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	08/14/2024

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 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 49039

Based on record review, staff interview, review of the police report, and review of the facility policy, the facility failed to provide adequate supervision and a safe environment to prevent a resident from recurrent overdosing in the facility. This affected one (Resident #88) of one resident reviewed for safe environment. The facility census was 129.

Findings include:

Review of Resident #88's medical record revealed an admitted [DATE] with a diagnosis including psychoactive substance abuse. Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #88 was cognitively impaired and he can independently ambulate via an electric wheelchair. Resident #88 received antianxiety, antidepressant, and opioid medications.

Review of Resident #88's physician orders starting on 05/25/24 revealed an order for Suboxone sublingual film 8-2 milligrams (mg), to be taken one film sublingually once a day for opioid dependence.

Review of Resident #88's care plan dated 07/25/24 revealed he exhibited behaviors such as consistently declining to sign out, due to polysubstance abuse. On 07/28/24, a urine drug test revealed fentanyl, marijuana, cocaine, and Suboxone in his system. He was found with a black tar substance in a paper and pipe, with the same substance in his room, and experienced multiple unwitnessed falls related to drug use. Staffing interventions include administering medications as ordered, allowing the resident to express feelings and needs, approaching the resident in a calm and friendly manner, assessing the resident's needs, documenting behaviors, encouraging family involvement, explaining tasks before initiating them, familiarizing the resident with belongings and surroundings, offering multiple choices, postponing care if the resident is resistant, listening to the resident's needs and adjusting the plan as appropriate, maintaining a safe environment, notifying the medical director and psychiatric services for increased behavioral symptoms, providing positive feedback for good behavior, and ensuring personal space.

Review of the initial psychiatry note dated 07/26/24 revealed Resident #88 was exhibiting severe generalized anxiety symptoms and expressed a desire for more activities at the facility. He reported feelings of depression and anxiety.

Review of the progress notes dated 07/27/24 at 7:13 P.M. revealed Resident #88 returned from a leave of absence.

(continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366201	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/14/2024
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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(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	Review of the change in condition evaluation dated 07/28/24 revealed Resident #88 had a fall resulting in loss of consciousness, likely due to an opioid overdose. Review of the incident and accident investigation form dated 07/28/24 revealed his nurse found Resident #88 sitting in the restroom with the door closed, facing the sink. He repeatedly said me. The resident was administered Narcan and sent to the hospital for evaluation. Review of the local police department incident report dated 07/28/24 revealed Resident #88's crack pipe was confiscated from his room, and he was charged with illegal use or possession of drug paraphernalia. On 07/28/24 at 9:19 A.M., an officer was dispatched to the facility for a reported overdose. The officer was handed a crack pipe found in Resident #88's left pant pocket. Licensed Practical Nurse (LPN) #222 informed the officer that Resident #88 was found sitting on the bathroom floor next to his wheelchair, unresponsive, with a small amount of blood observed. LPN #222 administered Narcan. Review of the hospital record dated 07/28/24 revealed Resident #88 was admitted for unresponsiveness, likely secondary to a drug overdose. The progress note dated 07/28/24 revealed the interdisciplinary team (IDT) met to review Resident #88's risk factors and safety measures. The incident was considered isolated and related to substance abuse. The IDT agreed on the intervention of immediate emergency department (ED) transfer for treatment and medication review upon return. The plan of care (POC) was reviewed and updated as needed. The progress note dated 07/29/24 revealed the facility received a call from the local hospital reporting Resident #88 tested positive for marijuana, buprenorphine, cocaine, and fentanyl. The progress notes dated 07/31/24 at 5:34 P.M. revealed Resident #88 was readmitted to the facility. Review of the admission/reassessment assessment dated [DATE] revealed Resident #88 had used recreational drugs in the past year and was concerned about withdrawal symptoms from substances and/or alcohol. The progress notes dated 08/01/24 revealed the event from 07/28/24 was discussed. The resident discussed continued treatment for substance use disorder, expressed remorse for the incident, and discussed attending recovery meetings. The facility provided the resident with a list of local meetings to promote recovery. The care plan was updated on 08/01/24 and revealed Resident #88 was seen by a local addiction agency weekly for injections and prefers to transport himself while refusing facility-scheduled transportation. Pertinent interventions include identifying behavior triggers and reducing exposure to them. Review of the change in condition evaluation completed 08/02/24 revealed Resident #88 had an altered level of consciousness after a fall due to a possible opioid overdose. The progress note dated 08/02/24 at 1:11 A.M. revealed Resident #88 was found on the floor in his room beside his bed with a glass pipe containing brownish-black residue. The transfer form dated 08/02/24 revealed Resident #88 was transferred due to an overdose related to drug use. The progress note at 6:03 A. M. indicated the resident had returned from the hospital. (continued on next page)

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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	Review of the local police department summons report dated 08/02/24 revealed Resident #88 was found with a glass pipe containing residue and was charged with drug paraphernalia use or possession. The officer was dispatched to the facility for an overdose report. Upon arrival, the officer made contact with Resident #88, who claimed he was not overdosing. Staff found him next to his bed with a glass pipe nearby. The officer was informed that an additional pipe was confiscated on 07/28/24 when he overdosed on fentanyl. Review of the hospital record dated 08/02/24 revealed Resident #88 was administered Narcan, and within one minute of its administration, he was sitting upright at the end of the bed asking to leave. Shortness of breath symptoms were suspected to be related to an opioid overdose. The progress notes dated 08/02/24 revealed the IDT team met to discuss risk factors and safety measures. The IDT agreed that the incident was isolated and related to drug use. They agreed on the intervention of having Resident #88 call for assistance if he falls to alert staff. The resident was offered narcotic addition (NA/alcoholic anonymous (AA) counseling and follow-up with an outpatient drug center for additional drug use and with an AA sponsor. Interview on 08/14/24 at 11:14 A.M. with LPN #222 revealed Resident #88 likely obtained drugs from outside the facility because he attends recovery meetings and treatment unsupervised. LPN #222 expressed doubt that Resident #88 attends the meetings as reported and does not think he should transport himself due to his history of substance use disorder. Interview on 08/14/24 at 11:19 A.M. with State tested Nursing Assistant (STNA) #319 confirmed Resident #88 frequently signs out of the building unattended. STNA #319 suspects he obtains drugs from outside the facility. Interview on 08/14/24 at 11:40 P.M. with LPN #238 confirmed no interventions were in place to prevent Resident #88 from overdosing again. LPN #238 noted that he frequently takes leave of absences without notifying anyone. Interview on 08/14/24 at 3:08 P.M. with the Director of Nursing (DON) confirmed adequate supervision was not in place to prevent Resident #88 from overdosing on 07/28/24 and 08/02/24. The DON confirmed the interventions were not currently in place to prevent Resident #88 from acquiring substances while on leave of absence and bringing them into the facility. Review of the facility policy titled Intoxication Related to Recreational Substance Abuse dated 01/02/24 revealed in order to ensure the safety of staff, visitors, and residents, the use and/or consumption of illegal drugs, illegal substances, and the overuse of alcohol are strictly prohibited in the facility. This was an incidental finding discovered during the course of the complaint investigation. This is an example of continued non-compliance from the surveys dated 06/18/24 and 07/23/24.

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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 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** 49039 Based on review of the facility policy, review of the hospital records, review of water temperature logs, record review, American Society of Heating, Refrigerating and Air-Conditioning Engineers (ASHRAE) recommendations and Center for Disease Control (CDC) guidance, and interviews with the local health department and staff, the facility failed to maintain a complete and accurate water management program to prevent the spread of Legionella. This affected one (Resident #9) of three residents reviewed for pneumonia and had the potential to affect all 129 residents residing in the facility. Findings include: Review of the medical record for Resident #9 revealed she was admitted to the facility on [DATE] with a diagnosis of chronic kidney disease stage IV. Review of the Minimum Data Set (MDS) 3.0 assessment completed 06/30/24 revealed she was cognitively intact and had no shortness of breath. Review of the progress note dated 07/29/24 revealed Resident #9's blood glucose (BG) was 40 earlier and now the BG was 60. Resident #9 remained lethargic and oxygen saturations were at 80% on room air. Due to concerns for lethargy, hypoxemia, and not following commands, Resident was sent to emergency room for further evaluation. Review of the hospital records dated 07/29/24 to 08/08/24 revealed Resident #9 was admitted to the hospital with the following problems: acute respiratory failure: admit resident to intensive care unit and full vent support. Severe sepsis: noted to have pneumonia on chest x-ray, urinary tract infection. Resident's admitting diagnosis included respiratory failure and severe sepsis. The Legionella antigen urine result dated 07/29/24 at 11:42 A.M. for Resident #9 revealed a positive result. The narrative stated a positive result is presumptive positive for the presence of Legionella pneumophila serogroup 1 antigen in urine, suggesting current or past infection. Review of an email from a representative from the [NAME] County Public Health Department (FCPHD) revealed Resident #9 had a positive Legionella urine antigen on 07/29/24 and was noted to have pneumonia on chest x-ray. Also positive strep pneumonia urine antigen. Review of the facility's water management program dated 07/2017 revealed the water management program used by the facility was based on the CDC and ASHRAE recommendations for developing a Legionella water management program. The water management program included the identification of areas in the water system that could encourage the growth and spread of Legionella including: storage tanks, water heaters. The water management plan included specific measures used to control the introduction and/or spread of Legionella such as temperature or disinfectants. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility's Water Management Plan for Legionella policy, dated 07/2024, revealed the facility promoted and encouraged member facilities to proactively establish and maintain a healthy, infection-free environment for their residents, staff, and visitors. Legionella species are naturally occurring, ubiquitous aquatic organisms that thrive in warm water temperatures, with optimal growth occurring between 77 degrees Fahrenheit (F) and 120 degrees F. To continuously eradicate Legionella bacteria, water should be stored at temperatures above 140 degrees F. Facilities must have mixing valves and/or anti-scald valves to ensure that water delivered to residents does not exceed 120 degrees F. The facility's control procedures stated hot water boilers should be set to 140 degrees F or higher. Facility staff must record the temperature of each hot water device weekly and adjust if the temperature falls below 140 degrees F to ensure compliance with the policy. Review of the facility's documentation revealed there were no temperatures obtained during the weeks of 06/03/24, 06/24/24, 08/05/24, and 08/12/24. The temperatures recorded were in resident rooms only and the temperatures recorded were below 120 degrees F. Interview on 08/13/24 at 2:04 P.M. with Maintenance Director (MD) #365 and the Administrator confirmed the facility was only obtaining water temperatures only in the resident's room. MD #365 denied checking the temperatures of the six hot water tanks weekly, stating his electronic form instructed him to only record temperatures in residents' rooms. MD #365 and the Administrator confirmed the hot water temperatures in the tanks were not monitored to ensure a safe storage temperature. The Administrator confirmed the facility's water management plan did not include parameters for safe water storage and the facility followed ASHRAE and CDC guidance. MD #365 confirmed the water temperatures were taken weekly directly from the residents' rooms, and those temperatures were recorded below 120 degrees F. Interview on 08/13/24 at 2:31 P.M. with the Administrator and Director of Nursing (DON) confirmed they were first made aware of the positive result on 07/29/24 from the FCPHD. The FCPHD was made aware of the positive result when the hospital reported it on 07/29/24 via urine result. The Administrator confirmed a call was conducted on 08/08/24 with the division manager of environmental health at the FCPHD, stating that the facility was held accountable, resulting in a presumptive positive. Review of the hot water temperatures received from MD #365, taken on 08/13/24 at 3:00 P.M., revealed the hot water tank in the 100 hallway was at 136.4 degrees F. Interview on 08/14/24 at 8:43 A.M. with a representative of the FCPHD confirmed they were notified Resident #9's urine tested positive for Legionella. The FCPHD's guidelines for diagnosing Legionnaires' disease required a diagnosis of pneumonia and a positive urine antigen test. Review of the CDC guidance titled Monitoring Building Water dated 03/15/24 revealed Legionella grows best within a certain temperature range (77-113 F). There was potential for Legionella growth in the absence of other legionella controls when warm water temperatures fall below 120 degrees F. Hot water guidance indicates to store hot water at temperatures above 140 degrees F. Ensure hot water in circulation doesn't fall below 120 F (49 C) and recirculate hot water continuously. Maintain water heaters at appropriate temperatures while following local and state anti-scald regulations. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the ASHRAE guidelines dated 12/2023 revealed water temperature is a significant factor that influences the survival and growth of Legionella. It notes that Legionella generally grow on artificial media at temperatures between 77 degrees F and 113 degrees F, with the optimal temperatures for legionella growth generally ranging between 85 degrees F and 108 degrees F. Legionella growth slows and begins to die off at water temperatures between 113 degrees F and 120 degrees F. Therefore, maintaining a hot-water temperature above 120 degrees F at all points throughout the entire building hot-water system is necessary to control the growth of Legionella. The review of temperature effects on Legionella's survival and growth reveals that 77 degrees F to 120 degrees F is the optimal growth range. As temperatures rise above this range, growth slows, and legionella begins to die. This was an incidental finding discovered during the course of the complaint investigation. This is an example of continued non-compliance from the survey dated 06/18/24.