STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365754	A. Building B. Wing	06/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32801 Based on observation, review of the medical record review, fall investigation, fall policy, hospital records and staff interviews, the facility failed to ensure Resident #98 who was at risk for falls, had care planned interventions in place, was assessed properly post fall, received timely medical treatment from falls with injury, and failed to investigate the root cause of the falls to implement appropriate falls interventions. This resulted in Immediate Jeopardy on 05/22/22 at 1:36 A.M., when Resident #98 reported to staff he had an unwitnessed fallen on 05/21/22 at 11:00 P.M., after having a seizure. The resident had requested to go to the hospital, however, was not sent due to the on-call nurse at the facility did not answer the phone. There was no evidence the physician was notified of the fall and resident request to go to the hospital. The facility did not initiate neurological checks, complete a fall investigation, or initiate a new fall intervention. Actual Harm occurred when Resident #98 sustained five additional falls (05/22/22, 05/23/22, 06/04/22, 06/05/22, and 06/12/22) that were not thoroughly investigated to determine the root cause, appropriate interventions were not initiated and/or revised, or the physician notified of all falls that ultimately resulted in the resident having to be admitted to the hospital on 06/12/22 with a Level II Trauma involving malar fracture (uncommon injury involving one or more of the bones that make up the malar region of the face), rib fracture, and subsequent surgery. In addition, a concern that did not rise to the level of Immediate Jeopardy occurred when Resident #21, #37 and #61, who were at risk for falls, did not have effective fall interventions in place to prevent falls, failed to determine the root cause of falls and/or failed to ensure timely follow up of radiology results for residents following falls. This affected four residents (Resident #21, #37, #61, and #98) of four residents reviewed for falls. The facility census was 101. On 06/15/22 at 5:40 P.M. Regional Nurse #310 was notified Immediate Jeopardy began on 05/22/22 at 1:36 A.M., when Resident #98 had reported an unwitnessed fall and then had five additional falls from 05/22/22 to 06/12/22 that were not thoroughly investigated to determine the root cause, appropriate interventions were not initiated and/or revised, or the physician notified of all falls that ultimately resulted in the resident having to be admitted to the hospital on 06/12/22 with a Level II Trauma involving malar fracture, rib fracture, and subsequent surgery. The Immediate Jeopardy was removed on 06/16/22 when the facility implemented the following corrective action: On 06/15/22 at 6:15 P.M., the Medical Director was notified by the Director of Nursing (DON). (continued on next page)

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 6/15/22 at 6:15 P.M., AD HOC QAPI team (Regional Nurse Consultant, VP Clinical Operations, VP Operations, Regional VP of Operations, Medical Director, Director of Nursing Services, Executive Director) met to develop the abatement plan. On 6/15/22 from 8:00 P.M. to 11:50 P.M., education in person and via phone was started with 19 of the 20 Licensed Nurses (LPN #303, LPN #304, LPN #308, LPN #309, RN #501, LPN #502, RN #503, LPN #504, RN #505, LPN #506, LPN #507, LPN #508, LPN #509, LPN #510, LPN #511, RN #512, LPN #513, LPN #514, and LPN #516) including the Director of Nursing on the fall management policy including notifications, interventions, fall risk assessments and root cause analysis with appropriate intervention. The licensed staff were also educated on the new incident and accident packet. The one Licensed Nurse (LPN #500) will be educated on or before their next scheduled shift. On 6/15/22 at 10:15 P.M., Regional Nurse Consultant reviewed progress notes for all 101 residents in the last 60 days to ensure fall incidents have a risk management completed. No Concerns were identified. On 6/15/22 at 11:35 P.M., Regional Nurse Consultant reviewed 101 residents to ensure that fall risk assessments have been completed in the last 90 days. Five Residents did not have a fall risk assessment completed in the last 90 days. Those residents were evaluated for fall risk condition to ensure appropriate interventions have been followed and/or implemented to reduce the risk of fall or injury related to fall. Care plans updated as needed. On 06/15/22 at 11:45 P.M., Director of Nursing Services (DNS) reviewed all residents (8) that had a fall in the last 60 days to ensure physician/NP notification, root cause analysis with appropriate intervention(s). Care plans and fall risk assessments updated as needed. Beginning on 06/15/22 a new incident and accident packet will be implemented to ensure a thorough investigation including root cause, appropriate intervention, post fall assessment, and notification. The packets will be reviewed by the DNS the next business day during the IDT (LPN #303, LPN #304, RN #512, LPN #513, LPN #514, LPN #516, Social Service (SS) #517, and Director of Resource (DOR) #518) meeting. Beginning on 06/16/22 audits will be conducted weekly for four weeks and then monthly for two months, and then as needed. Results of the audit will be forwarded to QAPI for review. Although the Immediate Jeopardy was removed on 06/16/22, the facility remained out of compliance at a Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) related to the concerns identified for Resident #21, #37 and #67 and as the facility was still in the process of implementing their corrective action and monitoring to ensure compliance. Findings include: 1. Review of the closed medical record revealed Resident #98 was admitted to the facility on [DATE] with diagnoses including fracture of the lower end of left tibia, seizures, chronic obstructive pulmonary disease, fracture of the third thoracic vertebra, injury of the blood vessels at the lower leg level, pedestrian injured in traffic accident involving unspecified motor vehicle and personal history of traumatic brain injury. The resident was ordered Tegretol and Dilantin medications for his seizures on admission. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #98's morse fall scales dated 05/12/22 revealed the resident was at a moderate risk for falls. Additional morse fall scale assessments completed on 05/19/22,05/24/22, 06/05/22, 06/07/22, 06/09/22, 06/12/22 revealed the resident was at high risk for falls. Record review revealed a plan of care was initiated on 05/13/22 and revised on 05/25/22 reflecting was at risk for fall related to injury due to diagnosis of fracture of the left tibia. On 05/13/22 the interventions included to keep call light and frequently used items in reach, appropriate footwear, and assist with toileting. Intervention dated 05/24/22 included staff to assist with transfers and to use a gait belt for all transfers, encourage to participate in activities, keep clear and well-lit pathway, mat on floor next to bed (resident has several mats on the floor next to his bed because he will crawl on the floor and sleep), medication review including Dilantin/Tegretol levels, and therapy to screen. On 06/09/22 an intervention to assist resident and ambulate when he becomes restless was added. Review of the five-day Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #98 had severe cognitive impairment and required extensive assistance from one staff member for bed mobility, transfers, walking in his room and corridor, toilet use and personal hygiene. The resident was assessed to require supervision from staff with locomotion on and off the unit and eating. The resident had unsteady balance with transition and walking, limited range of motion of lower extremities on one side and used a wheelchair. Record review revealed Resident #98 reported he had sustained an unwitnessed fall on 05/21/22 around 11:00 P.M. while having a seizure. The resident reported his speech was slurred and requested to go to the hospital. The nurse attempted to call the on call nurse three times without a response. There was no evidence the physician was notified. The facility did not complete a fall investigation nor was neurological assessments or new interventions initiated. The resident was not sent to the hospital per his request. On 05/22/22 at 8:30 A.M., a progress note revealed a nurse's aide reported to the nurse that Resident #98 had a cut on his left eyebrow. The resident reported that he had an unwitnessed seizure and fell to the floor from the bed after 2:00 A.M., this morning. The physician was notified, and new orders were received to send the resident to the emergency room . Neurological checks were initiated at 8:30 A.M., and completed again at 8:45 A.M. The resident returned to the facility at 2:30 P.M., with steri-strips to the left forehead, however the neurological checks were not continued. The facility had no paperwork regarding the emergency room visit prior to the survey investigation and was trying to call the hospital to obtain the records. Review of the hospital records dated 05/22/22 revealed there was discrepancies in the size of the laceration above the left eyebrow. The notes indicated the size was two centimeters to four centimeters. The physician indicated that the seizures was from missed doses of mediations. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #98's fall investigation dated 05/22/22 indicated the resident described having a seizure after 2:00 A.M. but doesn't recall the exact time. He stated that he had fallen out of bed and then climbed back into the bed after the seizure had stopped. There was no evidence there was a thorough investigation completed or intervention implemented. The neurological assessment flow sheet indicated that neurological checks would be performed every 15 minutes for one hour, every hour for four hours, and then every 4 hours for 19 hours. The neurological checks were only completed on 05/22/22 at 8:30 A.M. and 8:45 A.M. On 05/23/22 the Certified Nurse Practitioner (CNP) notes revealed the staff reported the resident had been physical aggressive towards staff at times and had fallen several times since admission. There were no new labs to review. The resident had a safety screening completed and was positive for fall risk and mitigation recommendation included the use of proper footwear. The resident was admitted with Haldol, however the CNP wrote new orders to discontinue the Haldol due to the resident was not psychotic and was a fall risk. On 05/24/22 A.M., at 12:52 A.M., there was a nursing note indicating the resident was noted to be combative with staff and Haldol was reordered. On 05/24/22 at 1:00 A.M., a psych note indicated the resident was referred for assessment and management of mood related behaviors, difficulties mood, and possible cognitive issues. The resident endorsed difficulties with depression and as well as anxiety. It was noted the resident had significant swelling of his lower lip and his left eye and laceration with stitches from a fall the previous day. The resident verbalized he was worried about what would happen to him and he was sad. The resident appeared to be visible appeared depressed and had great difficulty speaking. It was unclear if it was due to hurting his mouth during the fall or if this was his normal. Review of a fall investigation dated 05/24/22 at 1:31 A.M., revealed on 05/23/22 at 10:50 P.M., Resident #98 was found sitting on the floor in his room with a bruise on the lip and both knees. The fall was not documented in the medical record. The resident was assessed and had no indication of hitting his head, patient was unable to respond to the question if he hit is head or not. As needed Haldol was ordered, as well as new interventions of a mattress placed in front of the bed, low bed, repositioning, and frequent checks. The investigation indicated under the injury section that there were no injuries, even though the description indicated he had bruise on lip and both knees. The investigation was not thorough to include the root cause of the fall, if fall interventions were in-place, or the last time the resident was seen, etc. The neurological assessment flow sheet provided as part of the investigation dated 05/23/22 indicates that the neurological assessments started on 05/23/22 at 3:00 A.M., however the fall didn't occur until 10:50 P.M. Review of the paper and electronic medical records revealed no evidence Resident #98 had fallen on 05/23/22. A second fall plan of care was initiated on 05/24/22 and revised on 06/13/22 that indicated the resident was a fall risk related to history of falls related to psychoactive drug use, periods of confusion, gait/balance problems, and poor communication/comprehension. The resident was noted to crawl/sleep on the floor. Four mattresses placed on floor for safety. Intervention dated 05/24/22 included to wear appropriate footwear, call light and personal items in reach, clear and well-lit pathway, and to assist with toileting and transfers. On 05/25/22 therapy screening as needed was added, and wheelchair as an assistive device. On 06/09/22 one on one sitter as needed. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An IDT note dated 05/24/22 at 10:26 P.M., revealed that the resident's medication was reviewed and Dilantin and Tegretol levels. There was no evidence in the paper or electronic medical records that the resident's Dilantin or Tegretol levels had been checked since admission. Review of the Resident #98's medication records dated 05/2022 revealed an order was entered on 05/24/22 to obtain Dilantin and Tegretol levels and notify the physician of results. Notify the unit manager if refusal of every shift for one day. There was no evidence the lab results were obtained. On 05/24/22 9:00 P.M., Resident #98's medical record revealed the resident was noted to have a temperature of 102.2 and was given ice cream, cool towel, and Tylenol. On 05/25/22 at 7:18 A.M. review of a progress note revealed there was a change of condition note indicating Resident #98 was bleeding other than GI (gastrointestinal), shortness of breath, and seizure. A new intervention was to increase oral fluids. On 05/26/22 at 2:28 P.M., a nursing note revealed the resident remained in the hospital. There was no evidence when and why the resident was transferred to the hospital in the paper or electronic medical record. Review of Resident #98's hospital records dated 05/25/22 to 06/03/22 revealed the resident was admitted to the hospital with severe sepsis in the urine, seizures, and acute nasal bone fracture nonoperative. New orders for Keflex (antibiotic) for urinary tract infection (UTI) and increased Tegretol to 300 milligrams (mg). There was no evidence of the laboratory results. Resident #98 returned to the facility on [DATE]. The facility called the hospital during the survey on 06/16/22 and obtained the Tegretol and Dilantin levels. The resident Tegretol level was drawn on 05/25/22 at 8:19 A.M., and the level was 2.3 (low). The normal level was 4.0 to 12.0 micrograms per milliliter. On 06/04/22 a nursing note at 8:00 P.M., revealed the physical therapist noted Resident #98 on the floor in his room. His left forehead was cut open. The resident was instructed on the importance of staying in bed and waiting for staff to help. Currently the resident was one on one care. There was no evidence the physician was notified of the fall. Review of Resident #98's fall investigations revealed there was no evidence a fall investigation was completed on 06/04/22 to determine the root cause of the fall. Review of the fall investigation dated 06/05/22 at 6:30 P.M., revealed the resident had a fall in his room next to the bed. The site to the left eye reopened. The resident was not able to talk much but moans out his words and uses hand gestures. Instructed resident to sitting down and waiting for help to arrive before making attempts to get up. Mattress was placed on the floor to help prevent falls and additional safety due to the resident crawls onto floor. Curtains were tied up to help prevent the resident from hanging on them. There was no evidence of the root cause of the fall or evidence neurological assessments were completed. Review of the paper and electronic medical records revealed no evidence Resident #98 had fallen on 06/05/22. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #98's 24-hour resident flow record dated 06/08/22 at 12:00 P.M. to 06/09/22 to 12:00 A. M. revealed the resident was on 15-minute checks. There was no indication to why the resident on was on 15-minute checks for those dates. Review of CNP note dated 06/06/22 revealed the resident remained a fall risk. The note indicated she had discontinued the Haldol last visit due to the resident was a fall risk and not psychotic, however the physician had reordered the Haldol. New orders to discontinue the Haldol again due to the resident had multiple falls since admission to the facility. On 06/07/22 at 8:31 P.M., a nursing note reported the resident had a nosebleed. He was on the bed mat moaning. He could not get words out. He used his hands for gestures to point to the bleeding nose. He was administered Lorazepam to calm him down and to stop the nosebleed. There was no evidence the physician was notified. On 06/08/22 at 3:44 P.M., Resident #98's progress note indicated a new order for one on one supervision, however there was no written ordered noted. On 06/08/22 at 8:50 P.M., a progress note revealed Resident #98 was placed in a Broda chair at the nurse's station. The doctor was notified of nosebleed and new orders for Vaseline. Resident #98 was on one on one. Review of Resident #98's medical record revealed no evidence of when one on one supervision was initiated, completed, or stopped. On 06/12/22 at 8:20 A.M., a progress note revealed a nurse aide notified the nurse Resident #98 was found on the floor with a gash in his posterior occipital. The resident was sent to the hospital. Review of the hospital notes dated 06/12/22 revealed Resident #98 arrived as a level 2 trauma. The resident was noted holding his breath and grunting in pain. The CT scan showed bilateral anterior and lateral maxillary sinus wall, left medical sinus wall fracture, left interior and lateral orbital rim fracture, and bilateral comminuted nasal bone fracture which required open reduction internal fixation surgery. New fracture of the C6 was also noted on the x-ray and a c-collar was put in-place for six weeks. Resident #98 remained at the hospital at the time of the survey. On 06/14/22 at 3:21 P.M., interview with the DON and Registered Nurse (RN) #310 revealed the facility had not identified the root cause of all six falls or completed a thorough investigation. The falls that occurred on 05/21/22 and 06/04/22 did not have any type of investigation and the falls on 05/23/22 and 06/05/22 were not documented in the medical record. Neurological assessments were not completed on 05/21/22 or 05/22/22. RN #310 confirmed there was no written documentation the physician/CNP was notified of all incidents/change of conditions. There was no order written for one on one per the nurse's notes. It was up to the staff discretion when to implement the one on one. It was concerning one doctor was discontinuing orders for Haldol due there was no indication for use and the resident fall risk, and the other physician re-wrote them the same day they were discontinued. The facility was not able to determine why the resident was sent out per his request on 05/21/22. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of facility fall policy titled Fall Management, dated October 2019, revealed a neurological assessment will be initiated on all un-witnessed fall; 15 minutes for one hour, then every hour for four hours, then every four hours for twenty hours, and then every eight hours for 48 hours. All falls would be discussed by the interdisciplinary team at the first IDT meeting after the fall to determine root cause and other possible intervention to prevent future falls. The physician would be contacted immediately, if there were injuries, and orders would be obtained. If there were no injuries, notify the physician during normal business hours. 2. Medical record review revealed Resident #61 was admitted to the facility on [DATE] with diagnosis including multiple sclerosis, epilepsy, dementia, anxiety, muscle weakness, and neuromuscular dysfunction of the bladder. Review of Resident #61's morse fall scale dated 12/31/21 revealed the resident was at high risk for falls. Review of Resident #61's quarterly MDS 3.0 dated 01/01/22 revealed the resident cognition was intact and she was unsteady during transitions and walking. Review of Resident #61's progress notes dated 03/11/22 revealed the resident was found on the floor in the lobby. The resident reported she hit her head but was feeling ok. The physician was notified and ordered neurological assessments. Review of Resident #61's fall investigation revealed no evidence a fall investigation was completed to determine the root cause of the fall. Review of Resident #61's progress notes dated 03/12/22 revealed no evidence of a fall. Review of Resident #61's fall investigation dated 03/12/22 at 2:00 P.M., revealed the nurse was called by the activities director outside and notified the nurse that the resident was laying on the floor. On arrival the resident was found laying on the pavement on her left side with her left arm behind her and her head resting on the gravel. Resident reported she felt dizzy and tripped and fell getting off the bus. The resident had a small laceration to her left upper eye that was bleeding. The resident complained of bad headaches and dizziness and demanded to be sent to the hospital. The resident was transferred to the hospital. There was no evidence of the facility investigating the root cause of the fall or new interventions being implemented as a result of the fall. Review of Resident #61's fall plan of care initiated 03/24/21 and revised 04/14/21 revealed the resident was at risk for falls due to impaired mobility, weakness, multiple sclerosis, epilepsy, and bladder dysfunction. There had been no new fall interventions implemented since 2021. On 06/14/22 at 3:16 P.M., interview with the DON and RN #310 confirmed a fall investigation was not completed to determine the root cause for Resident #61's fall that occurred on 03/11/22 and the fall investigation completed on 03/12/22 was not thorough and did not include the root cause of the fall. The fall on 03/12/22 was not documented in the medical record. 3. Record review revealed Resident #21 was admitted to the facility on [DATE] with diagnosis including diabetes, paranoid schizophrenia, hypotension, seizures, history of falling, and mental disorder. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #21's quarterly MDS dated [DATE] revealed the resident had cognition impairment and required supervision with walking in room and toileting. The resident was not steady with balance during transitions and walking. Review of Resident #21's fall plan of care initiated 04/23/21 revealed the resident required assistance with toileting. Review of Resident #21's nursing note dated 03/09/22 at 10:00 P.M., revealed the resident reported she had an unwitnessed fall and twisted her left ankle. The left ankle and calf appeared swollen. The physician was notified and ordered x-rays. The ankle was iced and elevated awaiting x-ray. Pain medication given and will continue to monitor. Further review on 03/10/22 at 5:12 A.M., a late entry was entered that the nurse was called and updated by staff about x-ray results. The physician ordered to wait to get the confirmed fax prior to sending the resident out. The x-ray company was contacted by the primary nurse and a fax was sent. Physician confirmed with x-ray results and ordered to send resident to emergency room . At 5:30 A.M. the x-ray report indicated there was an acute comminuted spiral fracture involving the distal tibial diaphysis, with mild lateral and posterior displacement, and 15 degrees of apex anterior angulation. There was also an acute proximal fibular shaft fracture with displacement. At 6:00 A.M. the resident was transported to the hospital. Review of the x-ray reported dated 03/09/22 revealed the x-ray was reported at 12:58 A.M. on 03/10/22. The results included an acute comminuted spiral fracture involving the distal tibial diaphysis, with mild lateral and posterior displacement, and 15 degree of apex anterior angulation. There was also an acute proximal fibular shaft fracture with displacement. Review of the fall investigation report dated 03/09/22 at 8:40 P.M., revealed the resident was found sitting on bathroom floor due to a hypoglycemic episode. The resident complained of pain to left lower leg. The resident told the nurse she fell in the restroom and hurt her leg and she felt her sugar was low. A STAT (to be done right away) x-ray was ordered due to left lower extremity pain. The resident's blood sugar was checked and was low and glucagon was given. Review of the medication administration record dated 03/2022 revealed the residents blood glucose was 157 at 9:00 A.M., 132 at 11:00 A.M., 207 at 4:30 P.M., and 78 and 9:00 P.M. on 03/09/22. Further review revealed the resident blood glucose for the month ranged from 70-373. There was no evidence the resident had received pain medication on 03/09/22 or glucagon per the progress note and fall investigation. Interview on 06/14/22 at 2:24 P.M., with the DON and RN #310 confirmed the fall investigation was not thorough and accurate. There was no evidence the resident's blood glucose results and received glucagon per the incident report. RN #310 reported she did not know why there was a delay from 12:58 A.M. to 5:12 A.M. notifying the physician of the x-ray results. The physician should have been notified at 12:58 A.M., when the results were reported. RN #310 also verified there was no evidence the resident had received pain medication on 03/09/22 per the progress note. The progress note indicated the resident reported the fall at 10:00 P.M., however the fall investigation report indicated 8:40 P.M. 45440 (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	4. Resident #37 was admitted to the facility on [DATE] with the diagnoses of unspecified symptoms and signs involving cognitive function and awareness, dementia in other diseases classified elsewhere without behavioral disturbances, psychotic disorder with hallucinations due to known physiological condition, muscle weakness, and hypotension. Review of Resident #37's quarterly MDS dated [DATE] revealed he was cognitively impaired and needed supervision with one person for physical assistance in bed mobility, transfer, eating, and toileting. The quarterly MDS also revealed he needed supervision with setup help only in walking, and dressing. Review of quarterly fall assessment dated [DATE] revealed Resident #37 was a moderate risk for falling. Review of Resident #37's progress note dated 03/26/22 at 10:57 P.M. revealed Resident #37 was found on the floor in his room in front of the bathroom sink. This was an unobserved fall, neurological checks were initiated, and the resident was presenting with signs and symptoms(s/s) of pain rated an eight on a zero to ten scale. Review of Resident #37's fall investigation for the fall on 03/26/22 at 10:36 P.M. revealed the facility did not investigate the root cause of the fall. Resident #37's progress note dated 03/26/22 at 11:00 P.M. revealed a STAT right hip x-ray was ordered due to Resident #37's s/s of pain. Review of radiology form titled, Timeframe for STAT Exams, undated, revealed a technologist would complete STAT exams as quickly as they could, and the goal was to have STAT exams completed within four hours of the order being entered into the system. Review of Resident #37's physician March 2022 orders revealed he could receive Tylenol 325 mg, two tablets every six hours as needed for pain. Review of Resident #37's March Medication Administration Record (MAR) revealed he received Tylenol 325 milligrams (mg), two tablets at 11:10 P.M. on 03/26/22 for signs and symptoms of pain. Review of the progress note dated 03/27/22 at 1:11 A.M. revealed the Tylenol was effective for his pain. Review of Resident #37's progress note dated 03/27/22 at 2:55 A.M. revealed the x-ray company was contacted regarding continued need for STAT hip x-ray. Resident #37's progress note dated 03/27/22 at 6:58 A.M. revealed Resident #37 was presenting with facial grimacing and guarding his right hip due to pain rated an eight on a zero to ten scale. The note also revealed the pain was unrelieved by the Tylenol and an order was received to send Resident #37 to the emergency room . There was no evidence Resident #37 received additional Tylenol or pain-relieving interventions since Tylenol was administered at 11:10 P.M. Resident #37's progress note dated 03/27/22 at 7:29 A.M. revealed he was sent to the emergency room via emergency services transport. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365754	A. Building B. Wing	06/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Majestic Care of Columbus LLC	44 S Souder Ave Columbus, OH 43222

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident's discharge instructions from the acute care hospital, dated 04/01/22, revealed he was admitted to the facility with a diagnosis of a closed right hip fracture and on 03/28/22 he had surgery (an open reduction cannulated screw fixation) to the right femoral neck to correct/stabilize the fracture for healing. Review of Resident #37's care plan revealed the interventions of adding colored tape to his call light and a medication review were added on 03/31/22. Resident #37 returned to the facility on [DATE]. Review of an admission fall assessment dated [DATE] at 5:15 P.M. revealed Resident #37 was a high risk for falling. Resident #37's progress note dated 04/03/22 at 12:30 A.M. revealed Resident #37 was found sitting on the floor with his back against his bed. This was also an unobserved fall and neurological checks were initiated. Review of facility fall policy titled Fall Management, dated October 2019, revealed a neurological assessment will be initiated on all un-witnessed fall; 15 minutes for one hour, then every hour for four hours, then every four hours for twenty hours, and then every eight hours for 48 hours. All falls would be discussed by the interdisciplinary team at the first IDT meeting after the fall to determine root cause and other possible intervention to prevent future falls. The physician would be contacted immediately, if there were injuries, and orders would be obtained. If there were no injuries, notify the physician during normal business hours. Review of the facility fall investigation for the fall on 04/03/22 at 12:45 A.M. revealed the investigation did not identify the root cause of the fall. Review of Resident #37's neurological check documentation dated 04/03/22 revealed Resident #37 received assessments following his fall every 15 minutes for an hour, every hour for four hours, and every four hours for twelve hours. He received neurological assessments for a total of 20 hours and 45 minutes. Review of Resident 37's care plan revealed the interventions of assisting resident with toileting every two hour and add skid strips to the bathroom floor were added on 04/04/22 and a bladder tracker was added on 04/05/22. Review of Resident #37's significant change MDS dated [DATE] revealed the resident was rarely or never understood and needed extensive assistance of two plus people for physical assistance in bed mobility, transfer, dressing, toileting, and personal hygiene. Observation on 06/16/22 at 9:00 A.M. of Resident #37 revealed the resident was lying in bed dressed and covered with blankets. Resident #37's bed was in the low position, call light was within reach, and fall mat was on the floor to the left side of the bed. There was no color tape to the call light, and there were no skid strips on the floor next to the dresser or in the bathroom. On 06/14/22 [TRUNCATED]