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	10/02/2024

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19571 Based on observation, resident interview, and staff interview, the facility failed to maintain a safe, clean and comfortable environment. This affected two rooms on the 400 unit (room [ROOM NUMBER] and 408). The census was 137. Findings include: 1. On 09/19/24 at 2:35 P.M. observation of room [ROOM NUMBER] revealed a night stand with a drawer missing and finish coming off of it, food debris on floor, the wall had patches of drywall showing and the privacy curtain had dark stains. On 09/23/24 at 8:57 A.M. and 12:00 P.M. observations of room [ROOM NUMBER] revealed a mat to the floor with dark stains, a night stand with a drawer missing and finish coming off of it, there was food debris on floor, the wall had patches of drywall showing and the privacy curtain had dark stains. On 09/25/24 at 3:55 P.M. observations of room [ROOM NUMBER] revealed a mat to the floor with dark stains, a night stand with a drawer missing and finish coming off of it, there was food debris on floor, wall with patches of drywall showing and the privacy curtain had dark stains. This was verified on 09/25/24 at 3:55 P.M. during interview with the Director of Nursing. 07316 2. Observations on 09/17/24 at 11:55 A.M. revealed the sink in the bathroom in room [ROOM NUMBER] was clogged with standing, dirty water in the sink. Interview with the resident who resided in the room, revealed the sink gets clogged everyday. He stated the maintenance staff just unclogged it the day before and it just gets clogged again. Observations on 09/19/24 at 9:28 A.M. revealed the sink in the bathroom in room [ROOM NUMBER] was clogged with standing, dirty water up to the rim of the basin (ready to overflow). (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Maintenance Director #200 on 09/19/24 at 10:17 A.M. confirmed the sink in room [ROOM NUMBER] was clogged. He stated that a resident in room [ROOM NUMBER] puts food down the sink causing it to clog, although he did not know which resident (two residents residing in the room). He confirmed the sink had been clogged on previous occasions also. He stated he was not aware that the sink was clogged on 09/17/24 or 09/19/24, until the surveyor brought it to his attention. He stated he did not know if a work order had been put in for the clogged sink or not. Interview with Licensed Practical Nurse #168 (director of the memory care unit) on 09/19/24 at 10:30 A.M. confirmed the sink does get clogged frequently. She stated maintenance comes and unclogs the sink but then it just gets clogged again. She stated the residents in room [ROOM NUMBER] do not put food down the sink. She confirmed the residents would not be able to wash their hands with the sink basin completely full of dirty water. She stated she did not know why maintenance could not put something in the sink basin to strain/prevent particles from going down the sink if that is why they felt it was continually getting clogged. This deficiency represents non-compliance investigated under Master Complaint Number OH00157991 and Complaint Number OH00157451. This deficiency is evidence of continued non-compliance from the survey completed 06/18/24.

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 07316 Based on observations, medical record review, and staff interview, the facility failed to ensure residents who were unable to carry out activities of daily living received the necessary services to maintain good nutrition and personal hygiene. This affected three of five residents reviewed for personal hygiene (Residents #9, #24, and #30). The facility census was 137. Findings include: 1. Review of the medical record for Resident #24 revealed an admitted [DATE] and diagnoses including cerebral infarction, diabetes, dysphagia, protein-calorie malnutrition, and malignant neoplasm of the prostate. The resident had physician's orders for a dysphagia advanced texture diet, nectar thickened liquids, and must have one to one supervision for all meals. Review of a Minimum Data Set assessment completed 08/06/24 revealed the resident had range of motion impairment on one side in upper and lower extremity, required substantial/maximal assistance with eating, and was dependent upon staff for personal hygiene and transfers. The plan of care dated 12/08/23 stated the resident exhibited signs of cognitive impairment due to cerebral vascular accident and brain surgery. It stated he had difficulty with communication and had unclear speech at times. It further stated he needed assistance with activities of daily living including dressing, eating, and hygiene. Observations on 09/17/24 at 11:43 A.M. revealed Resident #24 to be in bed with a hospital gown on. The gown had dried food on chest area (lunch not served yet). His fingernails were observed to be dirty with a dark substance under the nails. Observations on 09/17/24 at 12:03 P.M. revealed the unit nurse to deliver a lunch tray to Resident #24. The resident still had dried food on his gown and his fingernails were still dirty. The nurse set the lunch tray down and left the room. There was no other staff in the room. Observations on 09/17/24 at 12:12 P.M. revealed Resident #24 was in bed with his eyes closed and the lunch tray was untouched. No staff had went into the room since 12:03 P.M. Observations on 09/17/24 at 12:20 P.M. (17 minutes after the lunch tray was delivered to the room), revealed Resident #24 had not received any staff assistance with the meal. At that time, the Director of Nursing confirmed the lunch tray was untouched, Resident #24's fingernails were dirty, and he had dried food on his gown that was not from this meal. She stated he needed a new lunch tray and needed assistance with eating. 2. Review of the medical record for Resident #30 revealed an admitted [DATE] and diagnoses including end stage renal disease and diabetes. The resident received hemodialysis three times weekly. Review of a Minimum Data Set assessment completed 09/05/24 revealed the resident had intact cognition and required substantial/maximal assistance with personal hygiene. Review of the plan of care revealed the resident needed assistance with activities of daily living related to debility, weakness, impaired mobility, end stage renal disease, thrombosis of right upper extremity, malaise, and osteoarthritis. The goal was to have care needs met daily. Interventions included staff assistance with personal hygiene. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observations on 09/12/24 at 9:45 A.M. revealed Resident #30 to be in bed. Her fingernails were dirty with a dark substance under the nails. Resident #30 stated, at that time, that she needed nail care. Observations on 09/12/24 at 12:40 P.M. revealed Resident #30 to be in bed. Her lunch tray was delivered to the room by staff. The resident was feeding her self. Her fingernails were noted to still be dirty with a dark substance under the nails. Interview with Licensed Practical Nurse #211 on 09/12/24 at 12:40 P.M. confirmed the resident's fingernails were dirty with a dark substance under the nails. She confirmed the substance looked like bowel movement under the nails. She stated she would not like to eat a meal with nails that looked like that. On 09/12/24 refusal of activities of daily living/nail care was added to the resident's plan of care. Observations on 09/17/24 at 12:24 P.M. revealed Resident #30's nails had been trimmed and cleaned. 3. Review of Resident #9's medical record revealed she was readmitted to the facility on [DATE]. Review of the admission minimum data set assessment (MDS) dated [DATE] revealed her cognition was intact. She was dependent on staff for toileting, shower/bathing and required partial to moderate assistance for personal hygiene. Is frequently incontinent of urine and always incontinent of bowel. Observation on 09/19/24 at 9:10 A.M. revealed the resident's nails were long with dried brown substance under her nails. State tested Nurse Aide (STNA) #150 revealed she won't let us cut them. The Surveyor asked about cleaning them and staff revealed she refuses. Review of the plan of care dated 07/01/24 revealed the SR needed assistance with activities of daily living, i. e. personal hygiene, bathing, showering, bed mobility, and dressing. There was no evidence the resident was non-compliant with care. This deficiency represents non-compliance investigated under Complaint Number OH00157451. This deficiency is evidence of continued non-compliance from the survey completed 06/18/24.

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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 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** 07316 Based on resident interview, record review, and staff interview, the facility failed to ensure a resident was provided with proper treatment and assistive devices to maintain vision. This affected one of eight open sampled records reviewed (Resident #55). The facility census was 137. Findings include: Review of the medical record for Resident #55 revealed an admitted [DATE] and a diagnosis of paranoid schizophrenia. A Minimum Data Set assessment completed 06/30/24 indicated the resident wore corrective lenses. The resident had a physician's order 08/25/22 that he may be seen by the optometrist. There was no evidence the resident had been seen by any physician related to his vision since admission. Interview with Resident #55 on 09/17/24 at 11:55 A.M. revealed he needed new glasses. He stated he was unable to see with his current glasses. Interview with Licensed Practical Nurse #168 on 09/19/24 at 10:30 A.M. revealed she was aware that Resident #55 was asking for new glasses. She stated the social worker was supposed to put him on a list to see the eye doctor about a month ago. She stated an eye doctor does come to the facility to see residents. However, she stated the facility no longer had a social worker. She stated she had not followed up to determine if he was on a list to see the eye doctor or when the eye doctor was coming. This deficiency represents incidental findings of non-compliance investigated under Complaint Number OH00157451.

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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** 07316 Based on observations, record review, resident interview, and staff interview, the facility failed to ensure a resident received physician ordered assistance devices to prevent falls. This affected one of three residents reviewed for falls (Resident #89). The facility census was 137. Findings include: Review of the medical record for Resident #89 revealed an admitted [DATE] and diagnoses including cerebral infarction, diabetes, end stage renal disease, and schizophrenia. Review of a Minimum Data Set assessment completed 08/22/24 revealed the resident had intact cognition and required substantial/maximal assistance with transfers. Review of nursing progress notes and incident and accident investigation forms revealed the following incidents noted: On 08/17/24 10:15 A.M.: noted sleeping on floor. Resident is a new admission to the facility and has intermittent periods of confusion. Re-oriented to room and bright color tape applied to call light as reminder. On 08/18/24 10:30 P.M.: noted on floor and having seizure like activity. Hematoma to center of forehead. Sent to emergency room for evaluation. Note on 08/19/24 at 8:26 A.M. indicated the resident returned from the hospital and cat scan of head was done with no issues found. A perimeter mattress was added to the bed for safety. On 08/25/24 1:20 P.M.: Noted sitting on floor in room with feces all over. No injury noted. Investigation noted intermittent periods of confusion and periods of impulsiveness/restlessness with poor safety awareness. An intervention to offer to assist with toileting after lunch was added. On 08/26/24 4:00 A.M.: unwitnessed fall. Noted sitting on floor. Continues to transfer without assistance. Intermittent periods of impulsivity and forgetfulness. It stated non skid strips were applied to the floor on the left side of the bed. (A physician's order was obtained on 08/31/24 for non skid strips to the floor on the left side of the bed). On 08/26/24 2:04 P.M.: Noted laying on floor on right side. Stated she was reaching for something on the floor. Reacher provided. On 08/27/24 4:00 P.M.: Noted lying on the floor. Noted with pulse of 48. Sent to the hospital for evaluation. Returned 08/30/24 after treatment for bradycardia. On 09/09/24 7:30 A.M.: Noted on floor by bed. No injury noted. Has a history of non compliance with asking for assistance. Bright colored sign to remind to use call light placed in room. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the plan of care dated 08/19/24 revealed the resident was at risk for falls. An intervention was added on 09/19/24 for non skid strips to the left side of the bed (even though they were ordered on 08/31/24). Interview with Resident #89 on 09/12/24 at 7:00 A.M. revealed she loses her balance a lot. She stated the staff tell her to call before she falls but she does not always do that. Observations on 09/12/24 at 7:00 A.M. revealed there were no non-skid strips on the floor beside the resident's bed on either side of the bed (bed not against the wall). Interview with Licensed Practical Nurse #218 on 09/19/24 at 8:25 A.M. confirmed Resident #89 did not have any non skid strips on the floor beside her bed. She stated the resident had a room change as a reason the non skid strips were not on the floor. (Record review revealed the resident had a room change to the current room on 08/30/24 after the non skid strips were added in the previous room on 08/26/24). This deficiency represents non-compliance investigated under Complaint Number OH00157451. This deficiency is evidence of continued non-compliance from the surveys completed 06/18/24, 07/23/24, and 08/14/24.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19571 Based on medical record review, observation, staff interview, review of the infection control log and facility policy and procedure, the facility failed to ensure proper infection control techniques were maintained when providing incontinence care. This affected one resident (#9) observed for incontinence care. The census was 137. Findings include: Review of Resident #9's medical record revealed she was readmitted to the facility on [DATE]. Review of the admission minimum data set assessment (MDS) dated [DATE] revealed her cognition was intact. She was dependent on staff for toileting, shower/bathing and required partial to moderate assistance for personal hygiene. The resident was frequently incontinent of urine and always incontinent of bowel. Observation on 09/19/24 at 9:10 A.M. of incontinence care to Resident #9 revealed State tested Nurses Aide (STNA) #150 used hand sanitizer and prepared water and put on gloves. The STNA provided privacy, washed from side to side and down the middle of the vaginal area, removed the old adult brief and bowel movement was observed. STNA #150 removed her gloves and put on new gloves without washing her hands and turned the resident to the left side continued to wash from front to back, removed gloves and put on new gloves without washing her hands (there was bowel movement observed on the washcloths), rinsed the resident and patted dry, removed gloves and washed hands and put on new gloves and replaced adult brief. Interview with STNA #150 on 09/19/24 at 9:20 A.M. verified she had not washed her hands in between glove changes. Review of the Hand Hygiene policy and procedure (dated 12/12/23) revealed the use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves. This deficiency represents incidental findings of non-compliance investigated under Complaint Number OH00157991.

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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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 07316 Based on observations, record review, and staff interview, the facility failed to ensure a resident with a gastrostomy tube received the appropriate enteral feeding as ordered by the physician. This affected one of seven open sampled records reviewed (Resident #24). The facility census was 137. Findings include: Review of the medical record for Resident #24 revealed an admitted [DATE] and diagnoses including cerebral infarction, diabetes, dysphagia, protein-calorie malnutrition, and malignant neoplasm of the prostate. The resident had a gastrostomy tube and had physician's orders for an enteral feeding of Glucerna 1.5 calorie at 100 cc's per hour. The enteral feeding was to run from 6:00 P.M. until 6:00 A.M. only. He also received a meal tray during the day. Review of a Minimum Data Set assessment completed 08/06/24 revealed the resident had range of motion impairment on one side in upper and lower extremity, required substantial/maximal assistance with eating, and was dependent upon staff for personal hygiene and transfers. The plan of care dated 12/08/23 stated the resident was at risk for complications due to requiring tube feeding related to dysphagia following cerebral vascular accident. Interventions included tube feeding and water flushes per physician order. The plan of care stated to provide nocturnal tube feeding schedule per physician's order. Observations on 09/12/24 at 6:45 A.M. revealed Resident #24 to be in bed with a bottle of Glucerna 1.5 infusing at 100/hour. The bottle was almost empty. Observations on 09/12/24 at 10:05 A.M. revealed Resident #24 to have a new bottle of Glucerna 1.5 infusing at 100/hour. The bottle indicated it was hung at 8:00 A.M. Interview with Licensed Practical Nurse #218 on 09/12/24 at 10:05 A.M. confirmed a new bottle of enteral feeding was hung at 8:00 A.M. by the night shift nurse. Interview with the Director of Nursing on 09/12/24 at 10:05 A.M. confirmed the enteral feeding should not be running during the day. She confirmed it should run from 6:00 P.M. to 6:00 A.M. She stated the enteral feeding was administered at night so he would have more appetite during the day. This deficiency represents incidental findings of non-compliance investigated under Complaint Number OH00157451.

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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 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** 07316 Based on medical record review, staff interview, and facility policy review, the facility failed to ensure residents were adequately monitored while receiving medications for blood pressure control. This affected two (Residents #71 and #140) of five residents reviewed for medication administration. The census was 137. Findings include: 1. Review of Resident #71's medical record revealed the resident was admitted to the facility on [DATE]. His diagnoses included chronic obstructive pulmonary disease (COPD), atrial fibrillation, and hypertension. Review of the Minimum Data Set (MDS) assessment, dated 03/14/24, revealed Resident #71 had severe cognitive impairment. Review of Resident #71 current physician orders, dated 04/14/24, revealed he had an order for Metoprolol Succinate ER (beta blocker used to treat heart arrhythmia's and high blood pressure) tablet 50 milligrams (mg) by mouth twice daily. The medication was to be held if his systolic blood pressure was less than 100 or pulse was less that 60. On 07/12/24 the physician discontinued the parameters. However on 09/10/24, 09/20/24 and 09/24/24 at 8:00 A.M. the apical pulse was 58 and the Metoprolol 50 mg was administered without any nursing judgement to hold the medication. Review of Medscape (medication information website) revealed individuals should not take this medication if they have a slow heart rate (bradycardia identified as a heart rate less than 60 beats per minute). This was verified during interview with the Director of Nursing on 09/25/24 at 1:30 P.M. 2. Review of the closed medical record for Resident #140 revealed an admitted [DATE] and diagnoses including end stage renal disease, diabetes, dementia, and chronic kidney disease. Review of medication administration records revealed the resident had received a beta blocker medication (Carvedilol 3.125 milligrams twice daily for high blood pressure) since admission. A beta blocker medication can be used to lower blood pressure. The resident did not have any physician's orders to monitor blood pressure/pulse and did not have any parameters set of when to notify the physician regarding abnormal blood pressures. The resident went to hemodialysis three times weekly. The plan of care stated the resident was at risk for impaired cardiac output related to hypertension and hypotension. An intervention stated to monitor vital signs as ordered and indicated and to notify physician of abnormalities. The plan of care further stated the resident had a right chest dialysis port and a non functioning left AV fistula. However, a progress note by the nurse practitioner on 06/27/24 stated the resident had bilateral upper extremity non functioning fistulas. It was not specified in the medical record how staff were to obtain blood pressures for the resident due to the fistulas in both arms. Review of vital sign records revealed staff documented blood pressures taken sometimes in the left arm and sometimes in the right arm. (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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of dialysis communication sheets (used by the facility to communicate with the dialysis center) revealed on 06/21/24 after dialysis the resident's blood pressure was documented as 174/107. There was no evidence the physician was aware or that any treatment was provided or any follow up blood pressures were taken that day or the next day. On 06/25/24 the blood pressure was 136/72. On 07/01/24 before dialysis the resident's blood pressure was 146/100. After dialysis it was 147/100. There was no evidence the physician was aware or that any treatment was provided or any follow up blood pressures were taken until the next day. On 07/02/24 the blood pressure was 141/70. On 08/05/24, prior to dialysis, the resident's blood pressure was 192/100. There was no evidence the physician was notified. After dialysis on 08/05/24 the blood pressure was 167/84. Interview with Nurse Practitioner (NP) #400 on 09/26/24 at 8:30 A.M. revealed she was not a nephrologist but she did not think you should use an arm to take blood pressures that contained a fistula, even if it was non-functioning. She stated a thigh blood pressure could be obtained. She confirmed she was not aware of the blood pressures documented on the dialysis communication sheets. She stated the nephrologist at the dialysis center takes the lead on blood pressures related to dialysis. She stated she felt a resident should have their blood pressure checked each shift when they are taking medication for blood pressure control. Interview with Physician (Nephrologist) #401 on 09/26/24 at 1:11 P.M. revealed it was determined on a case by case basis which arm should be used for monitoring blood pressures for a resident who had fistulas in their arm. However, he stated he was not the nephrologist caring for this resident and could not answer specific questions related to his care. (The surveyor had requested to speak to the Nephrologist from the dialysis center for Resident #140 and this was the physician provided). He stated if a resident has a chronic elevated blood pressure the physician is to be notified and an as needed blood pressure medication would be given. He stated the facility would be the one to give the medication, not the dialysis center. Interview with the Director of Nursing on 09/26/24 at 9:00 A.M. confirmed Resident #140 did not have physician's orders to monitor blood pressure/pulse. She confirmed his blood pressure was not monitored routinely. She confirmed the facility did not have a policy/procedure to follow for abnormal vital signs when the resident did not have physician ordered parameters of when to notify the physician. She confirmed the facility had not clarified with the dialysis center on what limb should be used for blood pressures. She confirmed there was no evidence the facility physician or the dialysis physician was aware of the elevated blood pressures for Resident #140 or that any treatment was provided or that the blood pressures were rechecked timely. This deficiency represents non-compliance investigated under Complaint Number OH00157451. This deficiency is evidence of continued non-compliance from the survey completed 06/18/24.

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	10/02/2024

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 07316 Based on observations, record review, and staff interview, the facility failed to ensure medication rates were not five percent or greater. The medication error rate was 10 percent (three errors of 29 opportunities for error). This affected two of five residents observed during medication administration (Residents #8 and #52). The facility census was 137. Findings include: 1. Observations on 09/12/24 at 7:43 A.M. revealed Licensed Practical Nurse (LPN) #208 to administer medications to Resident #8. The resident had a physician's order for Folic Acid 1 milligram daily at 8:00 A.M. as a supplement. The medication was not available to administer. On 09/12/24 at 7:43 A.M. LPN #208 stated she did not know why the medication was not available from the pharmacy and the facility did not have any in stock to give to the resident. She stated she would have to call the pharmacy to determine why the medication was not sent to the facility. 2. Observations on 09/12/24 at 8:05 A.M. revealed LPN #208 to administer medications to Resident #52. The resident was given Guaifenesin 400 milligrams. (A medication used to thin mucus and for coughing). The resident was not observed to receive Docusate Sodium 100 milligrams. (a laxative). Review of physician's orders revealed Resident #52 had a physician's order for Docusate Sodium 100 milligrams twice daily at 9:00 A.M. and 9:00 P.M. for constipation. Resident #52 did not have a physician's order for Guaifenesin. Interview with LPN #208 on 09/12/24 at 1:30 P.M. revealed she accidentally gave the Guaifenesin instead of the Docusate Sodium to Resident #52. She stated the bottles look similar (both are stock medications). She confirmed the resident did not have an order to give Guaifenesin but did have an order for Docusate Sodium. This deficiency represents non-compliance investigated under Complaint Number OH00157451.