

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

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Form Approved OMB
No. 0938-0391

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 06/23/2026
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)		
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.		

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 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 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: 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 (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, staff interviews, review of online resources from the Centers for Disease Control and Prevention (CDC), and facility policy review, the facility failed to ensure a comprehensive Water Management Plan was implemented to minimize the risk of waterborne pathogens including Legionella. This had the potential to affect all residents living in the facility. The facility also failed to ensure enhanced barrier precautions (EBP) were in place and failed to ensure staff utilized proper personal protective equipment (PPE) this affected two (#80 and #162) of three residents reviewed for EBP. The facility census was 151. Findings include: 1. Review of the Water Management Plan with Maintenance Director #200 revealed the facility's water management plan expired on [DATE] and had not been updated to include the current Administrator, Director of Maintenance and Infection Control Preventionist. Review of the water management implementation plan revealed no documentation from 05/2025 through current. Interview on [DATE] at 3:14 P.M. with Maintenance Director #200 verified the facility did not have a current Water Management Plan in place to prevent the growth of Legionella, and verified the facility had no documentation of the prior water management plan being implemented from 05/2025 to present. 2. Review of the medical record of Resident #80 revealed an admission date of [DATE]. Diagnoses included osteomyelitis and chronic obstructive pulmonary disease. Review of the comprehensive MDS assessment dated [DATE] revealed the resident had intact cognition. The resident required setup/cleanup assistance with eating, supervision with bed mobility, and partial/moderate assistance with toileting, bathing, and transfers. Review of physician orders revealed an order dated [DATE] to follow contact isolation protocols for right foot MRSA (methicillin-resistant staphylococcus aureus). Observation on [DATE] at 12:43 P.M. revealed Registered Nurse (RN) #620 in the room of Resident #80 with no personal protective equipment (PPE) on. Further observation revealed the door to Resident #80's room had the Centers for Disease Control (CDC) contact precautions sign and instructions for donning and doffing PPE. The signs indicated the need for a gown, gloves, mask, and eye protection. Interview on [DATE] at 12:45 P.M., RN #620 verified she did not don the appropriate PPE upon entering Resident #80's room. RN #620 stated she went in to answer the call light and verified PPE should be donned with any entrance into the room. Interview on [DATE] at approximately 3:00 P.M., the Director of Nursing (DON) verified full PPE should be applied prior to entering the room. 3. Review of the medical record revealed Resident #162 was admitted to the facility on [DATE]. Diagnoses included infection and inflammatory reaction to internal left knee prosthesis, hypertensive heart disease with heart failure, malignant neoplasm of the prostate, unspecified anxiety disorder, and secondary neoplasm of the bone. Review of the most recent Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #162 had moderately impaired cognition, had no behaviors, did not wander, and did not reject care. Review of the medical record revealed Resident #162 a physician order dated [DATE] for Enhanced Barrier Precautions when engaging in high contact resident care activities for open wound, every shift. Observation on [DATE] at 3:16 PM revealed Resident #162 had no sign posted on or near his door to alert staff and visitors that he required Enhanced Barrier Precautions and there was no Personal Protective Equipment (PPE) bin located either in the room or near the outside of the room. During an interview on [DATE] at 2:46 P.M. Licensed Practical Nurse (LPN) #484 verified there was no EBP sign or PPE cart either in the room or outside of door for Resident #162. During an interview on [DATE] at 3:13 P.M. Assistant Director of Nursing (ADON) #380 verified Resident #162 had just returned from hospital on [DATE] and was moved to a new room. The ADON stated she usually did a (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	walk through the facility every Monday morning to make sure all EBP signs were hung appropriately and PPE bins were in place but had not had time this morning while gathering items for the survey. During an interview on [DATE] at 4:33 P.M. ADON #380 confirmed the facility hung signs outside of resident rooms informing staff and visitors to the type of precautions a resident had and placed a PPE bin in or near the resident's room. Review of the policy titled, Infection Prevention & Control Program, dated [DATE], revealed a water management program has been established as part of the overall infection prevention and control program and control measures and testing protocols are in place to address potential hazards. The Maintenance Director serves as the leader of the water management program. Review of the facility policy titled, Transmission-Based Precautions, dated [DATE], revealed PPE should be donned upon room entry and discarded before exiting the room.		

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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.		

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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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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview and facility policy review, the facility failed to ensure care plans were timely reviewed and revised for one resident (#42), and failed to conduct quarterly care conferences for three residents (#5, #7 and #12) of eight reviewed for care plans. The facility census was 151. Findings include: 1. Review of the medical record revealed Resident #42 was admitted to the facility on [DATE] with diagnoses of atrial fibrillation, chronic obstructive pulmonary disease, non-traumatic subarachnoid hemorrhage, hypertensive heart disease and acute respiratory failure with hypoxia. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #42 had intact cognition and was occasionally incontinent bowel and always incontinent bladder. The resident required set up assistance for eating, moderate assistance for oral hygiene, bed mobility and transfers, maximal assistance for personal hygiene, and was dependent for toileting, bathing and dressing. Review of Section K. Swallowing/Nutritional Status, K0300 revealed Resident #42 triggered for a weight loss of 5% or more in the last month or loss of 10% or more in the last six months. Review of the care plan for Resident #42 dated 01/15/26 revealed Resident #42 presented with potential for nutritional risk related to hypertension, anemia, major depressive disorder, cardiac pacemaker, hypothyroidism and medications with nutritionally adverse side effects with the goal the resident would not exhibit significant weight change. Interventions were to document food/fluid intakes, honor food/fluid preferences as possible, lab/diagnostic work as ordered and report results to physician (MD) and follow up as indicated, provide and serve diet as ordered, provide and serve supplements as ordered, Registered Dietician (RD) to evaluate and make diet change recommendations as needed, therapy to screen quarterly and as needed, and weights as ordered/indicated with notification to physician of significant weight changes. Review of weights for Resident #42 revealed on 03/05/26 Resident #42 weighed 162.9 pounds and on 04/10/26 weighed 138.4 pounds. This represented a weight loss of 15.04 percent. Review of physician orders for Resident #42 revealed an order dated 03/18/26 for Resident #42 to be administered Mirtazapine (antidepressant) tablet 7.5 milligrams (mg), give 1 tablet by mouth at bedtime for depression/appetite. This was ordered prior to Resident #42's 15.04 percent weight loss between 03/05/26 and 04/10/26. Review of Resident Care Team Review document for Resident #42 dated 04/16/26 and authored by Registered Dietician (RD) #699 verified Resident #42's significant weight loss and revealed the resident was not receiving a dietary intervention. The RD's recommendations included a depression screening, weekly weights and an appetite stimulant. Weekly weights for Resident #42 were initiated on 05/06/26. Review of Resident Care Team Review document for Resident #42 dated 05/08/26 and authored by Registered Dietician Assistant (RDA) #695 revealed the resident did not have any new dietary (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	interventions. The RDA's recommendations included changing the diet consistency to pureed, administering Ensure Clear three times a day, and fortified potatoes. Review of the care plan for Resident #42 dated 01/15/26 revealed it was not updated to include the RD's recommendations for a depression screening, weekly weights, appetite stimulant, pureed diet consistency, Ensure Plus, and fortified potatoes. Interview on 06/10/26 at 10:30 A.M. with the Director of Nursing verified Resident #42's care plan had not been updated/revised to include the 04/16/26 and 05/08/26 RD recommendations that were implemented. 2. Review of the medical record revealed Resident #5 was admitted to the facility on [DATE]. Diagnoses included Type II Diabetes with chronic kidney disease, fibromyalgia, and hypertensive heart disease. Review of most recent Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #5 was cognitively intact, had no behaviors, did not wander, and occasionally rejected care. Review of the medical record revealed Resident #5 had two care conferences in the last 12 months documented on 04/08/26 and 11/18/25. During an interview on 06/10/2026 at 12:26 P.M. Licensed Social Worker (LSW) #385 verified Resident #5 did not have quarterly care conferences in the last 12 months LSW #385 verified the resident should have had a care conference in February 2025 and May 2025. 3. 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 the medical record revealed since admission, Resident #7 had care conferences on 09/24/25 and 01/20/26. During an interview on 06/10/2026 at 12:23 P.M. LSW #385 verified Resident #7 should have had a care conference in March or April 2026 and was due fo another care conference either this month or next month. 4. 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 the medical record revealed Resident #12 had two care conferences in the last 12 months on 10/17/25 and 04/08/26. During an interview on 06/10/2026 at 12:25 P.M. LSW #385 stated Resident #12 had an annual MDS in December 2025, and a quarterly MDS in February 2026 and should have had care conferences at those times. Review of policy titled Comprehensive Care Plan dated 05/16/24 revealed the comprehensive care plan will be reviewed and revised by the interdisciplinary team (IDT) after each comprehensive and quarterly MDS assessment. Review of policy titled Care Conferences dated 05/16/2024 revealed care conferences were scheduled to include the resident, representative, and IDT team as soon as possible after admission, routinely, and with a change in condition.		

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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, observation, staff interview, and policy review, the facility failed to provide dignified care to a resident with an external catheter. This affected one (Resident #162) of eight residents sampled for dignity. The facility census was 151. Findings include: Review of the medical record revealed Resident #162 was admitted to the facility on [DATE]. Diagnoses included infection and inflammatory reaction to internal left knee prosthesis, hypertensive heart disease with heart failure, malignant neoplasm of the prostate, unspecified anxiety disorder, and secondary neoplasm of the bone. Review of the most recent Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #162 had moderately impaired cognition, had no behaviors, did not wander, and did not reject care. Review of the medical record revealed Resident #162 had physician orders dated 06/01/26 for condom catheter output every shift. Observation on 06/08/2026 at 2:43 P.M. revealed Resident #162 lay in bed. A urinary catheter drainage bag was hanging on the side of the bed facing the hallway and urine content was visible from hallway. There was no dignity cover. During an interview on 06/08/2026 at 2:47 P.M. Licensed Practical Nurse (LPN) #433 verified Resident #162's urinary catheter drainage bag was visible from hallway and did not have a dignity cover. Review of policy titled Resident-Patient Rights dated 02/20/2026 revealed care members treated residents with kindness, respect, and dignity, and provided care the enhanced and promoted quality of life, patient preferences, and individuality.		

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NAME OF PROVIDER OR SUPPLIER Majestic Care of Cedar Village.		STREET ADDRESS, CITY, STATE, ZIP CODE 5467 Cedar Village Drive Mason, OH 45040	
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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, 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 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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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interviews, and facility policy review, the facility failed to develop comprehensive care plans. This affected one (Resident #12) of eight residents sampled for care plans. The facility census was 151. Findings include: 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 eye examination summary dated 02/04/26 revealed Resident #12 had a diagnosis for mild, incipient cataracts to both eyes. Resident #12 had new eyeglasses prescribed, but they needed to wait to order new glasses related to new insurance. She was due to be re-evaluated for eyeglasses on 02/11/26 for further evaluation and testing to guide diagnosis and therapy. Review of the medical record revealed Resident #12 did not have a care plan for vision needs. During an interview on 06/10/2026 at 3:53 P.M. (Assistant Director of Nursing) ADON #380 verified Resident #12 did not have a care plan for vision services related to her diagnosis of cataracts Review of policy titled Hearing and Vision Services dated 08/04/26 revealed the facility provided ongoing monitoring of sensory problems, reviewed factors and history regarding vision abilities from medical records, and developed and implemented care plans including assistive devices used, adaptive equipment used, and communication strategies. Review of policy titled Comprehensive Care Plans dated 05/16/24 revealed the facility developed and implemented a comprehensive person-centered care plan for each resident that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs.		

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, interviews, and facility policy review, the facility failed to provide timely services to maintain vision. This affected one (Resident #12) of two residents sampled for vision services. The facility census was 151. Findings include: 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 eye examination summary dated 04/04/26 revealed Resident #12 had a diagnosis for mild, incipient cataracts both eyes. Resident #12 had new eyeglasses prescribed, but they needed to wait to order new glasses related to new insurance. She was due to be re-evaluated for eyeglasses on 02/11/26 for further evaluation and testing to guide diagnosis and therapy. During an interview on 06/08/2026 at 11:33 A.M. Resident #12 stated her glasses were broken and she cannot read without them. She stated she cannot read her bills. During an interview on 06/10/2026 at 4:20 P.M. Licensed Practical Nurse (LPN)#419 verified Resident #12 had prescription for glasses since February 2026 and still did not have glasses due to concerns with insurance. 06/11/2026 10:37 AM Assistant Director of Nursing (ADON) #380 verified she was unaware Resident #12 had concerns with broken glasses, she verified the resident had a prescription since February and had insurance issues with getting glasses. ADON #380 stated the expectation would be that the clinic nurse would communicate there was a delay in getting glasses so the facility could determine the best course of action as a team. During an interview on 06/11/2026 at 10:50 A.M. LPN #419 stated she followed up the ophthalmologist who said insurance can and will pay for glasses but Resident #12 or family would have to go to Walmart to get them. Review of policy titled Hearing and Vision Services dated 08/04/25 revealed the facility ensured residents received timely services to maintain their highest practicable level of well-being.		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview, and review of the facility policy, the facility failed to ensure antipsychotic medication had an adequate clinical indication for use. This affected three residents (#2, #20 and #156) of five residents reviewed for unnecessary medications. The facility census was 151. Findings include: 1. Review of the medical record revealed Resident #20 was admitted to the facility on [DATE] with diagnoses of unspecified dementia and anxiety disorder. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #20 had severe cognitive impairment and was frequently incontinent bowel and always incontinent of bladder. The resident required set up assistance for eating and oral hygiene, supervision for bed mobility, moderate assistance for toileting and transfers, and maximal assistance for personal hygiene, bathing and dressing. Review of physician orders for Resident #20 revealed an order dated 02/27/26 for Risperidone (antipsychotic) oral tablet 0.25 milligrams (mg), give 0.25 mg by mouth two times a day for dementia. Review of 2021 [NAME] Pocket Drug Guide for Nurses revealed Risperidone was classified as an antipsychotic and had a Black Box Warning (BBW) that stated not for use in elderly patients with dementia; there was an increased risk of cardiovascular mortality; not approved for this use. Indications included treatment of schizophrenia and treatment of bipolar disorder. Interview on 06/09/2026 at 3:48 P.M. with the Director of Nursing (DON) verified dementia was not an acceptable diagnosis for Resident #20 to be administered Risperidone. 2. Review of the medical record for Resident #156 revealed an admission date of 06/04/26. Diagnoses included left femur fracture, left humerus fracture, left wrist fracture, Alzheimer's disease, and dementia without behavioral disturbance. Review of the activities of daily living (ADL) care plan, dated 06/05/26, revealed the resident required assistance with Activities of Daily Living (ADLs) related to left femur, humerus, ulna, and wrist fractures. The resident was dependent on staff for bed mobility, dressing, transfers, and toileting. Review of physician orders revealed an order dated 06/08/26 for Haloperidol (antipsychotic) 0.5 milligrams (mg), 1 tablet by mouth every six hours as needed for agitation. Interview on 06/09/26 at 3:27 P.M., the Director of Nursing (DON) verified agitation is not an appropriate diagnosis for Haloperidol. 3. Review of records for Resident #2 revealed an admission date of 05/01/26 with diagnoses including Alzheimer's disease, Type Two Diabetes mellitus (DM2), and dementia with other behavioral disturbance. Review of Minimum Data Set (MDS) dated [DATE] revealed Resident #2 had moderate cognitive impairment, and no identified mood issues. Resident #2 exhibited the following behaviors daily: delusions, verbal behaviors directed towards others, and other behaviors not directed at others. Resident #2 also significantly intruded on the privacy and activities of others, significantly disrupted care, rejected care, and wandered daily. Resident #2's list of active diagnoses revealed no identified psychiatric or mood disorder diagnoses. Review of Preadmission Screening and Resident Review (PASRR) dated 05/08/26 revealed Resident #2 had a diagnosis of Alzheimer's disease, and no other indications of serious mental illnesses were noted. The PASRR noted Resident #2 was receiving anti-psychotic medications. Review of physician's orders revealed an order dated 05/01/26 for Seroquel 50 milligrams (mg) twice a day for mood changes and dated 05/18/26. During an interview on 06/09/26 at 3:30 P.M. the Director of Nursing (DON) stated whoever put the orders in the electronic system would put in a diagnosis for a medication if one was not specified by physician. DON verified mood changes was not an appropriate diagnosis for Seroquel. Review of policy titled, Psychotropic Medication Use, effective 08/01/25, revealed the purpose of the policy was to ensure the safe, appropriate, and ethical use of psychotropic medications in the (continued on next page)		

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

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	treatment of individuals served by our organization, in accordance with clinical standards, regulatory requirements, and person-centered care principles promoting the health and well-being of individuals while preventing unnecessary use and chemical restraints. Diagnosis and targeted symptoms must be documented in the medical record for any psychotropic medication use.		

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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 (continued on next page)		

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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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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.		

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident interview, staff interview, and facility policy review, the facility failed to ensure bed rails were adequately secured to the bed. This affected one (#23) of one resident reviewed for bed rails. The facility census was 151. Findings include: Review of the medical record of Resident #23 revealed an admission date of 08/20/25. Diagnoses included heart failure, Type II Diabetes Mellitus, and ischemic cardiomyopathy. Review of the quarterly minimum data set (MDS) assessment dated [DATE] revealed the resident had intact cognition. The resident required supervision for bed mobility. Review of physician orders revealed an order dated 08/20/25 for 1/4 side rails on both sides of the bed. Review of the plan of care dated 08/27/25 revealed the resident required assistance with activities of daily living related to impaired mobility, weakness, debility, and edema. Interventions included to provide 1/4 side rails to aid in bed mobility. Interview on 06/08/26 at 11:22 A.M., the resident stated his side rails kept falling down because they were so loose. The resident stated the side rails had been tightened several times but kept coming loose. Observation at the time of the interview revealed, the resident pulled the side rail and it was not secure. The rail moved approximately four inches from center on each side of the rail. Interview on 06/09/26 at 9:08 A.M., Registered Nurse (RN) #620 verified Resident #23's side rails were not adequately secured. Interview on 06/09/26 at 9:26 A.M., Maintenance Director (MD) #200 stated he had tightened Resident #23's side rails several times, however the locking nut kept getting loose. Review of the facility policy titled, Bed Rails, dated 03/23/26, revealed, if bed rails are used, the facility ensures correct installation, use, and maintenance of the rails.		