STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365754	A. BUILDING _____ B. WING _____	10/01/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MAJESTIC CARE OF COLUMBUS LLC	44 S SOUDER AVE COLUMBUS, OH 43222

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 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** Based on medical record review, review of showering schedules, staff, resident and family interview and policy review, the facility failed to provide a resident with showers per the facility shower schedule and policy/procedure. This affected one (#12) out of three residents who were assessed for dependent showers/baths. The facility census was 102. Findings: Review of Resident #12's medical record revealed the resident was admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #12 had mild cognitive deficit. Her functional status is listed as a total two person assist for bed mobility, transfers, dressing and toileting. Review of the care plan dated 06/18/19 revealed a plan in place indicating Resident #12 has impaired physical mobility and requires assistance with all activities of daily living (ADL) tasks related to Devic's disease, [MEDICAL CONDITION], weakness, chronic [MEDICAL CONDITION]-trach present. Resident #12 utilizes motorized wheelchair for mobility and oral call light-blows into it. She is total care for ADL's except once in wheelchair she can get around by herself. Interventions included: Total assist/dependent for care, transfers, bed mobility, eating, toileting, personal hygiene. Non-ambulatory and Hoyer lift for transfers. Review of the facility bathing schedule, dated 06/18/29, revealed Resident #12 was to receive two showers a week on Wednesday and Saturdays during the first shift. Further review of the ADL documentation for shower/bath for 07/2020, 08/2020 and 09/2020 revealed large gaps in the shower/bath documentation. During 07/2020 Resident #12 received two showers (07/04/20 and 07/15/20). During 08/2020 Resident #12 received seven showers (08/01/20, 08/04/20, 08/12/20, 08/16/20, 08/19/20, 08/23/20, and 08/26/20). During 09/2020 Resident #12 received four showers (09/02/20, 09/06/20,09/09/20, 09/16/20) up to 09/17/20. In 07/2020, Resident #12 should have received nine showers and received two, in 08/2020 she should have received nine showers and received seven and in 09/2020 she should have received five showers and received four. Interview with Resident #12 on 09/17/20 at 11:15 A.M. revealed she was not comfortable speaking with the state and would prefer the state contact her family. Interview with Resident #12's family on 09/21/20 at 10:15 A.M. revealed showers and their mothers grooming has been hit or miss. Resident #12's family revealed staff does not brush his mother's teeth and will let it go for two weeks at a time. Interview with the Director of Nursing (DON) on 09/17/20 at 12:00 P.M. confirmed she has been having this problem since arriving at this facility. The DON confirmed the lack of showering for Resident #12 and revealed she is working with staff on this. Review of the policy titled Showers dated 08/19/17 revealed residents would be offered a shower/bath twice weekly. This deficiency substantiates Complaint Number OH 086, Complaint Number OH 277, Complaint Number OH 174, Complaint Number OH 211, Complaint Number OH 160 and Complaint Number OH 047.
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** Based on medical record review, observations and interviews with staff and wound clinic staff, the facility failed to provide coordination of care between a physician's office and the facility by failing to answer their phone, causing a resident to miss a wound clinic appointment. This affected one (#25) of four residents reviewed for out of facility wound care. The facility census was 102. Findings include: Review of Resident #25 medical record revealed the resident was admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. Resident #25 was discharged back to home with his father on 07/28/20. Review of the quarterly Minimal Data Set ((MDS) dated [DATE] revealed Resident #25's mental status was intact. His functional status is listed as supervise; one-person assists. Further review of Resident #25's medical record revealed the resident was being seen by a wound clinic related to a non-pressure skin condition to the bilateral lower extremities. Observation on 09/21/20 at 2:10 P.M. revealed this surveyor attempted to phone the facility on 09/21/20 at 2:10 P.M. The surveyor reached the facility receptionist and asked to speak to the second floor. The phone rang nine times and then went back to the receptionist. Receptionist called the floor again and another nine times and the phone calls were sent back to the receptionist. This surveyor called back the facility and asked to speak to the third floor and the phone rang eight times and someone picked up. This surveyor called the facility again and asked to speak to the Director of Nursing (DON) and she never picked up her phone. DON's call went to voice mail. Interview with the DON on 09/21/20 at 2:20 P.M. confirmed the unit phones are at the nurse's station and if a nurse is busy, the phones won't get answer. The DON confirmed she knew there was a concern on communication with nurses on the units. She also revealed walkie-talkies with wide range reception had been ordered on [DATE] but had not arrived. She revealed the facility receptionist can alert the nurse of an incoming phone call. Education has begun on this issue. Interview with Wound Clinic Staff (WCS) #1 on 09/23/20 at 11:00 A.M. revealed the facility nurse phoned the physician's office on 06/22/20 regarding Resident #25's leg skin condition ([MEDICAL CONDITION] of both legs). WCS #1 revealed the facility nurse called the office because Resident #25 had completed his antibiotics and his leg was warm and she thought he needed more antibiotics. The facility nurse also explained Resident #25 had tested positive on 6/08/20 for COVID-19 and would need two negative COVID-19 tests before coming out of quarantine for 14 days. WCS #1 also revealed the facility nurse instructed WCS #1 to call her personal cell phone and not the unit phone. WCS #1 revealed the unit phones are not answered. WCS #1 revealed the physician's office tried to reach the facility (five times) on 06/24/20 to do their COVID-19 testing, but the phone was not answered. WCS #1 stated on 06/25/20 Resident #25 failed to show up for his appointment at the wound care office. This deficiency substantiates the Complaint Number OH 706.
F 0835 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Administer the facility in a manner that enables it to use its resources effectively and efficiently.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, review of a police report, staff interview and policy review, the facility failed to implement their policy regarding resident sign out procedures. This affected one (#1) of three residents reviewed for elopement. Facility census was 102. Findings include: Review of the medical record for Resident #1 revealed he was admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. Review of the quarterly Minimum Data Set (MDS) assessment, dated 02/27/20, revealed he was cognitively intact, required supervision of one person for all activities of daily living. Review of Resident #1's assessment dated [DATE] revealed he was a low risk of elopement. Review of physician orders [REDACTED].#1

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 0835 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) could go on leave of absence (LOA) with a responsible party and his medications. Further review of Resident #1's medical record including sign out sheets revealed no evidence the resident signed out of the facility for a LOA on 03/08/20 or 03/09/20. Review of the police report, dated 03/09/20, revealed they were contacted on 03/09/20 at 2:58 P.M. regarding a missing person, identified as Resident #1. Reporting person states the listed missing who is her father, over whom she has guardianship, left on foot from a residential facility and walked on foot to her residence on Sunday, 03/08/20. Daughter invited the Resident #1 in, but he declined and left on foot. Resident #1 has dementia, high level of [MEDICAL CONDITION] and [MEDICAL CONDITION] disorder. Usually doesn't take his medications, may be smoking crack. May have an old ID with him. Daughter of missing states she has guardianship. Stated the missing resident has threatened her in the past. Review of the nurse's notes dated 03/08/20 at 10:28 P.M. revealed nurse got report on previous shift that Resident #1 had gone out of center on LOA. Until the end of first medication pass at night Resident #1 was not back. This nurse placed a call to primary contact, who stated Resident #1 is at her place. Resident #1 will not be returning to center tonight per conversation. ending on how he does. Interview with the Social Worker on 09/10/20 at 1:49 P.M. revealed she had a care conference with Resident #1's family on 03/06/20 at 1:30 P.M. She revealed Resident #1 and Power of Attorney (POA) agreeable to Medications/Treatments/Plan of Care with following noted changes: The guardian will provide a copy of the guardianship paperwork. Majestic Care still does not have a copy yet. Discussed behaviors, Resident #1 has been compliant with all request. He has not shown any signs of duress or resistance, very friendly and interacts well with staff. Discussed his going to the gas station to get cigarettes and comes back to the facility. No concerns at this time. Interview on 09/14/20 at 11:00 A.M., with Administrator and Director of Nursing (DON) revealed they were not at this facility when the incident involving Resident #1 took place and can find no other information concerning this incident. Administrator revealed sign out sheets for 03/2020 are missing. The Administrator revealed Resident #1's family had been asked repeatedly for her guardianship paperwork/POA paperwork but to this date they have not received it. He stated Resident #1 is his own person as far as the facility is concerned. Interview with Licensed Practical Nurse (LPN) #22 on 09/15/20 at 9:50 A.M. revealed if a residents wishes to leave the floor to go somewhere off the premises they have a sign out sheet they are to use. This sheet is kept in their medical chart. She also revealed she does not remember Resident #1 and could not say if he told someone he was leaving. Review of facility policy titled Signing Residents Out dated 08/2006, revealed the facility was to have the resident sign out and give a time of return. The facility failed to produce the sign out sheets. This is an incidental finding discovered during the complaint investigation.