 3042667, Complaint Number 2743663 and Complaint Number 2731043.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, the facility failed to prepare, serve, and store food in a manner to prevent against the potential spread of foodborne illness. This had the potential to affect 149 rresidents who received food from the kitchen. The facility identified two residents (#02 and #03) who did not receive food from the kitchen. The facility census was 151. Findings include: 1. Observation on 06/08/26 at 12:49 P.M. revealed a cart, which contained approximately 25 cups of juices, in the hallway in front of the nurse station of the [NAME] unit, the cups of juice were covered with several loose paper towels. Certified Nursing Assistants (CNA) #410 and #630 were observed taking cups of juice off the cart, placing them on resident lunch trays, and carrying the trays down the hall with the juice cups uncovered, to deliver to resident rooms. Interview on 06/08/26 at 12:50 P.M., CNA # 410 verified the cups of juice were covered with paper towels in the hallway and were not being covered once removed from the cart and being delivered to resident rooms. Interview on 06/09/26 at 9:49 A.M., Registered Dietitian (RD) #699 verified beverages should be covered when being taken down to hall to deliver to resident rooms. 2. Observation on 06/10/26 at 7:13 A.M. revealed Dietary Aid (DA) #600 stirring and serving hot cereal into individual containers. DA #600 had her hair tied back in a ponytail, which extended several inches down her back, and was not wearing a hairnet. Interview completed during the observation with DA #600 verified she was not wearing a hairnet while preparing food. 3. Observation on 06/10/26 at 8:46 A.M. revealed an unidentified person wearing scrubs enter the kitchen next to the tray line area, which was actively serving breakfast. The unidentified person had multiple braids, approximately six inches in length each and did not apply a hair restraint upon entering the kitchen. Director of Nutrition & Food Service (DNFS) #605 was observed telling the unidentified person to put on a hairnet, however the unidentified person kept walking and did not acknowledge DNFS #605. DA #690 then approached the unidentified person and directed the person to the other end of the kitchen, to obtain a hairnet. Interview at the time of the observation, DNFS #605 verified the unidentified person did not don a hairnet. DNFS #605 stated the person was a nursing assistant from the assisted living, however, was unsure of her name. 4. Observation on 06/10/26 at 8:50 A.M. revealed DA #600 removed an empty pan of pancakes from the steam table, placed it on top of the hot holding cart, opened the hot holding cart with her gloved hand, retrieved a new/full pan of pancakes from the hot holding cart, and placed the pan in the steam table. DA #600 then continued plating food and utilized the same gloved hand to handle the pancakes directly and placed them on plates. Interview on 06/10/26 at 8:52 A.M., DA #600 verified she touched a potentially soiled surface with her gloved hand and then directly handled food with the same gloved hand. Further observation on 06/10/26 at 8:53 A.M., DA #600 removed her gloves and applied a clean pair of gloves. DA #600 was not observed to perform hand hygiene between the glove changes. Interview on 06/10/26 at 8:54 A.M. DA #600 verified she did not perform hand hygiene between the glove changes. When queried, DA #600 stated she did not have anything available to sanitize her hands between the glove changes. 5. Observation on 06/10/26 at 8:57 A.M. revealed a fan resting on stacks of milk crates blowing directly into the tray line area. The intake vent of the fan was coated in a grey, fuzzy material. Interview on 06/10/26 at 9:42 A.M., DNFS #605 verified the fan was dirty and directed toward the tray line area. 6. Observation on 06/10/26 at 9:32 A.M. of the pantry refrigerator on the Peach unit revealed a yellow liquid in the drawers and bottom of the inside of the refrigerator. Interview at the same time, DNFS #605 verified the yellow liquid in the drawers and bottom of the inside of the refrigerator and verified the refrigerator needed to be cleaned. DNFS #605 stated he was unsure who was responsible for ensuring unit refrigerators were maintained in a clean and sanitary manner. 7. Observation on 06/10/26 at 11:03 A.M., [NAME] #615 retrieved a stock pot from storage, placed it directly on the floor below the grill and began filling it with water from the spigot above. Continued observation on (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	06/10/26 at 11:04 A.M., [NAME] #615 picked the pot, now full of water, off the floor and placed it on the stove and took another pot that was on the stove and placed it directly on the floor and filled it with water, and placed it on the stove. Interview on 06/10/26 at 11:05 A.M., [NAME] #615 verified he placed the clean pots on the floor to fill them with water, and then placed them back on the stove. 8. Observation 06/11/2026 at 8:58 A.M. revealed Certified Nursing Assistant (CNA) #325 setting up the breakfast tray for Resident #8. CNA #325 unpeeled the half banana and used her bare hands to place the fruit on the resident's plate. During an interview on 06/11/2026 at 9:00 A.M. CNA #325 confirmed she had used her bare hands to unpeel Resident #8's half banana and place fruit on plate. Review of the facility policy titled, Kitchen Sanitation, dated 10/06/25, revealed the facility would ensure sanitary food handling practices would be maintained in the preparation and service areas at all times. Equipment would be clean and free of spills. Food would be covered. Review of the facility policy titled, Food Production, dated 10/06/25, revealed food will be served with clean utensils or gloves worn for a single use task with hand hygiene performed. Review of the facility policy titled, Safe Food Handling, dated 03/02/26, revealed staff should wear hair restraints to effectively keep their hair from contacting exposed food.

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, interview and facility policy review, the facility failed to provide quarterly screening for therapy services. This affected one (Resident #7) of three residents sampled for therapy services. The facility census was 151. Findings include: Review of the medical record revealed Resident #7 was admitted to the facility on [DATE]. Diagnoses included Type II Diabetes, Chronic Obstructive Pulmonary Disease (COPD), chronic diastolic heart failure, unspecified anxiety disorder, unspecified chronic kidney disease, and unspecified anxiety disorder. Review of the most recent Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #7 was cognitively intact, had no behaviors, did not wander, and frequently rejected care. Review of care plan dated 09/28/25 revealed Resident #7 required assistance with (activities of daily living) ADL's. Interventions included assisting with ADLs as needed, encouraging resident to participate to the fullest extent, and for therapy to screen routinely, evaluate, and treat as ordered. During an interview on 06/08/2026 at 11:22 A.M. Resident #7 stated his arms were getting weaker from being in bed, and he could use therapy. Review of the medical record revealed Resident #7 received Physical and Occupational Therapies from 09/23/25 to 10/16/25 and was discharged due to lack of progress and lack of compliance/participation in therapy. During an interview on 06/11/2026 at 9:14 A.M. Director of Therapy Services #800 confirmed Resident #7 had not been evaluated for therapy services since he was discharged in October 2025. He confirmed each resident was supposed to be screened quarterly. Review of policy titled Therapy Screen For Rehabilitation Needs dated 12/05/25 revealed quarterly facility-wide screens were conducted to identify residents who might benefit from skilled therapy. This deficiency represent noncompliance investigated under Complaint Number 2787374, Complaint Number 2785032 and Complaint Number 2743663.