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 _____	06/17/2020

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 0578 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of the facility's policy, interview with a power of attorney and interview with facility staff, the facility failed to ensure the resident's code status in the electronic medical record were accurate. This affected one (Resident #108) of three residents reviewed for advanced directives. The facility census was 113. Findings include: Review of the medical record for Resident #108 revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of the resident's physician orders, dated [DATE], revealed an order for [REDACTED]. Review of the nurse's note, dated [DATE] at 6:30 P.M., revealed Resident #108 became unresponsive, no detectable signs of life were noted, and cardiopulmonary resuscitation (CPR) was immediately initiated and 911 was called. Interview with the resident's Power of Attorney (POA) on [DATE] at 11:09 A.M. stated the resident was a full code status. Interview with Director of Nursing on [DATE] at 10:49 A.M. verified Resident #108 was a full code status and the physician order, dated [DATE], for a code status of DNRCC in the electronic medical record was inaccurate. Interview with Licensed Practical Nurse #200 on [DATE] at 12:21 P.M. verified Resident #108 was a full code and the physician order [REDACTED]. Review of the facility's policy titled Emergency Procedure-Cardiopulmonary Resuscitation, last revised February 2018, revealed if the resident's DNR status is unclear, CPR will be initiated until it is determined that there is DNR or physician's orders [REDACTED]. This deficiency substantiates Complaint Number OH 272.
F 0584 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident and staff interview, review of the facilities policy and procedure and record review, the facility failed to ensure the resident rooms were maintained at a comfortable temperature. This affected four (Resident #4, #5, #7 and #8) of five residents reviewed for room temperatures. The facility census was 113. Findings include: 1. Review of the medical record for Resident #4 revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of the nursing evaluation dated 05/22/20 revealed Resident #4 had no memory problems and was able to both communicate his needs/wants and understand others. Observation of Resident #4's room temperature on 06/04/20 at 1:50 P.M. revealed the room was 82 degrees Fahrenheit (F). Maintenance Director (MD) #400 was present at the time of the observation and verified the room was 82 degrees F. Interview with Resident #4 on 06/04/20 at 2:45 P.M. revealed he felt it was too hot in his room. 2. Review of the medical record for Resident #5 revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of the annual Minimum Data Set (MDS) assessment, dated 05/21/20, revealed Resident #5 was moderately cognitively impaired. Observation of Resident #5's room temperature on 06/04/20 at 1:50 P.M. revealed the room was 82 degrees F. MD #400 was present at the time of the observation and verified the room was 82 degrees F. Interview with Resident #5 on 06/05/20 at 2:45 P.M. revealed he felt it was too hot in his room and wanted the air conditioning unit in the building to be fixed. 3. Review of the medical record for Resident #7 revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of the quarterly MDS assessment, dated 04/24/20, revealed Resident #7 was moderately cognitively impaired. Observation of Resident #7's room temperature on 06/04/20 between 1:31 P.M. and 2:05 P.M. revealed Resident #7's room was 80 degrees F. MD #400 was present at the time of the observation and verified the room was 80 degrees F. Interview with Resident #7 on 06/04/20 at 2:50 P.M. revealed he felt his room has been too hot on several occasions over the past few weeks. 4. Review of the medical record for Resident #8 revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of the quarterly MDS assessment, dated 04/10/20, revealed Resident #8 was cognitively intact. Observation of Resident #8's room temperature on 06/04/20 between 1:31 P.M. and 2:05 P.M. revealed Resident #8's room was 80 degrees F. MD #400 was present at the time of the observation and verified the room was 80 degrees F. Interview with Resident #7 on 06/04/20 at 2:50 P.M. revealed he felt his room has been too hot on several occasions over the past few weeks. Interview with MD #400 on 06/04/20 at 1:31 P.M. revealed the facilities central air condition (AC) unit has been broken since 05/18/20. During the interview, MD #400 stated the central AC unit has been breaking off and on for several years however this time the central AC unit needs to be replaced. It will take roughly 12 weeks for the central AC unit to be replaced. He said the portable AC units were being placed in all resident rooms that were greater than 81 degrees F. Interview with the Administrator on 06/08/20 at 3:05 P.M. revealed every resident room has a small AC unit near the window however since the central AC unit was broken, there was a higher demand on all of the small room AC units which was causing them to break quicker. Review of the facility's undated policy titled Extreme Weather Conditions revealed repairs of heating and air conditioning units will be considered a priority during extreme weather or anticipated extreme temperatures during winter and summer months. In the event of delay in repair or replacement of necessary temperature control equipment, the Administrator and Director of Nursing Services will be promptly notified to initiate procedures for resident comfort. Residents may be relocated temporarily to other rooms if the situation is isolated such as with individual heating of AC units or the temperature is considered a health and safety hazard to residents. When relocation is not practical, rooms are to be assessed for temporary alternative measures, such as providing electrical fans, opening or closing windows and vents to the outside, moving beds away from drafts and eliminating drafts via caulking or temporary coverings. This deficiency substantiates Complaint Numbers OH 397 and OH 106.

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.