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	04/07/2026

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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(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. Based on observations, interviews, and facility policy review, the facility failed to ensure staff could communicate with a Spanish speaking resident. This affected one (Resident #122) of one resident reviewed for communication. The facility census was 123.Findings include:Review of the medical record for Resident #122 revealed an admission date of 03/20/26 with diagnoses to include but not limited to disseminated malignant neoplasm, secondary malignant neoplasm of the bone and genital organs, ovary, right lung, intraabdominal lymph nodes, retention of urine, neoplasm related to pain, depression, anemia in neoplastic disease, muscle weakness, and unsteadiness on feet.Review of the admission Minimum Data Set (MDS) for Resident #122 revealed a Brief Interview for Mental Status (BIMS) of 14, indicating the resident was cognitively intact Additionally, the MDS for Resident #122 revealed her ethnicity as Mexican and her preferred language as Spanish.Review of the care plan for Resident #122 indicated no focus on Resident #122's primary language as Spanish or interventions for communication.Observation on 03/30/26 at 8:45 A.M. of Resident #122 lying in bed. Resident #122 called her daughter because she does not speak English.Interview on 03/30/26 at 8:45 A.M. with Resident #122's daughter stated Resident #122 calls her all throughout the day and night to translate for her. Resident #122's daughter stated in the beginning the facility mentioned a translator, but the facility has not provided one.Interview on 04/01/26 at 8:13 A.M. with Licensed Practical Nurse (LPN) #315 stated Resident #122 only understands English a little and calls her daughter when she needs something. LPN #315 stated Resident #122 can say pain medicine, but not much else in English. LPN #315 stated the facility had a website or interpreter services, but he didn't use them because Resident #122 was always on the phone with her daughter when Resident #122 needed something.Interview on 04/01/26 at 8:31 A.M. with Admissions Coordinator #207 stated if a resident doesn't speak English, then the admission Coordinator #207 meets with the family member who can speak English. admission Coordinator #207 stated he goes over the admission paperwork and packet with the family member who can translate and understand English. Admissions Coordinator #207 stated if there was no family member who could speak English, then he thought the facility had a translator service. Admissions Coordinator #207 stated Resident #122 was admitted to the facility and spoke very little English. Admissions Coordinator #207 stated Resident #122 called her daughter, and he went over the admission packet over the phone with Resident #122's daughter. Admissions Coordinator #207 stated Resident #122 signed the admission paperwork while her daughter was on the phone. Admissions Coordinator #207 stated he called Resident #122's daughter and told her he needed to get the paperwork signed and ask her to translate over the phone and then have Resident #122 sign which is what happened. Admissions Coordinator #207 stated Resident #122 can understand English if you talk a little slower with her. Admissions Coordinator #207 stated he used hand gestures to speak with Resident #122. Interview on 04/01/26 at 8:47 A.M. with MDS #208 stated there were a lot of staff members of different ethnicities who worked at the facility, so staff usually have someone who can interpret for staff and families/residents. Interview on 04/01/26 at 9:07 A.M. with Social Service #725 stated if someone doesn't speak English, then the resident will call their loved ones, or we do have an interpreter we can call. Social Service #725 stated she had completed the BIMS assessment through a Resident's loved one. Social Service #725 stated Resident #122 (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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	called her daughter to complete the BIMS via the phone, but Resident #122's daughter wanted to be in the building because it would be easier. Social Service #725 stated Resident #122's daughter did come into building and the BIMS and Patient health Questionnaire-nine (PHQ-9) (a tool used by clinician to screen for and measure the severity of adult depression based on symptoms over the past two weeks) was completed through Resident #122's daughter. Social Service #725 stated she did explain to Resident #122's daughter to not add anything to Resident #122's answer. Social Service #725 stated there was no reason that she did not call an interpreter service. Social Service #725 stated she would call the interpreter service if the resident could not reach a loved one. Social Service #725 stated Resident #122 did not understand any English and only understood the BIMS and PHQ-9 questions through Resident #122's daughter translating. Social Service #725 stated she does not call an interpreter service if a resident has reached out to a loved one. Social Service #725 stated she used an interpreter in a past facility but not at this facility. Social Service #725 stated she felt the interpreter service conveyed what she said and did not add anything to it. Social Service #725 stated it would be better to use an interpreter service instead of a loved one because it is non-bias and they aren't going to add anything to what the residents are saying. Social Service #725 stated she had not observed anyone using interpreter services in this facility. Social Service #725 stated she does not know where the interpreter service number is located and does not know the number to call an interpreter.Interview on 04/01/2026 at 9:52 A.M. with Regional Social Worker #727 stated the facility has an account for an interpreter service. Regional Social Worker #727 stated the staff can call the number to access an interpreter and it will direct them to the language which they need. Regional Social Worker #727 stated the facility does have an account for interpreting, and the staff should be calling to use it. Regional Social Worker #727 stated the nurses will talk to the family member to interpret; social services should definitely use the interpreter service to do the MDS assessments for non-English speaking persons. Interview on 04/02/26 at 7:14 A.M. with LPN #312 stated she would ask on the other units to see if there was a Spanish speaking staff member to be able to interpret. LPN #312 did not use an outside interpreter service and was not sure if the facility had an interpreter service. Interview on 04/02/26 at 8:26 A.M. with Unit Manager #407 stated Resident #122's primary language is Spanish. Unit Manger #407 stated when she would go into Resident #122's room, then Resident #122 would call her daughter to interpret for her. Unit Manger #407 stated the facility had an interpreter service which was in place when she started so the staff should know about it. Interview on 04/02/26 at 8:47 A.M. with the Director of Nursing (DON) stated Resident #122 communicated more common things like if she needed something, but for more in-depth things, we do have an interpreter service and an app on the phone if the staff needed an interpreter. The DON stated she did not know the policy at this facility, but staff always need to be careful using family as an interpreter because the family could change the question or meaning because staff do not know the language. The DON stated the staff are aware there is an interpreter service for the facility and the papers should be in the nurses' stations. Review of the facility policy Culturally Competent Care dated 08/05/25 revealed the purpose of the policy is to ensure that all residents/patients receive care that respects and responds to their cultural linguistic, spiritual, and individual preferences, thereby enhancing quality of life, dignity, and health outcomes. This violation represents non-compliance investigated under Complaint Number 2641533.

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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. Based on observations and interviews, the facility failed to maintain a safe, clean, and homelike environment. This affected one (Resident #113) of five residents reviewed for environment. The facility census was 123.Findings include:Observation on 03/30/26 at 8:37 A.M. of Resident #113's room revealed a hole in the wall about a foot long behind the bed. The dry wall had crumbled into several pieces. Interview at 03/30/26 at 8:37 A.M. with Resident #113 revealed the hole in the wall had been there since he moved to the room about two months ago.Interview on 03/31/26 at 7:25 A.M. with Unit Manager #407 verified the dry wall behind Resident #113's bed was crumbling in the wall and was about one foot long. Unit Manager #407 verified there was another area of the wall near the heating unit which looked like the plaster was coming off the walls and a black substance in the heating unit openings which did not come off when she attempted to remove it. Unit Manager #407 stated the black substance looked like mold in the heating unit. Review of the facility Admissions Packet undated revealed the rights of the residents of a home shall include, but are not limited to, the following: safe and clean-living environment. Review of the facility policy, Physical Environment, dated 01/01/26 revealed the purpose of the policy is 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. This deficiency represents non-compliance investigated under Complaint Numbers 2724325, 2718817, and 2599640.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 interview, medical record review, and facility policy review, the facility failed to conduct care planning meetings with the resident and/or their representative. This affected two residents (Resident #104 and #125) of thirty three records sampled. The facility census was 123 residents. Findings include: 1. Review of Resident #104's medical record revealed an original admission date of 12/28/22 and a readmission date of 03/26/26. Resident #104 had diagnoses that included metabolic encephalopathy, hemiplegia and hemiparesis following other nontraumatic intracranial hemorrhage affecting left dominant side, and unspecified sequelae of other nontraumatic intracranial hemorrhage. Review of Resident #104's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had severe cognitive impairment and was dependent for toileting, shower/bathe self, upper body dressing, lower body dressing, putting on/taking off footwear, and personal hygiene. Resident #104 was always incontinent of bowel and bladder. Further review of Resident #104's medical record on 04/01/26 at 11:00 A.M. revealed the last documented care conference with the resident and/or the resident representative was conducted on 06/20/24. Interview with Regional Social Worker #727 on 04/01/26 4:14 P.M. confirmed there was no documentation of a care conference for Resident #104 since 2024. Interview with Regional Social Worker #727 on 04/02/26 at 7:51 A.M. revealed resident care conferences should follow the MDS schedule. 2. Resident #125 was admitted to the facility on [DATE]. Her diagnoses were chronic respiratory failure, chronic obstructive pulmonary disease, paraplegia, pruritus, vascular dementia, chronic pain syndrome, anxiety disorder, heart failure, acute respiratory failure, dermatitis, major depressive disorder, anemia, dependence on supplemental oxygen, shortness of breath, and muscle weakness. Review of her MDS assessment, dated 02/10/26, revealed she was cognitively intact. Review of Resident #125's progress notes, dated September 2025 to April 2026, revealed no care conferences documented as being held in September 2025 and March 2026, which is when they were scheduled to occur. Interview with Regional Social Services #727 on 04/01/26 at 11:23 A.M. confirmed care conferences for Resident #125 had not been completed as scheduled in September 2025 and March 2026. She confirmed they will get them scheduled as soon as possible. Interview with the Administrator on 04/01/26 at 1:58 P.M. confirmed she completed a care conference with Resident #125 and her family on 03/02/26. She confirmed she had it recorded, but has not documented the information of the care conference on any document for review and/or implementation at this time. Review of policy, 'Care Conferences' effective 11/01/24 and revised 05/16/24 revealed care (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	conferences will be scheduled as soon as possible after admission, routinely, and with a change in condition. This deficiency represents non-compliance investigated under Complaint Number 2599640.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure wound treatments were initiated timely for a resident with a skin alteration. This affected one (Resident #36) of three residents reviewed for pressure ulcers. The facility census was 123. Findings include:Review of the medical record for Resident #90 revealed an admission date of 07/17/24 with diagnoses of polyneuropathy, morbid obesity, type 2 diabetes mellitus (T2DM), and lymphedema.Review of the comprehensive Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #90 is cognitively intact, is dependent on staff for toileting hygiene, and is always incontinent of bowel and bladder.Review of the care plan dated 02/11/26 revealed Resident #90 has impaired skin integrity of the plantar aspect of the third toe. Interventions included assessing and documenting skin condition, completing wound treatment as ordered, and notifying the physician of any worsening wound.Review of the wound assessment report dated 02/11/26 revealed Resident #90 had a community acquired deep tissue injury (DTI) of the plantar aspect of the third toe, with 100 percent intact epithelium and evidence of deeper tissue injury, attached wound edges, and intact periwound. The wound measured 1.00 centimeters (cm) in length and 1.00 cm in width. Treatment orders included cleansing with wound cleanser twice per day, applying skin prep to surrounding tissue, and leaving the wound open to air.Review of the progress note dated 02/11/26 at 10:09 P.M. by the Director of Nursing (DON) revealed the resident was seen by the wound nurse practitioner, treatment orders were in place, and the wound nurse would continue to monitor.Review of progress notes from 02/12/26 through 02/15/26 revealed no documentation that treatment orders to cleanse with wound cleanser twice per day, apply skin prep to surrounding tissue, and leave open to air were initiated or completed.Review of the physician order dated 02/16/26 revealed treatment for the plantar aspect of the third toe pressure injury to cleanse with wound cleanser twice per day, apply skin prep to surrounding tissue, and leave open to air.Review of the Medication Administration Record (MAR) dated 03/01/26 through 03/31/26 revealed the plantar aspect of the third toe pressure injury treatment was initiated on 02/16/26 during night shift.Review of the wound assessment report dated 02/18/26 revealed the plantar aspect of the third toe had 100 percent intact epithelium with evidence of deeper tissue injury, attached wound edges, and intact periwound. The wound measured 1.00 centimeters (cm) in length and 1.00 cm in width. Treatment orders were to cleanse with wound cleanser twice per day, apply skin prep to surrounding tissue, and leave open to air.Interview on 04/06/26 at 1:54 P.M. with Regional Nurse #726 confirmed Resident #90's wound treatments were not initiated timely.Interview on 04/06/26 at 4:07 P.M. with the DON and the Administrator confirmed Resident #90's treatment was not initiated timely. Review of wound management policy dated 05/20/24 revealed the facility is to ensure residents with impaired skin integrity are recognized by the care team, treated timely and interventions are not exhausted until the skin is healed. This deficiency represents non-compliance investigated under Complaint Number 2800477 and Complaint Number 2724325.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure weekly and daily weights were completed as ordered, failed to notify the physician of significant weight changes, failed to ensure contradictory weight orders were not in place, and failed to ensure reweights were completed timely and orders were transcribed correctly. This affected three residents (Resident #1, Resident #43, and Resident #90) out of seven residents reviewed for nutrition. The facility census was 123.Findings include:1.Review of the medical record for Resident #1 revealed an admission date of 2/27/26 with diagnoses of hemiplegia, metabolic encephalopathy, dysphagia, anoxic brain damage, gastrostomy status, and aphasia.Review of the admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #1 was dependent upon staff for activities of daily living, including eating, and received 51 percent or more of total calories and fluid intake via abdominal tube feeding.Review of the care plan initiated 03/08/26 and revised on 04/05/26 revealed Resident #1 was at nutritional risk with significant weight loss in one month. Interventions included registered dietitian evaluation, tube feed changes and recommendations as needed, weights as ordered or indicated, and notification of the physician for significant weight changes.Review of the hospital record dated 02/27/26 revealed Resident #1 weighed 135 pounds (lbs) during hospital admission.Review of the physician order dated 02/28/26 revealed weekly weights one time a day every seven day(s) for post admission weight monitoring for four weeks. Additionally, enteral feed was ordered every shift, continuous at 45 milliliters per hour (ml/hr).Review of the medication administration record (MAR) dated February 2026 revealed weekly weights one time a day every seven day(s) for post admission weight monitoring for four weeks, however on the assigned weigh day of 02/28/26 had no weight value documented.Review of the weight summary dated 03/07/26 revealed Resident #1 weighed 130.8 lbs.Review of the nutritional dietary enteral review dated 03/08/26 revealed Resident #1 received nutrition via percutaneous endoscopic gastrostomy (PEG) tube, with the most recent weight at 130.8 pounds and a basal metabolic rate of 22.4. Tube feeding was provided at 45 ml/hr, totaling approximately 1620 calories per day. The dietitian was to follow weekly for weights and tube feed tolerance.Review of emails titled, 'weights pending and reweights,' from Dietitian #727 to Unit Manager #507 dated 03/15/26 and 03/19/26 revealed Resident #1 required a weekly weight, with a request to enter weights into the electronic medical record as soon as possible.Review of the MAR dated March 2026 revealed weekly weights as ordered, with a weight completed on 03/07/26 at 130.8 lbs, however on assigned weigh days of 03/14/26 and 03/20/26 no weights were documented in the MAR. An additional weekly weight due 03/27/26 was also not obtained.Interview on 04/02/26 at 2:17 P.M. with Dietitian #727 confirmed weekly weights ordered on 02/28/26 were not completed on 03/14/26 and 03/20/26 as ordered. The dietitian stated the resident should have remained on weekly weights due to tube feeding status, however a current active order was not in place at that time. The dietitian confirmed nursing staff are required to obtain weekly weights according to the facility policy for residents receiving enteral nutrition. The dietitian reported sending emails to Unit Manager #507 as reminders, but did not receive a response or the weights.Interview on 04/02/26 at 2:46 P.M. with Unit Manager (UM) #507 confirmed Resident #1 was ordered weekly weights upon admission and should have remained on weekly weights due to tube feeding. UM #507 confirmed weights due on 03/14/26, 03/20/26, and 03/27/26 were not completed, and the medical record did not contain documentation explaining why, nor any refusals. UM #507 stated the scale required for Hoyer lift transfers was out of service.Interview on 04/02/26 at 05:10 P.M. with the Administrator and Regional Nurse #726 indicated they were not aware of any scale malfunction. There was no documentation in the medical record showing the scale was out of service during the period when weights were missed, and the dietitian did not report concerns regarding scale availability or equipment issues that would prevent weekly weight collection. Regional Nurse #726 confirmed residents receiving tube feed nutrition are required (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to receive a weekly weight.Review of the treatment administration record (TAR) dated April 2026 revealed monthly weights every day shift from the first through the fifth, with a reweigh if greater than a five pound change. On 04/04/26 a weight of 123.8 pounds was recorded.Review of the weight summary dated 04/04/26 revealed Resident #1 weighed 123.8 pounds, a 5.35 percent loss since 03/07/26.Review of the weight summary dated 04/05/26 revealed Resident #1 weighed 124.6 pounds.Review of the dietary progress note dated 04/05/26 revealed the resident weighed 123.8 pounds, showing a 5.3 percent weight loss in one month. Basal metabolic rate was 21.2. Weekly weights were to continue, and tube feed rate was increased to 55 ml/hr.Interview on 04/06/26 at 09:39 A.M. with the Administrator and Regional Nurse #726 revealed they denied the scale was not functioning and acknowledged the resident had significant weight loss. They reported bringing in a rental scale to verify the weight.Interview on 04/06/26 at 03:13 P.M. with Dietitian #727 confirmed Resident #1 exhibited a weight loss of 5.3 percent in one month. New intervention included an increase in tube feed formula to 55 ml/hr and continuation of weekly weights. The dietitian reported uncertainty about the initial 130.8 lb weight from 03/07/26 and stated weekly weights should continue to obtain an accurate weight trend. The dietitian reported the resident remained at a healthy basal metabolic rate.Review of weight monitoring policy dated 07/01/25 revealed weekly weights should be obtained and recorded in the electronic medical record for four weeks for new admission to the facility and residents determined to be at high nutritional risk.2. Review of the medical record for Resident #43 revealed an admission date of 12/30/25 with diagnoses of chronic respiratory failure, end stage renal disease (ESRD), chronic diastolic heart failure, complete atrioventricular block (AV block), pulmonary hypertension due to lung diseases, type 2 diabetes mellitus, essential hypertension, paroxysmal atrial fibrillation (PAF), and bradycardia.Review of the admission MDS 3.0 assessment dated [DATE] revealed Resident #43 is cognitively intact, does not reject care, and has not had a significant weight change in the past six months.Review of the care plan dated 12/31/25 revealed Resident #43 is at risk for fluid imbalance due to chronic kidney disease, poor intake, recent infection, congestive heart failure, pulmonary hypertension, and fluid restriction. Interventions include completing weights as ordered and notifying the physician of significant weight changes.Review of the physician order with a start date of 03/06/26 and discontinued 04/02/26 revealed daily weights every day shift for chronic heart failure.Review of the physician order dated 03/07/26 revealed weekly weights every week for four weeks for post admission weight monitoring.Review of the weight summary revealed that on 03/07/26 the resident weighed 159.3 pounds (lbs), on 03/10/26 the resident weighed 177.5 lbs which is an 18.2 pound and 11.42 percent gain from 03/07/26, on 03/12/26 the resident weighed 177.0 lbs, and on 03/14/26 the resident weighed 179.0 lbs.Review of the weight summary and Treatment Administration Record (TAR) revealed missing daily weights on 03/09/26, 03/11/26, 03/15/26, and 03/18/26.Review of progress notes from 03/08/26 through 04/01/26 revealed no weight refusals and no physician notification of the weight change.Review of the physician visit dated 03/13/26 revealed the physician was asked to see the resident for weakness and debility. The note documented general weakness that was moderate to severe and chronic and stable, chronic back and lower extremity pain, depression related to circumstances, stable chronic shortness of breath with activity also known as dyspnea on exertion (DOE), and fair oral intake. Skilled nursing facility (SNF) records and laboratory results were reviewed. The note did not document physician awareness of the resident's weight gains recorded on 03/10/26.Interview on 04/02/26 at 02:22 P.M. with Dietitian #727 revealed the resident had no active nutrition problems at that time but was at risk for fluid imbalance due to dialysis and chronic heart failure. The dietitian stated a significant weight change for this resident is two to three pounds in one day or five pounds in one week. The dietitian confirmed dialysis weights should flow into the vitals summary. The dietitian stated the facility has ongoing issues getting weights as ordered and did not find any documentation showing physician notification or resident refusals for the weight changes between 03/07/26 and 03/14/26.Interview on 04/02/26 at 02:52 P.M. with UM #507 revealed the medical record did not show (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the physician was notified of the weight change from 03/10/26 to 03/12/26 which was about 18 pounds and 11.42 percent difference. UM #507 stated this change was concerning because the weights stayed high on later days. UM #507 confirmed there were duplicate orders for daily weights and weekly weights that conflicted. UM #507 stated nurses are expected to document weight refusals in a progress note and to notify the physician of significant changes and could not provide any note showing refusals or physician notification for this period.Interview on 04/06/26 at 10:26 A.M. with Physician #999 revealed he could not recall being told about the approximately 18 pound change between 03/07/26 and 03/12/26. The physician stated a change this large in a resident with end stage renal disease (ESRD) and chronic heart failure is significant and the physician should be notified. The physician reported he would expect a progress note if he had been notified. 3. Review of the medical record for Resident #90 revealed an admission date of 07/17/24 with diagnoses of morbid obesity, type 2 diabetes mellitus (T2DM), lymphedema, and proteinˆcalorie malnutrition.Review of the admission MDS 3.0 assessment dated [DATE] revealed Resident #90 is cognitively intact, does not reject care, requires substantial or maximal assistance with bed mobility, is unable to ambulate, and has not had a significant weight change in the past six months.Review of the care plan dated 07/24/24 revealed Resident #90 has potential for nutritional risk related to a therapeutic diet, high body mass index (BMI) for height, obesity, depression, and extensive food dislikes. Interventions include obtaining weights as ordered and notifying the physician of significant weight changes.Review of the weight summary revealed on 01/04/26 the resident weighed 328.6 pounds (lbs). On 02/01/26 the resident weighed 315.0 lbs, which is a 13.6 lb and 4.14 percent loss.Review of the physician order placed by Unit Manager (UM) #508 with a start date of 02/01/26 and an end date of 01/30/26 revealed a daily weight every night shift for one day.Review of progress notes dated 02/01/26 through 02/08/26 revealed no documented refusals and no documented attempts to obtain a reweight.Review of the dietitian note dated 02/16/26 revealed Resident #90 refused a weight that week and no new weight was obtained. The note listed a recent weight of 315.0 lbs on 02/01/26 and a body mass index (BMI) of 55.8. The dietitian noted possible weight changes due to diuretic use and refusals, recommended weight loss, continuation of weekly weights, and follow up as needed.Interview on 04/02/26 at 4:30 P.M. with Unit Manager (UM) #507 confirmed a reweight was needed after a 13.6 lb loss and confirmed the order entered by UM #508 was not entered correctly.Interview on 04/02/26 at 4:49 P.M. with UM #508 confirmed Resident #90 had a 13.6 lb loss on 02/01/26. UM #508 stated a daily weight order was entered with a start date of 02/01/26 and an end date of 01/30/26, which made the order inactive due to the wrong dates. UM #508 stated the intent was to obtain a reweight, but the reweight was not completed.Interview on 04/06/26 at 4:09 P.M. with the Director of Nursing (DON) and the Administrator confirmed the physician order was not placed correctly and a reweight was not completed.Review of the weight monitoring policy dated 06/15/25 revealed residents who weigh over 100 pounds require a reweight if the weight changes more than 5 pounds.This deficiency represents non-compliance investigated under Complaint Number 1270133.

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure proper administration of oxygen and failed to ensure a valid physician order was in place for oxygen use. This affected two (Resident #90 and #87) out of three residents reviewed for oxygen administration. The facility census was 123. Findings include: 1.Review of the medical record for Resident #90 revealed an admission date of 07/17/24 with diagnoses of asthma, morbid obesity, edema, lymphedema, muscle weakness, and anxiety. Review of the care plan dated 10/16/24 revealed Resident #90 is at risk for respiratory distress related to asthma. Interventions include administering oxygen as ordered and monitoring oxygen saturation as ordered and as indicated. Review of active physician orders dated 04/01/26 revealed no current orders for oxygen administration. Observation on 03/31/26 at 2:48 P.M. and 4:27 P.M. revealed the resident was receiving oxygen by nasal cannula at five liters per minute. Interview on 03/31/26 at 4:29 P.M. with Licensed Practical Nurse (LPN) #512 confirmed Resident #90 was receiving oxygen by nasal cannula at five liters. Interview on 04/01/26 at 5:51 A.M. with LPN #216 confirmed Resident #90 was receiving oxygen by nasal cannula at five liters and did not have an active physician order for oxygen. Interview on 04/01/26 at 5:54 A.M. with the Director of Nursing (DON) confirmed Resident #90 was receiving oxygen by nasal cannula at five liters. Interview on 04/01/26 at 9:48 A.M. with the DON confirmed Resident #90 did not have an active physician order for oxygen. The DON stated the resident should receive continuous oxygen at two to three liters per minute and reported the resident has behaviors of turning up oxygen. The DON confirmed oxygen is a medication and nursing staff should verify the five rights of medication administration every shift, including right dosage, and confirm there is an active physician order. 2.Review of the medical record for Resident #87 revealed an admission date of 04/5/25 with diagnoses to include but not limited to metabolic encephalopathy, anorexia nervosa, myositis ossificans progressiva, right lower leg, polyneuropathies, dry beriberi, severe protein-calorie malnutrition, sequelae of unspecified nutritional deficiency, tachycardia, vitamin B12 deficiency anemia, other specified disorders of the liver, unspecified psychosis not due to a substance, mood disorder, major depressive disorder, thiamine deficiency, ascorbic acid deficiency, hypercalcemia, anxiety disorder, pericardial effusion, and hypotension. Review of the quarterly Minimum Data Set (MDS) dated [DATE] for Resident #87 revealed a Brief Interview for Mental Status (BIMS) score of thirteen which indicated no cognitive impairment. Additionally, the MDS revealed Resident #87 was dependent on staff for all care. Review of the Medication Administration Record (MAR) and Treatment Administration Record (TAR) (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dated for March 2026 revealed no order for oxygen noted. Review of the care plan for Resident #87 dated 03/19/26 revealed a focus of Resident #87 has a diagnosis of pneumonia with interventions to include administer oxygen as ordered. Review of a progress note dated 03/18/26 revealed two views of chest x-ray result indicates perihilar infiltrates, order received oxygen saturations at 97% with oxygen at two liters via nasal cannula. Review of progress note dated 03/19/26 revealed Resident #87 continues with antibiotic for upper respiratory infection, no signs or symptoms of adverse reaction noted. Resident #87 returned from family scheduled chest x-ray appointment per emergency medical services (EMS) personnel resident does not have any appointments today, the family did not show up. Oxygen saturations at 96% with oxygen at two liters via nasal cannula. Review of multiple progress notes dated 03/18/26 to 03/21/26 which stated Resident #87 was on two liters of oxygen via nasal cannula. Interview on 04/02/2026 at 5:04 P.M. with the Executive Director who stated there was no oxygen order for Resident #87. Review of the oxygen administration policy dated 08/01/25 revealed oxygen is administered under the orders of a physician.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and medication records, the facility failed to appropriately manage pain for Resident #122. This affected one resident (#122) of the three residents reviewed for pain management. The facility census was 123.Findings include:Review of the medical record for Resident #122 revealed an admission date of 03/20/26 with diagnoses to include but not limited to disseminated malignant neoplasm, secondary malignant neoplasm of the bone and genital organs, ovary, right lung, intraabdominal lymph nodes, retention of urine, neoplasm related to pain, depression, anemia in neoplastic disease, muscle weakness, and unsteadiness on feet. Resident #122 spoke Spanish and had limited ability to speak English. Review of the admission Minimum Data Set (MDS) for Resident #122 revealed a Brief Interview for Mental Status of fourteen which indicated no cognitive impairment. Additionally, the MDS revealed no psychosis, no verbal or physical behaviors, and no rejections of care. Furthermore, the MDS revealed Resident #122 had a pain frequency rated as almost constantly which occasionally effected sleep and pain rated at eight. The MDS revealed Resident #122 received radiation.Review of the care plan revealed Resident #122 had chronic pain due to metastatic cancer which had spread to multiple other sites with interventions to notify physician of unrelieved or worsening pain and to provide resident and family with information about pain and options available for pain management to discuss and record preferences.Review of an order dated 03/20/26 revealed oxycodone hydrochloride (HCl) Oral Tablet ten milligrams (mg) give one tablet by mouth every four hours as needed for severe pain.Review of an order dated 03/21/26 revealed observe for signs or symptoms of pain every shift. If pain present, document level and location of pain, treat trying nonpharmacological interventions prior to medicating if appropriate. Document in the Progress Notes every shift.Review of an order dated 03/26/26 revealed Buprenorphine Transdermal Patch Weekly 20 microgram per hour (MCG/HR) apply one patch, transdermal, one time a day every Thursday for pain and remove per schedule.Observation on 03/30/26 at 8:45 A.M. of Resident #122 lying in bed on her left side with her right ankle which was red and puffy exposed lying on the bed. Resident #122 with tears in her eyes pointed to her right ankle and stated pain.Interview on 03/30/26 at 8:45 A.M. with Resident #122's daughter stated when Resident #122 is asleep, she misses her pain medication which is as needed every four hours. Resident #122's daughter stated Resident #122 has tumors in her ankle and lower back and should have scheduled pain medication. Resident #122's daughter stated they have spoken to staff regarding scheduling the pain medication, but it still isn't scheduled.Interview on 04/01/2026 at 8:05 A.M. with Certified Nursing Assistant (CNA) #705 stated Resident #122 asked for pain medications a lot. CNA #122 stated Resident #122 can say pain medicine in English. CNA #705 stated Resident #122 asked for pain medication sometimes every two to three hours and as soon as she woke up from sleeping. Interview on 04/01/26 at 8:13 A.M. with Licensed Practical Nurse (LPN) #315 stated Resident #122 came to the facility recently from an outside hospital with a right swollen ankle and Resident #122 was on pain medication and chemotherapy. LPN #315 verified that Resident #122 had foley catheter and lymphedema on her left shoulder. LPN #315 stated Resident #122 always asked for pain medication after three hours and the order was for every four hours. LPN #315 stated he thought there was an alarm on Resident #122's phone to remind her to call for pain meds at three hours. LPN #315 stated he did not talk to the doctor about Resident #122's pain. LPN #315 stated the lowest pain number Resident #122 said to him was five, but that Resident #122's pain was usually an eight or ten. LPN #315 stated Resident #122 never said her pain was at zero. LPN #315 stated yesterday Resident #122 was having pain in her left shoulder and Resident #122's daughter had taken Resident #122 back to the hospital on [DATE].Interview on 04/02/26 at 7:14 A.M. with LPN #312 stated she asked the residents if they are having pain, and have the resident rate pain, where, how often, severity, then give an as needed pain medication. LPN #312 stated if the resident does not have an as needed pain medication ordered, then she would get vital signs and call (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the physician. LPN #312 stated after giving pain medications, then she would monitor for effectiveness. LPN #312 stated when Resident #122 would ring her call light, she would go and give her pain medications because of Resident #122's diagnosis. LPN #312 stated Resident #122's pain medications were for every four hours, and that Resident #122 would ring on her call light every four hours for the pain medication. LPN #312 stated with Resident #122's diagnosis, she knew Resident #122 was in pain, so she would go right down with the pain medications. LPN #312 stated the highest pain rating Resident #122 gave was a seven and the lowest rating was a two or three. LPN #312 stated Resident #122 would show her fingers to indicate a number, but the lowest rating was only after the pain medications had been given to Resident #122. LPN #312 stated she did not think about Resident #122 needing pain medications scheduled since Resident #122 was getting them every four hours. LPN #312 stated she was not sure if the nurses were giving pain meds every four hours during the night. Interview on 04/02/2026 at 7:30 A.M. via phone with LPN #313 stated Resident #122 would ring her call light, and LPN #313 would ask Resident #122 on a scale of one to ten what her pain was and where the pain was located. LPN #313 stated Resident #122 could say, I'm in pain, and Resident #122's daughter would translate. LPN #313 stated if Resident #122's daughter was not there, then Resident #122 would say she was in pain and would hold up her fingers up to say the rating number. LPN #313 stated Resident #122's highest pain rating was six or seven and the lowest rating was zero after the pain meds. LPN #313 stated Resident #122 always requested pain medication, and the pain medications were ordered every four or six hours as needed. LPN #313 stated she never woke Resident #122 up to give Resident #122 pain medications, but Resident #122 would wake up herself and request pain medications. LPN #313 stated she did not think about scheduling Resident #122's pain medications or talking to anyone about scheduling Resident #122's pain medications. LPN #313 stated Resident #122 did not complain about anything except her pain. Interview on 04/02/26 at 8:26 A.M. with Unit Manager #407 who stated Resident #122 had a diagnosis of cancer which is scattered throughout her body. Unit Manager #407 stated the pain management care plan is implemented on admission to the facility. Unit Manager #407 stated the resident's pain regimen is reviewed when the nurse notices that something is not working, through a resident's body language or the frequency of when a resident is asking for pain medications. Unit Manager #407 stated there is a facility nurse practitioner who is in the facility on most days and night shift staff can contact the provider to communicate regarding the resident's pain. Unit Manager #407 stated the facility should have open communication with the provider regarding a resident's pain medications and if the facility provider cannot adjust or increase the pain medications, then possibly receive a pain management referral. Unit Manger #407 stated she was not aware that Resident #122 was requesting pain medications every three hours. Unit Manager #407 stated she was not aware that Resident #122's daughter wanted the pain medication scheduled and that none of the nurses had come to her to discuss Resident #122's pain medications. Unit Manager #407 stated if Resident #122 was requesting pain medications every three to four hours, then the provider should have been notified.Interview on 04/02/26 at 8:47 A.M. with the Director of Nursing (DON) stated she was not aware of Resident #122 asking for pain medications every three hours but did know that Resident #122 was receiving pain medications every four hours. The DON stated that instead of scheduling Resident #122's pain medications, the facility should have gotten something for in between to get Resident #122 to the four hours. The DON stated it would not have hurt to call the provider and let them know Resident #122 was requesting pain medication every four hours. The DON stated she was not aware of Resident #122's daughter talking to the staff about scheduling Resident #122's pain medications. The DON stated she was not aware Resident #122 was getting pain medication every three hours in the hospital. The DON stated they just go by the orders received from the hospital, but maybe if they had looked more into her paperwork, then they would have known. Review of discharge paperwork for Resident #122 dated 03/20/26 revealed Resident #122 was ordered oxycodone 10mgs one tablet by mouth every three hours as needed for moderate pain or severe pain. Review of the Continuity of Care (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for Resident #122 dated 03/20/26 revealed a prescription for oxycodone 10 mg take zero point five to one tablet by mouth every four hours as needed for moderate pain to severe pain, maximum 40 mg daily. The DON reviewed the Continuity of Care dated 03/20/26 and the discharge paperwork dated 03/20/26 and acknowledged there was a difference in the oxycodone prescription which needed to be clarified.Review of the facility policy Pain Management dated 01/02/24 revealed in order to help a resident attain or maintain his/her highest practicable level of physical, mental, and psychosocial well-being and to prevent or manage pain, the facility will: recognize when the resident is experiencing pain and identify circumstances when the pain can be anticipated. Evaluate the resident for pain and the causes(s) upon admission, during ongoing scheduled assessments, and when a significant change in condition or status occurs (e.g. new pain or an exacerbation of pain). Manage or prevent pain, consistent with the comprehensive assessment and plan of care, current professional standards of practice, and the resident's goals and preferences. The interdisciplinary team is responsible for developing a pain management regimen that is specific to each resident who has pain or who has the potential for pain. The following are general principles the facility will utilize for prescribing analgesics: evaluate the resident's medical condition, current medication regimen, cause and severity of the pain and course of illness to determine the most appropriate analgesic therapy for pain, consider evidence-based practice tools to assist in the assessment of the resident's pain, consider administering medication around the clock instead of as needed or combining longer acting medications wit as needed medications for breakthrough pain, utilize the most effective and least invasive route for analgesic administration (e.g. oral, rectal, topical, injection, infusion pump and/or transdermal), use lower doses of medication initially and titrate slowly upward until comfort is achieve.This deficiency represents non-compliance investigated under Complaint Numbers 2899477 and 2800477

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to address pharmacy recommendations or initiate medication changes in a timely manner. This affected two (Residents #55 and #90) out of five residents reviewed for pharmacy recommendations. The facility census was 123. Findings include:1.Review of the medical record for Resident #90 revealed an admission date of 07/17/24 with diagnoses of insomnia, intellectual disabilities, muscle weakness, constipation, major depressive disorder, neuralgia, and neuritis. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #90 is cognitively intact and is receiving psychotropic drugs. Review of the care plan dated 10/16/24 revealed Resident #90 receives psychotropic medication and is at risk for adverse side effects related to the use of antidepressants, antiˆanxiety medications, and sleep aids. Interventions include administering medications as ordered by the physician and reviewing quarterly and as needed to maintain the lowest effective dose. Review of the monthly medication review (MMR) dated 06/24/25 revealed a recommendation for a gradual dose reduction (GDR) of trazodone 50 milligrams every night. The physician response recorded on 08/01/25 was disagree, stating past reduction attempts resulted in problematic behavior, staff inability to provide care, and psychiatric instability. Review of the physician order dated 08/01/25 revealed amitriptyline tablet 25 milligrams at bedtime for depression, with a discontinue date of 02/10/26. Review of the MMR dated 12/19/25 revealed a recommendation for a gradual dose reduction of amitriptyline to 10 milligrams every night, with the physician response agree on 02/06/26. Interview on 04/07/26 4:09 P.M. with the Director of Nursing (DON) and the Administrator confirmed Resident #90's pharmacy recommendations from 06/24/25 and 12/19/25 were not reviewed and acted upon timely. Review of the drug regimen review and reporting policy dated 01/27/25 revealed all identified irregularities and recommendations must be acted upon in a timely manner, and no later than 30 days. 2. Resident #55 was admitted to the facility on [DATE]. His diagnoses were chronic obstructive pulmonary disease, peripheral vascular disease, chronic respiratory disease, type II diabetes, hereditary and idiopathic neuropathy, heart failure, hypertensive heart disease, morbid obesity, atherosclerotic heart disease, sensorineural hearing loss, muscle weakness, anemia, chronic kidney disease, major depressive disorder, atrial fibrillation, hyperlipidemia, and anxiety disorder. Review of his MDS assessment, dated 03/18/26, revealed he was cognitively intact. Review of Resident #55 pharmacy recommendation, dated 12/19/25, revealed a recommendation for a gradual dose reduction (GDR) for sertraline 50 milligrams (mg) to sertraline 25 mg. The provider did not address this recommendation until 02/06/26, in which they agreed with the recommendation to lower the dose. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the DON on 04/01/26 at 3:42 P.M. confirmed this pharmacy recommendation was not addressed in a timely manner. She confirmed they address pharmacy recommendations within a month of them being issued by the pharmacist.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, medication administration observation, and facility policy review, the facility failed to ensure staff administered medication following infection control procedures. This affected one (Resident #73) of four residents reviewed for infection control. The facility census was 123.Review of the medical record for Resident #73 revealed an admission date of 09/06/18 with diagnoses of end stage renal disease, hyperlipidemia, gastroesophageal reflux disease, polyneuropathy, hypertension, heart failure, and paroxysmal atrial fibrillation. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #73 is cognitively intact and requires set up or clean up assistance with eating. Observation of medication administration on 04/02/26 from 8:16 A.M. to 8:24 A.M. for Resident #73 revealed Licensed Practical Nurse (LPN) #511 began preparation of medications without practicing hand hygiene. Further observation revealed an Eliquis tablet 5 mg (Apixaban) was dropped on the cart, LPN #511 picked up the tablet with bare fingers and placed it into the medication cup. Two fludrocortisone acetate tablets 0.1 mg were popped directly from the pill package into the nurse's hand and then placed into the medication cup. After preparation, applesauce was added to the medications and the nurse entered the room. LPN #511 spoon fed the medications with applesauce to Resident #73, then exited the room and signed off the medications. Hand hygiene was not performed before preparation, during preparation, before resident contact, or after medication administration. Interview on 04/02/26 at 8:28 A.M. with LPN #511 confirmed hand hygiene was not conducted before medication preparation, before entering Resident #73's room, before touching pills or tablets, and after administering medications. Interview on 04/06/26 at 04:04 P.M. with the Director of Nursing (DON) and the Administrator revealed staff are required to perform hand hygiene before medication preparation and before touching pills or devices, and after resident contact or glove removal. Review of the medication administration policy dated 12/12/23 revealed staff are to perform hand hygiene prior to administering medication and after administration.