STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366201	A. BUILDING _____ B. WING _____	03/16/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, resident interview, staff interview, and facility policy and procedure, the facility failed to notify the state agency of an allegation of verbal abuse for Resident #2. This affected one (Resident #2) out of three residents reviewed for abuse. The census was 123. Findings Include: A medical record review for Resident #2 revealed an admission date of [DATE] and the [DIAGNOSES REDACTED]. Review of the nurses notes for Resident #2 on 12/12/19 at 6:58 P.M. revealed the nurse found the resident smoking outside the facility, outside of the smoking times. The nurse was unable to confiscate cigarettes and lighters. The resident stated he would sign out with a Leave of Absence (LOA) and go smoke across the street. The resident was educated about smoking policy by management on that day. Review of STNA #32's witness statement, dated 12/13/19, revealed she was at the nurses station completing charting when LPN #36 was yelling down the hall because Resident #2 went smoking when it wasn't the designated smoking time. LPN #36 asked STNA #32 what the resident's name was, then she began yelling at him. The resident then asked her to sign him out of the building and LPN #36 told the resident that he could just sign himself out against medical advice (AMA). The STNA then went off on the LPN for talking to the resident in that manner. Interview on 03/16/20 at 2:55 P.M. with Resident #2 revealed he did not remember the incident on 12/12/19 and that he felt like he was treated with dignity and respect. He had no concerns related to abuse or addressing concerns. Interview on 03/16/20 at 3:20 P.M. with State tested Nurse Assistant (STNA) #32 revealed on 12/12/19 the facility implemented a new smoking policy that all residents needed to go out to smoke with staff present and residents didn't like the new policy. She stated Resident #2 went outside by himself and she heard Licensed Practical Nurse (LPN) #36 yelling at the resident like she wanted to fight him. She stated the nurse followed the resident up the hallway yelling at the resident to give her his cigarettes and lighter. STNA #32 revealed she told the nurse not to talk to the resident like that. She further revealed Resident #2 told LPN #36 that he was going to go across the street and smoke and the nurse told him to sign out against medical advice (AMA). STNA #32 stated the resident was visibly upset about the incident and LPN #36 was talking nasty to Resident #2. Interview on 03/16/20 at 3:30 P.M. with the Administrator (who was present during STNA #32's interview), revealed based on the interview conducted with STNA #32, she should have reported the incident as a Self Reported Incident (SRI). She stated she previously thought it was a customer service issue but she didn't complete a full investigation and she now believed it should have been reported. She stated she should have asked more questions to get the full story. Review of facility policy titled Abuse Prevention Program, dated 02/22/18, revealed when an alleged or suspected case of mistreatment, neglect, injuries of unknown source or abuse was reported, the facility Administrator, Director of Nursing or individuals designated would immediately (not to exceed 24 hours if the event does not result in serious bodily injury and no later than two hours if the event is an allegation of abuse, significant injury or neglect with serious bodily injury) notify the following persons or agencies of such incidents: The State agency responsible for surveying/licensing the facility, the resident's representative, the physician, and any agency as required by state law. This deficiency substantiates Complaint number OH 884.
F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, resident interview, staff interview, and facility policy and procedure, the facility failed to thoroughly investigate an allegation of verbal abuse for Resident #2. This affected one resident (#2) out of three residents reviewed for abuse. The census was 123. Findings Include: A medical record review for Resident #2 revealed an admission date of [DATE] and the [DIAGNOSES REDACTED]. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #2 had a Brief Interview of Mental Status (BIMS) of 15 indicating intact cognition, required supervision for bed mobility, transfers, locomotion, dressing, toilet use and personal hygiene, and required limited assistance for locomotion via wheelchair. Review of the MDS assessment dated [DATE] revealed the resident had a BIMS of 13 indicating intact cognition, required supervision for bed mobility, transfers, locomotion, toilet use and personal hygiene, and required limited assistance for dressing and locomotion via wheelchair. Review of the nurses notes for Resident #2 dated 12/12/19 at 6:58 P.M. revealed the nurse found the resident smoking outside the facility and outside of the smoking times. The nurse was unable to confiscate cigarettes and lighters. The resident stated he would sign out with a Leave of Absence (LOA) and smoke across the street. The resident was educated about smoking policy by management on that day. Interview on 03/16/20 at 3:20 P.M. with State tested Nurse Assistant (STNA) #32 revealed on 12/12/19 the facility implemented a new smoking policy that everyone needed to go out to smoke with staff present and residents didn't like the new policy. She stated Resident #2 went outside by himself and she heard Licensed Practical Nurse (LPN) #36 yelling at the resident like she wanted to fight him. She stated the nurse followed the resident up the hallway yelling at the resident to give her his cigarettes and lighter. STNA #32 revealed she told the nurse not to talk to the resident like that. She further revealed Resident #2 told LPN #36 that he was going to go across the street and smoke and the nurse told him to just sign out against medical advice (AMA). STNA #32 stated the resident was visibly upset about the incident and LPN #36 was talking nasty to Resident #2. Interview on 03/16/20 at 3:30 P.M. with the Administrator (who was present during STNA #32's interview), revealed based on the interview conducted with STNA #32, she should have reported the incident as a Self Reported Incident (SRI). The Administrator stated she previously thought it was a customer service issue but she didn't complete a full investigation and she now believed it should have been reported as an allegation of abuse. She stated she should have asked more questions to get the full story. She further revealed she took LPN #36 off the schedule until she could complete coaching with her, which was completed on 01/07/20. She revealed only two witness statements were documented (STNA #32 and Resident #1). The Administrator stated the nurse never worked with the resident before or after the incident. Review of STNA #32's witness statement, dated 12/13/19, revealed she was at the nurses station completing charting when LPN #36 was yelling down the hall because Resident #2 went smoking when it wasn't the designated smoking time. LPN #36 asked STNA #32 what the resident's name was, then she began yelling at him, he had then asked her to sign him out of the building and she stated to the resident that he could just sign himself out AMA. The STNA then went off on the LPN for talking to the resident in that manner. Review of Resident #1's witness statement, dated 12/12/19, revealed she had an issue with LPN #36 having an attitude with the residents who were smoking and she made the residents feel very small with her nasty statements and throwing statements in their face about her having a place to go. Review of the coaching form, dated 01/07/20, revealed LPN #36 was coached by the Administrator over the phone regarding her attitude and approach to residents and staff, and even if the residents and staff don't agree with the new smoking policy, she cannot be disrespectful and talk to the residents as the staff is upset. Conversations needed to be had during closed doors and concerns brought to the supervisor. She voiced understanding over the phone. Review of facility policy titled Abuse Prevention Program, dated

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

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.

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F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) 02/22/18, revealed when an alleged or suspected case of mistreatment, neglect, injuries of unknown source or abuse was reported, the facility Administrator, Director of Nursing or individuals designated would immediately (not to exceed 24 hours if the event does not result in serious bodily injury and no later than two hours if the event is an allegation of abuse, significant injury or neglect with serious bodily injury) notify the following persons or agencies of such incidents: The State agency responsible for surveying/licensing the facility, the resident's representative, the physician, and any agency as required by state law. The policy indicated mental abuse was defined as, but was not limited to, humiliation, harassment, threats of punishment, or withholding of treatment of [REDACTED]., roommate and visitor, interview of other residents who the accused employee provided care and services. Employees who had been accused of resident abuse would be suspended from duty immediately until the results of the investigation could be reviewed by the Administrator and the results of the investigation should be recorded on a report form. This deficiency substantiates Complaint number OH 884.
F 0805 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, staff interview, and facility policy and procedure, the facility failed to provide a safe puree dessert to residents requiring puree diet. This had the potential to affect two residents (#5 and #6) out of three residents reviewed for nutrition. The census was 123. Findings Include: An observation on 03/16/20 at 11:50 A.M. of the tray line revealed the regular lunch desert was chocolate chip Cannoli's in a hard shell. The puree dessert was observed as the Cannoli filling with whole chocolate chips mixed in. Surveyor intervened due to safety concern for the residents receiving puree desserts. An interview on 03/16/20 at 11:50 A.M. with Cook #35 confirmed the whole chocolate chips in the puree dessert. He stated he didn't agree with it either, but the recipe stated that was what the purees were suppose to receive, and he shrugged his shoulders and continued to make room trays. An interview on 03/16/20 at 11:50 A.M. with the Dietary Manager #37 and Dietitian #34 confirmed the puree dessert shouldn't have whole chocolate chips. Dietician #37 stated the dessert would need pureed. Both staff agreed a resident who required a puree diet, eating whole chocolate chips was a safety concern. Review of the recipe for puree Cannoli dessert revealed the Cannoli shells should be pureed in the food processor until fine in consistency, adding milk until the desired consistency was reached, then add the thawed Cannoli cream filling and process until all was smooth. Interview on 03/16/20 at 2:30 P.M. with the Administrator revealed two residents received puree meals (Resident #5 and #6). Review of the medical record for Resident #5 revealed an admission date of [DATE] and the [DIAGNOSES REDACTED]. The Minimum Data (MDS) assessment, dated 03/08/20, revealed a Brief Interview of Mental Status (BIMS) of 13 indicating intact cognition and supervision of one staff for eating. The assessment further revealed the resident coughed or choked during meals and he required a mechanically altered diet. A care plan, dated 03/08/20, revealed the resident had a potential for nutrition risk related to mechanically altered diet, requiring assistance with tray set up/feeding as needed/allows with interventions to provide and serve mechanically altered diet as ordered. A physician order, dated 03/11/20 revealed the resident had an order for [REDACTED]. The assessment further revealed the resident held food in his mouth and cheeks after meals, complained of difficulty or pain when swallowing, and required a mechanically altered diet. An undated care plan revealed the resident had a potential for nutrition risk related to mechanically altered diet with interventions to provide and serve mechanically altered diet as ordered. A physician order, dated 0[DATE] revealed the resident had an order for [REDACTED].
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** Based on observation, staff interview, and facility policy and procedure, the facility failed to ensure food and ice were prepared, stored, and served in sanitary conditions to prevent contamination and failed to run the dishwasher at the appropriate temperature. This had the potential to affect all 123 residents residing in the facility. Findings Include: Initial tour of the kitchen on 03/16/20 at 8:50 A.M . revealed the following concerns: 1. Observation of the kitchen on 03/16/20 at 8:50 A.M. with Dietary Manager #37 revealed the temperature of the dishwasher wash cycle was 152 degrees Fahrenheit (F) and the rinse cycle was 190 degrees F. The dishwasher took eight runs to get to the appropriate temperature. The dishwasher was in the middle of a slick metal table used to slide the dishwashing trays on. Dietary Manager #37 explained the dirty items came in on the right and were placed in the dishwashing trays, they were run through the dishwasher and exited the dishwasher on the left where there was a slick metal table for the dishes to dry on. There were two trays of clean dishes on the clean dish side on the left. A used, wet, brown rag was observed hanging on the clean side of the dishes next to the tray of clean dishes. There were also two used/dirty pitchers sitting on the metal table with the clean dishes. The slick metal table on the clean side, was noted to have an approximately one foot by one foot area of wet crumbs. The dishwasher was also noted with crumbs caking the top, sides, front, and bottom. Interview on 03/16/20 at 8:50 A.M. with Dietary Manager #37 revealed it shouldn't take the dishwasher that long to heat up. She stated maybe two or three cycles. She stated the thermometer was wrong on the outside and she obtained a dishwasher thermometer that went inside the dishwasher. Dietary Manager #37 confirmed the above observations in the dishwashing room and further stated the dishwasher should be cleaned daily. 2. Observation of the kitchen on 03/16/20 at 9:05 A.M. with Dietary Manager #37 revealed the inside of the ice machine had a pink, brown and black speckled film on it. When wiped with a paper towel, the film transferred to the paper towel and was observed to be slimy. Dietary Manager #37 confirmed the ice machine was unsanitary. She stated it was cleaned every month by the Cook #35. 3. Observation of the kitchen on 03/16/20 at 9:10 A.M. with Dietary Manager #37 revealed the large mixer had dried orange substance caked on the outside and white and brown substance caked on the inside of the cover. She stated the orange substance was from the pumpkin moose that they had made around a week ago. The six top stove was observed with black and brown substance caked on the top of the stove, and underneath the range element. Spiral noodles and a salt packet was observed under the range surface element. Observation and interviews on 03/16/20 at 10:15 A.M. revealed Dietary Manager #37 instructing Dietary Aide #31 and Dietary Aide #38 on the appropriate temperature of the dish washer wash cycle (150 degrees F), she stated the thermometer on the dishwasher might not be working correctly and they needed to utilize the digital thermometer that was placed inside the dishwasher. Multiple observations revealed Dietary Aide #31 running the dishwasher without the digital thermometer in the dishwasher and the thermometer attached to the dishwasher was reading a wash temperature of 132 degrees F. When asked to run the digital thermometer, the temperature read 144.9 degrees F, confirming an inappropriate temperature for the dishwasher. When asked why she wasn't using the digital thermometer, she stated that water temperature was really hot already. This deficiency substantiates complaint number OH 890 and is an example of continued non-compliance from the surveys dated 01/23/20 and 02/27/20.