STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366201	A. Building B. Wing	07/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Majestic Care of Whitehall	4805 Langley Avenue Whitehall, OH 43213

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20298 Based on record review, observation, staff and resident interviews, and policy review, the facility failed to timely provide one resident (#63) with an operating electric wheelchair. This affected one (Resident #63) of three residents reviewed for accomodation of needs. The facility census was 130. Findings include: Medical record review revealed Resident #63 was admitted on [DATE] with diagnoses including right side hemiplegia from a stroke. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #63's cognition was intact. The current care plan revealed the resident required two staff for lift transfers to his wheelchair. Interview and observation with Resident #63 on [DATE] at 7:12 A.M. revealed he had an electric wheelchair that was not working, but he would like to use this wheelchair instead of a standard wheelchair. Observation of the resident's room revealed the electric wheelchair was in the resident's bathroom not charging and the resident was in bed. Interview with Therapy Director #99 on [DATE] at 8:00 A.M. revealed the battery for Resident #63's wheelchair died because the night shift staff were not properly charging the battery. She obtained a quote from the wheelchair company for the battery replacement on [DATE] and asked to former Administrator to approve the expense of 460 dollars which did not happen. Interview with the Director of Nursing (DON) and Administrator on [DATE] at 8:25 A.M. revealed the DON was not aware of the concern with night shift not charging the battery for Resident #63's electric wheelchair. The Administrator stated he was not aware of this need for approval for the wheelchair battery to be ordered. The Administrator stated he will order the battery that day ([DATE]). Review of the policy titled Accommodation of Needs dated February 2023 revealed the staff will make reasonable accommodations to promote resident's independent functioning, dignity, and well being. This deficiency represents non-compliance investigated under Complaint Number OH00155945.

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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NAME OF PROVIDER OR SUPPLIER Majestic Care of Whitehall		STREET ADDRESS, CITY, STATE, ZIP CODE 4805 Langley Avenue Whitehall, OH 43213	

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20298 Based on medical record reviews, review of a Self-Reported Incident investigation, policy review, and staff interviews, the facility failed to timely notify the responsible party and physician of an elopement incident from the secured unit for Resident #4. This affected one (#4) of three residents reviewed for elopement. The facility census was 130. Findings include: Medical record review revealed Resident #4 was admitted to the facility on [DATE] with diagnoses including dementia, psychosis, and anxiety. Review of the most recent Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #4 had severely impaired cognition and was ambulatory. Review of an elopement assessment dated [DATE] revealed Resident #4 had no elopement history, was exit seeking, wandered, and resided on the secured unit. Review of a Self-Reported Incident involving the elopement of a different resident (#6) on 06/30/24 revealed the next day on 07/01/24 when investigating it was discovered that Resident #4 also got out of the secured unit and into the parking lot around 12:05 P.M. Resident #4 was returned to the secured unit within 10 minutes by a staff person who observed the resident in the parking lot. Licensed Practical Nurse (LPN) #60 and the state tested nursing assistants (STNAs) working in the secured unit did not report Resident #4's elopement the Director of Nursing (DON) on 06/30/24 until they were questioned on 07/01/24. Resident #4 was assessed on 07/01/24 with no injuries. Interview with the DON on 07/22/24 at 10:00 A.M. verified LPN #60 did not report the 06/30/34 elopement incident involving Resident #4 to her until 07/01/24. Resident #4's physician and responsible party/daughter were not notified of the incident until the afternoon of 07/01/24 more than 24 hours later. LPN #60 was not available for an interview during the investigation. Review of the policy titled Change in Condition/Notification of Physician dated 12/12/23 revealed the nurse will notify the physician and resident's responsible party when an incident occurs involving the resident within 24 hours. Review of the policy titled Elopement and Wandering dated 12/12/23 revealed after a resident elopement incident, the physician and responsible party will be notified. This deficiency represents non-compliance investigated under Complaint Number OH00155945.

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20298 Based on medical record reviews, review of a Self-Reported Incident (SRI) investigation, policy review, and staff interviews, the facility failed to ensure staff provided adequate supervision to prevent a resident, with altered mental status and exhibited exit seeking behaviors, from leaving the facility unsupervised. This affected one (Resident #6) of three residents reviewed for elopement. The facility census was 130. Findings include: Medical record review revealed Resident #6 was admitted to the facility on [DATE]. Diagnoses included Alzheimer's dementia and anxiety. Review of the most recent Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #6 had severely impaired cognition and was ambulatory. Review of the elopement assessment dated [DATE] revealed Resident #6 had no elopement history, wandered aimlessly, was exit seeking, and resided on the secured unit. Review of the facilities Self-Reported Incident investigation revealed an allegation of neglect was reported to the State Survey Agency. Resident #6 had eloped from the secured unit on 06/30/24 at approximately 12:05 P.M. when the exit door alarm sounded. State tested Nursing Assistant (STNA) #72 found another resident (Resident #4) outside in the parking lot after responding to the exit door alarm. The STNA did not report to any staff immediately that she had found Resident #4 in the parking lot. When Licensed Practical Nurse (LPN) #60 returned from her break at 12:30 P.M. she was informed that Resident #4 eloped and was found in the parking lot by staff from a different unit. LPN #60 initiated a resident head count and discovered Resident #6 was missing; the Director of Nursing (DON) was notified and arrived at the facility around 1:00 P. M. Resident #6 was found by STNA #75 at around 1:10 P.M. more than an hour later off the facility premises 0.2 miles away. It appeared that Resident #6 walked along a pathway that was behind four houses that was not near a street or dangerous area between the facility grounds and the area she was found. The investigation revealed that when the alarm sounded at 12:05 P.M. the STNAs on the secured unit did not respond but Activity Staff #78 went outside the alarming door and did not observe any residents outside. The staff did not report Resident #4's elopement to the DON, physician or responsible party until 07/01/24. Resident #4 was assessed on 07/01/24 with no injuries. When Resident #6 returned to the secured unit, she was assessed with no injuries on 06/30/24. Staff did not observe either resident leave the secured unit and there was no video footage, but the conclusion was most likely both residents exited the facility together at 12:05 P.M. when the alarm sounded. The root cause identified the STNAs did not answer the door alarm timely, and did not complete a thorough search or timely head count. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Majestic Care of Whitehall	4805 Langley Avenue Whitehall, OH 43213

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the DON and Corporate Registered Nurse (CRN) #100 on 07/22/24 at 10:00 A.M. verified none of the staff observed Residents #4 or #6 exit the memory care. Staff did not report the 06/30/34 elopement involving Resident #4 until 07/01/24, STNAs did not answer the door alarm timely, complete a thorough search or timely head count. The DON stated they had no video footage but most likely the two residents exited at the same time without staff supervision and none of the staff received written counseling; however, there was all staff training regarding elopements. Interview on 07/22/24 at 4:05 P.M. with STNA #72 confirmed she worked a different unit and returned Resident #4 from the parking lot to the secured unit when she was returning from her break around 12:15 P. M. on 06/30/24. Interviews on 07/23/24 with STNA #82 at 6:42 A.M. and Activity Staff #78 at 10:05 A.M. verified that on 06/30/34 at 12:05 P.M., they did not observe any residents exiting the secured unit, did not answer the door alarm timely, complete a thorough search for residents or timely head count until after 12:30 P.M., then realized Resident #6 was missing. LPN #60 was not available for an interview during the investigation. Review of the policy titled Elopement and Wandering dated 12/12/23 revealed residents who were at high risk for elopement including unsafe wandering will be provided with adequate supervision to prevent incidents. Adequate supervision will be provided to help prevent elopements. Any staff aware of a missing resident will alert personnel using the facility approved code alert and search for the resident. Upon return, the resident will be assessed, and the physician and responsible party will be notified. This deficiency represents non-compliance investigated under Control Number OH00156043 and Control Number OH00155570. This is an example of continued non-compliance from the survey dated 06/18/24.

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20298 Based on medical record reviews, policy review, and interviews with residents, staff, and physician, the facility failed to provide a resident with timely physician services. This affected one (Resident #115) of seven residents reviewed for physician services. The facility census was 130. Findings include: Medical record review revealed Resident #115 was admitted [DATE] with diagnoses including cirrhosis of the liver, emotional distress, and generalized pain. Review of the resident's most recent Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #115 had intact cognition. Resident #115's physician was Physician #70. Further review of the medical record revealed the resident's most recent examination from Physician #70 was on 05/07/24. Resident #115 was not seen by a physician assistant, nurse practitioner, or clinical nurse specialist from 05/07/24 to 07/22/24. Interview with Resident #115 on 07/22/24 at 10:30 A.M. revealed Physician #70 had not examined him in 11 weeks and he had concerns about his kidney function, x-rays completed in May 2024, and pain issues he wanted to discuss with the physician. Interview with Corporate Registered Nurse (CRN) #100 on 07/22/24 at 12:55 P.M. verified Physician #70's last examination of Resident #115 was on 05/07/24 which was 86 days ago. Resident #115 had no other visits from the Medical Director or a certified nurse practitioner (CNP) during since 05/07/24. Telephone interview with Physician #70 on 07/22/24 at 1:00 P.M. verified his last examination of Resident #115 was on 05/07/24. He had no explanation for the delay in his examination of Resident #115. Review of the policy titled Physician Visits dated 12/12/23 revealed the physician or delegate approved by law must review the resident's total program of care including medications and treatment at least every 60 days after the first 90 days after admission. Each visit, the physician developed, signed and dated a progress note for each visit plus signed and dated all physician orders. This deficiency represents non-compliance investigated under Complaint Number OH00156040.