STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365624	A. Building B. Wing	10/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Majestic Care of Perrysburg	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)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and policy review, the facility failed to ensure care plans were implemented and contained resident specific goals and preferences regarding discharges. This affected two (#53 and #54) of seven residents reviewed for care plans. The facility census was 51.Findings include:1. Review of the medical record for Resident #53 revealed an admission date of 06/02/25 and discharge date of 08/01/25. Diagnoses included but were not limited to hypertension, congestive heart failure, chronic pain disorder, and major depressive disorder.Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #53 was cognitively intact.Review of the care plan dated 06/03/25 revealed Resident #53's discharge plan included interventions for social services to assist with discharge planning. The care plan was not specific to the resident's preference and potential for future discharge and lacked evidence the facility determined the resident's desire to return to the community. 2. Review of the medical record for Resident #54 revealed an admission date of 09/11/25 and discharge date of 10/13/25. Diagnoses included but were not limited to pneumonia, kidney transplant status, end stage renal disease, and anemia.Review of the MDS assessment dated [DATE] revealed Resident #54 was cognitively intact.Review of the care plan dated 09/11/25 revealed no specific care plan to address Resident #54's discharge planning was initiated. Interview on 10/23/25 at 11:16 A.M. with MDS Nurse #122 revealed care plans are updated at a minimum of quarterly, with significant changes, new orders, falls, and other events during interdisciplinary team (IDT) meetings. MDS Nurse #122 stated the dietary, social services, and activity departments completed their own care plans. MDS Nurse #122 verified Resident #53 and Resident #54 did not have a completed discharge care plan that was resident specific as to the goal of discharge location. Review of policy titled, Comprehensive Care Plan, revised on 05/16/24, revealed the purpose was to develop and implement a comprehensive person-centered care plan for each resident/patient, consistent with resident/patient rights, that includes measurable objectives and timeframes to meet a resident's/patient's medical, nursing, and mental and psychosocial needs that are identified in the resident's/patient's comprehensive assessment. The comprehensive care plan will describe, at a minimum, the following: the resident's/patient's goals for admission, desired outcomes, and preferences for future discharge and resident/patient specific interventions that reflect the resident's/patient's need and preferences and align with the resident's/patient's cultural identity, as indicated.This deficiency represents non-compliance investigated under Complaint Number 2630192.

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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(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 - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and policy review, the facility failed to ensure falls were thoroughly investigated to determine a root cause, documented in the medical record, and immediate interventions were put in place which were appropriate. This affected three (#5, #13, and #54) of three residents reviewed for falls. The facility census was 51.Findings include:1. Review of the medical record for Resident #5 revealed an admission date of 12/08/23 with diagnoses including but not limited to dementia mild with agitation, syncope and collapse, muscle weakness, difficulty walking, and cognitive communication deficit.Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #5 had severe cognitive impairment and required supervision or touching assistance for bed mobility, transfers, and ambulation. Review of the care plan dated 09/03/25 revealed Resident #5 was at risk for falls related to dementia, side effects of medications, diagnosis of syncope and collapse, muscle weakness, and cognitive communication deficit. Interventions included to encourage call light use, encourage use of a walker, frequent checks, instruction on safety measures for a new environment, medication review for increased agitation in the afternoon, monitor closely while in the bathroom, provide activities for distraction, antibiotic therapy, and be sure the resident's call light was within reach and encourage the resident to use it for assistance as needed, the resident needed prompt response to all requests for assistance, maintain the bed in low position, collect urinalysis for culture and sensitivity, encourage to use a wheelchair, a floor mat, non-skid socks (09/04/25), provide a gait belt when walking with staff, identification that the resident puts self on the floor (10/06/25), and therapy evaluation.Review of Resident #5's fall follow-up note dated 09/05/25 revealed the interdisciplinary team (IDT) met and discussed the fall that occurred on 09/04/25. Resident #5 was found on the floor and was unable to explain what happened. The resident was assessed and no injuries were noted. The resident was assisted off the floor. The immediate intervention was to don non-skid socks on the feet. Neurological checks were initiated and the physician and family were notified of fall. The current care plan was reviewed and noted that appropriate interventions were in place. A new intervention implemented was to ensure the resident had non-skid socks on and the care plan was updated.Review of an alert note dated 09/27/25 revealed Resident #5 fell in the dining room. The resident was noted to be sitting on his bottom. There were no injuries noted and range of motion was within normal limits in all extremities. The resident denied any pain or discomfort and all parties were notified. Further review revealed no documentation of an immediate intervention was put in to place.Review of a fall follow-up note dated 09/29/25 revealed the IDT met and discussed Resident #5 fall that occurred on 09/27/25. The resident was found on the floor in the dining room and the resident was unable to explain what occurred due to diagnoses. Resident #5 was assessed and no injuries were noted from the fall. An immediate intervention was to place non-skid socks on the resident. Neurological checks were initiated and the physician and Power of Attorney (POA) were notified. The current care plan was reviewed and a new intervention for therapy to assess the resident was added.Review of a general progress note dated 09/30/25 revealed Resident #5 was found lying down on the floor face up in his room. There were no injuries, pain, or discomfort noted and neurological checks were initiated. The resident's Guardian, physician, and unit manager were notified. There was no documentation of an immediate intervention put into place.Review of a general progress note dated 10/04/25 revealed Resident #5 was found sitting on the floor in the activity room. The resident voiced no complaints of pain or discomfort. It was noted the resident sustained a skin tear to the right wrist. A new dressing was applied to the right wrist, neurological checks were initiated, and the Director of Nursing (DON), unit manager, physician, and Guardian notified. There was no documentation of an immediate intervention put into place per the note.Review of a fall follow-up note dated 10/06/25 revealed the IDT met and discussed Resident #5's fall that occurred on 10/04/25. The resident was found on the floor in the activity room and was unable to say what happened. Resident #5 was assessed and noted to have a skin tear to the right wrist. The resident was assisted off the floor and taken to his room. An immediate intervention was to place non-skid socks on the resident's feet. Neurological checks were initiated and the physician and POA were notified. The current care plan was reviewed and a new intervention to encourage the resident to use a wheelchair was implemented.Review of all fall follow-up progress notes from 09/04/25 through 10/13/25 for Resident #5 revealed no root cause analysis or thorough investigation of the falls.2. Review of the medical record for Resident #13 revealed an admission date of 01/21/25 with diagnoses including but not limited to dementia

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, review of meal tickets, resident and staff interview, and policy review, the facility failed to ensure nutritional assessments were completed timely to determine dietary preferences and failed to ensure food preferences were honored. This affected two (#32 and #54) of four residents reviewed for nutrition. The facility census was 51.Findings include:1. Review of the medical record for Resident #32 revealed an admission date of 02/27/25 with diagnoses including but not limited to congestive heart failure, Parkinsonism, type two diabetes mellitus, weakness, hypertension, and malignant neoplasm of the prostate. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #32 had moderate cognitive impairment.Review of a care plan dated 02/27/25 revealed Resident #32 presented with a potential nutritional risk related to a therapeutic diet and diabetes with interventions included to honor food/fluid preferences, and provide and serve diet as ordered. There was no specified intervention indicating the resident requested no pork or beef. Review of a nutrition interview document dated 03/04/25 revealed Resident #32 liked chicken and fish and dislikes or avoids pork and beef.Review of Resident #32's current physician orders revealed a diet order for a regular diet with thin liquids and no mention of the resident requesting no pork or beef.Review of a nutrition/dietary note dated 03/05/25 revealed the dietician met with Resident #32 related to the resident being a new admission. The resident indicated he has a good appetite and was eating well at the facility with no issues. The resident also identified he liked chicken and fish. Further review revealed the resident's current diet order was a regular diet, regular texture, and thin liquids, with good oral intakes. Review of a meal ticket for Resident #32 dated 10/23/25 revealed an indication for no pork and beef.Interview on 10/22/25 at 11:29 A.M. with Resident #32 stated he does not want any beef or pork because it messes with his stomach. Resident #32 stated he preferred chicken and fish and verified he had received beef and pork on his tray on occasion. Observation on 10/22/25 at 12:00 P.M. of Resident #32 in the family room on the 200 hall revealed the resident had beef brisket, mashed potatoes, carrots, and a corn muffin on his plate. Interview on 10/22/25 at 12:02 P.M. with Unit Manager (UM) #200 verified Resident #32 had beef brisket, mashed potatoes, carrots, and corn muffin on his plate at lunch.2. Review of the medical record for Resident #54 revealed an admission date of 09/11/25 and discharge date of 10/13/25. Diagnoses included but were not limited to kidney transplant status, end stage renal disease, gastroesophageal reflux disease, anemia, and diabetes.Review of the MDS assessment dated [DATE] revealed Resident #54 was cognitively intact.Review of a nutrition/dietary note dated 09/17/25 revealed the dietician met with Resident #54 on that date and determined the resident's current diet order was a two gram sodium diet, with regular texture, thin liquids, and no pork. Resident #54 reiterated immediately he did not want any pork with his meals. Resident #54 also requested a controlled carbohydrate diet.Interview on 10/22/25 at 9:15 A.M. via telephone with Resident #54 revealed he did not want pork on his trays due to religious reasons and he would get pork on his tray. Resident #54 stated he would have send the meal trays it back to get something else. Resident #54 stated it never got completely fixed and he would still get pork on his tray on occasion after the dietician was made aware.Interview on 10/23/25 at 11:47 A.M. with Dietary [NAME] (DC) #256 stated she had been doing tray line for so long it was routine to her so she did not look at the meal tickets thoroughly. DC #256 stated she just glanced at the tickets. DC #256 stated she made cheat sheets on the rack above the tray line for reference and for new staff to help assist them. Observation of the cheat sheets, during interview with DC #256, confirmed Resident #32's sheet revealed to serve no pork and had no mention of not serving beef.Interview on 10/23/25 at 1:45 P.M. with the Administrator revealed dietary preferences are put into the meal suite and are sent to the kitchen. The Administrator stated when she interviewed Resident #32 he verbally told her he did not like pork and did not mention not liking beef. The Administrator verified it was not documented anywhere and his meal tickets contained the notation for no pork or beef. The Administrator verified no nutritional interview was completed for Resident #54 upon admission to determine food preferences. The Administrator stated sometimes the residents think they are getting pork but it was not pork. For example, they served turkey sausage on 10/22/25 and the residents thought it was pork sausage.Review of the policy titled, Nutrition Assessment, dated 08/01/25, revealed each resident/patient will be interviewed within 72 hours of admission to determine food and meal preferences as well as to assess nutrition status and factors that may put the resident/patient at risk for altered nutrition. A registered dietician will assess the nutritional status of each resident/patient at a minimum at time of