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	11/06/2024

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 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** 32654 Based on observation, record review, staff interview, and policy review, the facility failed to ensure Resident #59 was treated with respect and dignity. This affected one resident (#59) of nine sampled residents. The facility census was 118. Findings include: Review of the medical record for Resident #59 revealed an initial admitted [DATE] with the diagnoses including but not limited to early onset Alzheimer's disease, chronic obstructive pulmonary disease, severe dementia with mood disturbance, psychotic disorder with delusions, major depressive disorder, hypertension, hyperlipidemia, osteoarthritis, mood disorder, sleep disorders, atrial fibrillation, anxiety disorder, insomnia, wandering in diseases, hypothyroidism, constipation, sleep apnea and drug induced secondary Parkinsonism. Review of the plan of care dated 10/28/22 revealed the resident needed assistance with activities of daily living due to impaired mobility, weakness, debility, secondary Parkinsonism, dementia, osteoarthritis, anxiety, depression and psychotic mood disorder. Interventions included resident required staff assistance with dressing. Review of the resident's comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a severe cognitive deficit. Review of the resident's monthly physician orders for November 2024 identified orders dated 10/28/22 for non-skid footwear. On 11/04/24 at 10:48 A.M., observation of Resident #59 revealed he was wandering behind the memory care unit nurse's station with one yellow non-skid sock on the right foot and a white low cut sock on the left foot. Licensed Practical Nurse (LPN) #235 was notified the resident's socks were not matching and of the same type. LPN #235 took Resident #59 to his room to change his socks. On 11/04/24 at 10:50 A.M., observation of Resident #59 revealed the resident had a yellow non-skid sock on his right foot and a navy blue non-skid sock on his left foot. LPN #235 verified the resident was not being treated in a dignified manner by having mismatched non-skid socks on. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled, Dignity, dated 01/02/24 revealed it is the practice of the facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment that maintains or enhances each resident's quality of life by recognizing each resident's individuality. This deficiency represents non-compliance investigated under Complaint Number OH00159215.

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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** 32654 Based on medical record review, staff interview, and policy review, the facility failed to ensure Resident #133's physician was notified of a blood pressure outside of the physician ordered parameters. This affected one (Resident #133) of nine sampled residents. The facility census was 118. Findings include: Review of the medical record for Resident #133 revealed an initial admitted [DATE] with the latest readmission of 08/21/24 with the diagnoses including but not limited to end stage renal disease (ESRD), puncture wound with foreign body of thorax, osteonecrosis of multiple sites, chronic obstructive pulmonary disease (COPD), stenosis of vascular prosthetic devices, implants and grafts, dependence on hemodialysis, renal osteodystrophy, chronic kidney disease (CKD), endocarditis, atrial fibrillation, seasonal allergic rhinitis, bipolar disorder, hypertension, hyperlipidemia, constipation, anemia and nicotine dependence. Review of the plan of care dated 06/07/24 revealed the resident was at risk for impaired cardiac output related to diagnoses anemia, hyperlipidemia, hypertension and hyperlipemia. Interventions included notify physician or Certified Nurse Practitioner (CNP) of blood pressures greater than 150/90, complete progress note, vital signs as ordered and indicated, notify physician of abnormalities, observe for signs/symptoms of cardiac dysfunction, administer medication as ordered, diet as ordered and follow up with cardiologist as needed/indicated. Review of the resident's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had no cognitive deficit. Review of the resident's monthly physician orders for November 2024 identified orders dated 10/03/24 to notify physician/Certified Nurse Practitioner (CNP) of blood pressure greater than 150/90, and complete a follow up progress note. Review of the resident's blood pressure revealed on 10/27/24 the resident's blood pressure was 161/93, on 10/28/24 the resident's blood pressure was 154/84, on 10/29/24 the resident's blood pressure was 153/92 and on 11/03/24 the resident's blood pressure was 159/87. Further review revealed no notification to the physician of the blood pressures outside of the physician ordered parameters or a follow up progress note. On 11/05/24 at 2:10 P.M., interview with the Director of Nursing (DON) verified the resident's physician was not notified of the blood pressures outside of the physician ordered parameters and a follow up progress note was not documented in the resident's medical record. It is the policy of this facility to promptly identify, respond to, and report changes in resident condition to the resident's physician/Certified Nurse Practitioner (CNP)/Physician Assistant (PA) and resident/resident representative. A significant change is a major decline or improvement of the resident's status. The nurse would notify the physician/NP/PA and the resident/resident representative when abnormal labs, weights, or vital signs.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32654 Based on medical record review and staff interview, the facility failed to ensure sutures were removed as physician ordered for Resident #133. This affected one resident (#133) of nine sampled residents. The facility census was 118. Findings Include: Review of the medical record for Resident #133 revealed an initial admitted [DATE] with the latest readmission of 08/21/24 with the diagnoses including but not limited to end stage renal disease (ESRD), puncture wound with foreign body of thorax, osteonecrosis of multiple sites, chronic obstructive pulmonary disease (COPD), stenosis of vascular prosthetic devices, implants and grafts, dependence on hemodialysis, renal osteodystrophy, chronic kidney disease (CKD), endocarditis, atrial fibrillation, seasonal allergic rhinitis, bipolar disorder, hypertension, hyperlipidemia, constipation, anemia and nicotine dependence. Review of the resident's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had no cognitive deficit. Review of the resident's plan of care dated 10/25/24 revealed the resident has a laceration above his left eye with sutures in place and the sutures were to be removed in five to seven days. Interventions included observe for increase in size of bruise or development of new bruising, observe for signs of pain, provide pain medication as needed, observe resident environment for potential to cause skin trauma, document abnormal findings and notify physician, keep area clean and dry, observe for symptoms of infections (redness, drainage, warmth, increased pain), and treatment as ordered. Review of the medical record revealed the resident's sutures were removed at day 10 instead of the physician ordered five to seven days. On 11/05/24 at 2:10 P.M., interview with the Director of Nursing (DON) verified the sutures were removed at day 10 instead of the physician ordered five to seven days.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 32654 Based on observation, staff interview and facility policy review, the facility failed to maintain appropriate infection control practices during the administration of eye drops to prevent potential infection. This affected one resident (#70) of two residents observed for eye drop administration. The facility census was 118. Findings Include: On 11/04/24 at 9:33 A.M., observation of medication administration revealed Licensed Practical Nurse (LPN) #210 applied (donned) a pair of gloves at the medication administration cart, gathered Resident #70's medications which included a nasal spray and eye drops and entered the resident's room. The LPN assisted Resident #70 to take her oral medications. The LPN then used a tissue and wiped the tip of the Fluticasone 50 micrograms (mcg) nasal spray applicator. The LPN then administered two sprays of the Fluticasone 50 mcg in each nostril. The LPN using the same gloves administered one eye drop in each of the resident's eyes. LPN #210 verified the lack of infection control practices by not washing hands and changing gloves between the Fluticasone 50 mcg nasal spray administration and the artificial tears administration. Review of the facility policy titled, Hand Hygiene, dated 01/02/24 revealed all staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents or visitors. This applies to all staff working in all locations of the facility.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 32654 Based on observation and staff interview, the facility failed to maintain a safe and functional environment when the transition strips (slim strips fitted at the base of doorways to bridge the gap between different floor surfaces or levels) were not in place to level the resident room floor and the hallway floor. This had the potential to affect eight residents (#14, #35, #41, #64 #65, #70, #105, and #115) of 22 residents residing on the [NAME] hallway. The facility census was 118. Findings Include: On 11/04/24 at 9:27 A.M., observations of Resident #14, #35, #41, #64 #65, #70, #105, and #115 rooms revealed the transition strips were missing in the doorway causing an unleveled surface entering and exiting the resident rooms. On 11/06/24 at 12:05 P.M., interview with the Director of Nursing (DON) revealed the facility had removed carpet and replaced with different floor. The facility provided no additional information as to why the transition strips were not replaced.