

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  12/10/2025
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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review, observation, interview, and policy review, the facility failed to ensure a call light was within reach. This affected one (#46) of six residents reviewed for call lights. The facility census was 55. Findings include: Review of the medical record for Resident #46 revealed an admission date of 01/13/25 with diagnoses including but not limited to adult failure to thrive, hemiplegia/hemiparesis affecting non-dominant left side, and major depressive disorder. Review of The Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had severe cognitive impairment. The resident was dependent on staff for activities of daily living with the exception of eating. Review of the care plan dated 10/08/25 revealed the resident is at risk for falls related to decline in functional mobility, stroke with left sided weakness, and non-ambulatory status. Interventions included ensure call light is within reach and encourage resident to use it for assistance as needed. Observation and interview on 12/09/25 at 1:19 P.M. with Resident #46 revealed the resident stated he did not have a call light most times. Call light was observed to be on the floor behind the headboard of his bed out of his reach. Resident #46 was up in his wheelchair sitting beside the bed. Resident #46 stated he could use his call light if he was able to reach it. Interview on 12/09/25 at 1:14 P.M. with Certified Nursing Assistant (CNA #200) verified that Resident #46 call light was not in reach of the resident and it should be. Further observation on 12/10/25 at 8:58 A.M. of Resident #46's call light revealed the call light was on the floor out of reach of the resident. Resident #46 was resting in bed. Interview on 12/10/25 at 8:59 A.M. with CNA #116 verified the call light was on the floor out of reach of the resident. Review of policy titled, Call Lights, dated 01/02/24 revealed staff will ensure the call light is within reach of resident and secured as needed. This deficiency represents an incidental finding during the complaint investigation.</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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review, interview, and policy review, the facility failed to report an allegation of an injury of unknown origin to the State Agency. This affected one (#31) of three residents reviewed for abuse. The facility census was 55. Review of the medical record for Resident #31 revealed an admission date of 03/27/25 with diagnoses including but not limited to anoxic brain damage, gastrostomy status, tracheostomy status, anxiety, cognitive communication deficit, and dysphagia. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was rarely/never understood and had severe cognitive impairment. The resident was dependent on staff for all activities of daily living. Review of the care plan dated 11/10/25 revealed the resident had the potential/actual impairment to skin integrity. Interventions included avoid scratching and keep hands and body parts from excessive moisture, keep fingernails short, and use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surfaces. Review of the skin evaluation dated 10/25/25 marked incomplete, revealed multiple scratches to left arm. Incident report opened in error. Review of progress notes revealed no documentation regarding any scratches to left arm. Review of physician orders for October 2025 revealed no orders for scratches to left arm. Review of the facility's Self-Reported Incidents (SRI) revealed no SRI was completed for this incident. Interview on 12/10/25 at 2:07 P.M. with the Director of Nursing (DON) revealed he did not strike out the skin evaluation dated 10/25/25. The DON stated two events were opened on a Saturday and he only struck out one of them. DON verified they could not locate any nurse's notes or other documentation to support where the scratches came from or that the resident had scratches. Interview on 12/10/25 at 2:11 P.M. with Registered Nurse (RN #142) revealed that they were called into the resident's room and assessed the scratches to the residents left arm. RN #142 verified they did not put in an order for treatment to the scratches. RN #142 stated they completed a Risk Management and notified the family who already knew about them. RN #142 stated they did not know how the scratches happened so they did not fill out the predisposing factors on the risk. Interview on 12/10/25 at 2:18 P.M. with DON verified Resident #31's scratches were not investigated as to how they obtained them. DON verified it would be an injury of unknown origin if there was no supporting documentation as to where they came from and should have been investigated. Review of policy titled Abuse, Mistreatment, Neglect, Exploitation and Misappropriation dated 07/01/25 revealed all incidents and allegations of abuse, neglect, exploitation, mistreatment and misappropriation of resident/patient property and all injuries of unknown source must be reported immediately to the Administrator or designee. Injury of unknown source is an injury when all the following are met: the source of the injury was not observed by any person, the source of the injury could not be explained by the resident, and the injury is suspicious because of the extent of the injury, the location of the injury, the number of injuries observed at one particular point in time, or the incidence of injuries over time. Once the Administrator and Department of Health are notified, an investigation of the allegation violation will be conducted. This deficiency represents non-compliance investigated under Complaint 2655109.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review, interview, and policy review, the facility failed to investigate a injury of unknown origin. This affected one (#31) of three residents reviewed for abuse. The facility census was 55. Findings include: Review of the medical record for Resident #31 revealed an admission date of 03/27/25 with diagnoses including but not limited to anoxic brain damage, gastrostomy status, tracheostomy status, anxiety, cognitive communication deficit, and dysphagia. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was rarely/never understood and had severe cognitive impairment. The resident was dependent on staff for all activities of daily living. Review of the care plan dated 11/10/25 revealed the resident had the potential/actual impairment to skin integrity. Interventions included avoid scratching and keep hands and body parts from excessive moisture, keep fingernails short, and use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surfaces. Review of the skin evaluation dated 10/25/25 marked incomplete, revealed multiple scratches to left arm. Incident report opened in error. Review of progress notes revealed no documentation regarding any scratches to left arm. Review of physician orders for October 2025 revealed no orders for scratches to left arm. Interview on 12/10/25 at 2:07 P.M. with the Director of Nursing (DON) revealed he did not strike out the skin evaluation dated 10/25/25. The DON stated two events were opened on a Saturday and he only struck out one of them. DON verified they could not locate any nurse's notes or other documentation to support where the scratches came from or that the resident had scratches. Interview on 12/10/25 at 2:11 P.M. with Registered Nurse (RN #142) revealed that they were called into the resident's room and assessed the scratches to the residents left arm. RN #142 verified they did not put in an order for treatment to the scratches. RN #142 stated they completed a Risk Management and notified the family who already knew about them. RN #142 stated they did not know how the scratches happened so they did not fill out the predisposing factors on the risk. Interview on 12/10/25 at 2:18 P.M. with DON verified Resident #31's scratches were not investigated as to how they obtained them. DON verified it would be an injury of unknown origin if there was no supporting documentation as to where they came from and should have been investigated. Review of policy titled Abuse, Mistreatment, Neglect, Exploitation and Misappropriation dated 07/01/25 revealed all incidents and allegations of abuse, neglect, exploitation, mistreatment and misappropriation of resident/patient property and all injuries of unknown source must be reported immediately to the Administrator or designee. Injury of unknown source is an injury when all the following are met: the source of the injury was not observed by any person, the source of the injury could not be explained by the resident, and the injury is suspicious because of the extent of the injury, the location of the injury, the number of injuries observed at one particular point in time, or the incidence of injuries over time. Once the Administrator and Department of Health are notified, an investigation of the allegation violation will be conducted. This deficiency represents non-compliance investigated under Complaint 2655109.</p>		