

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365624	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/15/2025
NAME OF PROVIDER OR SUPPLIER Majestic Care of Perrysburg		STREET ADDRESS, CITY, STATE, ZIP CODE 28546 Starbright Blvd Perrysburg, OH 43551	

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)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>(continued on next page)</p>

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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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interviews, wound clinic staff interview, and review of facility policy, the facility failed to ensure wound care treatments and follow-up appointments were completed as ordered. This affected three (#127, #134, and #160) of four residents reviewed for wound care. The facility census was 58. Findings include: 1. Review of the medical record for Resident #127 revealed he was admitted on [DATE] with diagnoses that included atherosclerotic heart disease, peripheral vascular disease, hypertension, and atherosclerosis of native arteries of the left leg with ulceration of the heel and midfoot. Review of the annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #160 was cognitively intact and did not refuse care. Review of the current care plan for Resident #127 revealed Resident #127 had an open chest lesion. The interventions included treatment to chest per orders. Review of the physician orders and treatment administration records (TAR) for Resident #127 revealed active orders, beginning on 02/21/25, for daily wound care to his chest wound to cleanse with normal saline, pat dry and apply collagen with silver to the wound bed and cover with a boarder dressing. Further review of the TARs revealed wound care was not completed on 03/03/25, 04/23/25, 05/02/25, 05/10/25, 05/22/25, 06/03/25, 06/05/25, 06/07/25, 06/21/25, 06/22/25, 06/30/25, 07/31/25, 08/10/25, and 08/23/25. 2. Review of the medical record for Resident #134 revealed he was admitted on [DATE] with diagnoses that included disorder of lipoprotein, myelodysplastic syndrome (disorder affecting bone marrow), and non-pressure chronic ulcer of the right heel and midfoot with the fat layer exposed. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #160 was moderately cognitively impaired, and he did not refuse care. Review of the current care plan for Resident #134 revealed he had impaired skin integrity. The interventions included wound treatment as ordered. Review of the physician orders and TARs for Resident #134 revealed orders beginning on 08/21/25 for daily wound care to a diabetic foot ulcer on his right foot to cleanse with normal saline, pat dry, apply petroleum jelly, apply Xeroform (a petroleum infused dressing), and cover with boarder gauze. Further review of the TAR revealed wound care was not completed on 08/23/25, 08/24/25, and 08/28/25. Continued review of the physician orders and TARs for Resident #134 revealed orders beginning on 08/28/25 for daily wound care to a diabetic foot ulcer on his right foot to cleanse with normal saline, pat dry, apply hydrogel, apply Xeroform, and cover with a foam dressing. Further review of the TAR revealed wound care was not completed on 08/28/25. Interview on 09/11/25 at 4:10 P.M. and 5:20 P.M. with the Director of Nursing (DON) confirmed wound care was not completed for Resident #127 on 03/03/25, 04/23/25, 05/02/25, 05/10/25, 05/22/25, 06/03/25, 06/05/25, 06/07/25, 06/21/25, 06/22/25, 06/30/25, 07/31/25, 08/10/25, and 08/23/25 as ordered, and for Resident #134 on 08/23/25, 08/24/25, and 08/28/25 as ordered. 3. Review of the medical record for Resident #160 revealed he was admitted on [DATE] with diagnoses that included cerebral palsy, lymphedema, and cellulitis of bilateral lower extremities. Review of the admission MDS assessment dated [DATE] revealed Resident #160 was cognitively intact and did not refuse care. Review of the hospitalization after visit summary dated 07/17/25 for Resident #160 revealed wound care orders for Unna boots (wound dressing wraps) to bilateral lower extremities to be changed on Mondays, Wednesdays, and Fridays. Further review of the hospitalization after visit summary revealed he had a scheduled follow-up appointment at a wound clinic on 07/28/25. Review of the care plan dated 07/18/25 for Resident #160 revealed he had impaired skin integrity. The interventions included for staff to complete wound treatment as ordered. Review of physician orders and the July TAR for Resident #160 revealed wound care orders dated 07/25/25 for Unna boots to bilateral lower extremities to be changed on Mondays, Wednesday, and Fridays. Further review of the TAR revealed wound care was not completed on 07/21/25 and 07/23/25. Interview on 09/15/25 at 9:52 A.M. with the Administrator and Registered Nurse (RN) #101 confirmed Resident #160 was admitted with orders for Unna boots to his bilateral lower extremities to be changed on Mondays, Wednesdays, and Fridays. Further interview confirmed the Unna boots should have been changed on 07/21/25 and 07/23/25 but were not. Interview on 09/15/25 at 10:01 A.M. with Scheduling Personnel at the wound clinic confirmed Resident #160 was scheduled for a wound care follow-up appointment on 07/28/25 and was listed as being a no show for that appointment. Interview on 09/15/25 at 10:40 A.M. with the Administrator and RN #101 confirmed Resident #160's follow-up appointment at the wound clinic on 07/28/25 was not documented in the resident's electronic health record and the resident was not taken to the appointment. Review of facility policy titled, INAMEI Care Wound</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and review of facility policy, the facility failed to ensure pressure ulcer treatments were completed as ordered. This affected two (#134 and #140) of four residents reviewed for wound care. The facility census was 58. Findings include: 1. Review of the medical record for Resident #134 revealed he was admitted on [DATE] with diagnoses that included disorder of lipoprotein, myelodysplastic syndrome (disorder affecting bone marrow), and non-pressure chronic ulcer of the right heel and midfoot with the fat layer exposed. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #160 was moderately cognitively impaired, and he did not refuse care. Review of the current care plan for Resident #134 revealed he had impaired skin integrity. The interventions included wound treatment as ordered. Review of the physician orders and treatment administration records (TAR) for Resident #134 revealed orders beginning on 06/21/25 for daily wound care to a pressure ulcer on his right foot to cleanse with normal saline, apply collagen, cover with an abdominal dressing, wrap with Kerlix (fluffy gauze), and secure with tape. Further review of the TARs revealed wound care was not completed on 06/06/25, 06/15/25, 06/16/25, 06/22/25, 06/23/25, 07/01/25, 07/12/25, 07/26/25, 08/01/25, 08/02/25, 08/05/25, and 08/11/25. 2. Review of the medical record for Resident #140 revealed he was admitted on [DATE] with diagnoses that included traumatic brain injury, intracranial abscess and granuloma, tracheostomy, gastrostomy, and acquired absence of part of the head and neck. Review of the quarterly MDS assessment dated [DATE] revealed Resident #140 was unable to be assessed cognitively due to a traumatic brain injury, and he did not refuse care. Review of the care plan dated 03/19/25 for Resident #140 revealed he had a pressure injury to his right outer foot. The interventions included to administer treatments as ordered. Review of the current care plan for Resident #140 revealed he had a pressure injury to his left foot. The interventions included to provide wound care per treatment orders. Review of the physician orders and TARs for Resident #140 revealed orders beginning on 12/17/24 for daily wound care to his left foot to cleanse with normal saline, pat dry, apply skin prep (a protective barrier), and leave open to air. Further review of the TARs revealed wound care was not completed on 03/03/25, 03/04/25, or 03/22/25. Review of the physician orders and TARs for Resident #140 revealed orders beginning on 12/18/24 for daily wound care to his right outer foot to cleanse with normal saline, pat dry, apply Medihoney and calcium alginate, cover with abdominal dressing, and wrap with Kerlix. Further review of the TARs revealed wound care was not completed on 03/03/25. Review of the physician orders and TARs for Resident #140 revealed orders beginning on 03/21/25 for twice daily wound care to his right outer foot to cleanse with normal saline, pat dry, and apply skin prep. Further review of the TARs revealed wound care was not completed on 03/22/25 and 03/23/25. Review of the physician orders and TARs for Resident #140 revealed orders beginning on 09/11/25 for daily wound care to his left foot to cleanse with normal saline, pat dry, apply skin prep, and cover with border gauze. Further review of the TARs revealed wound care was not completed on 09/12/25. Interview on 09/11/25 at 4:10 P.M. and 5:20 P.M. with the Director of Nursing (DON) confirmed wound care was not completed for Resident #134's pressure ulcer on 06/06/25, 06/15/25, 06/16/25, 06/22/25, 06/23/25, 07/01/25, 07/12/25, 07/26/25, 08/01/25, 08/02/25, 08/05/25, and 08/11/25, and for Resident #140 on 03/03/25, 03/04/25, 03/22/25, 03/23/25, and 09/12/25. Review of facility policy titled, [NAME] Care Wound Management Policy, dated 05/20/24, revealed the facility would promote the treatment and healing of skin integrity impairment and optimize healing solutions. This deficiency represents non-compliance investigated under Complaint Number 2575262.</p>		