Printed: 06/25/2026
Form Approved OMB
No. 0938-0391

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	04/24/2026

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, staff interview and review of facility policy, the facility failed to ensure resident respect and dignity was maintained. This affected one (#5) of three residents reviewed for respect and dignity. The facility census was 52.Findings include: Review of the medical record revealed Resident #5 was admitted to the facility on [DATE]. Diagnoses included hemiplegia and hemiparesis following cerebral infarction, dysphagia and dementia without behavioral disturbance.Review of the comprehensive Minimum Data Set (MDS) assessment, dated 04/15/26, revealed Resident #5 was rarely/never understood. Resident #5 was dependent on staff for eating. Review of revised care plan dated 04/01/26 revealed Resident #5 had an Activities of Daily Living (ADL) self-care performance deficit. Interventions included partial assistance of one staff member to eat. Observation on 04/14/26 at 8:22 A.M. revealed approximately 13 residents were in the secured unit dining area awaiting breakfast. Certified Nursing Assistant (CNA) #110 assisted with passing out breakfast trays to the residents in the dining area. CNA #110 was exiting the secured unit, turned back and yelled from the hallway to another CNA, who was in the dining room assisting with breakfast, that Resident #5 was a feeder (meaning Resident #5 required assistance with eating). Interview on 04/14/26 at 8:35 A.M. with CNA #110 verified she yelled out that Resident #5 was a feeder. CNA #110 confirmed referring to the resident as a feeder was not dignified and respectful and apologized. Review of the facility policy titled, Residents Rights, dated 02/20/26, revealed care team members would treat each resident/patient with kindness, respect and dignity. This deficiency represents non-compliance investigated under Master Complaint Number 2979608 and Complaint Numbers 2975430 and 2799367.

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

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 04/24/2026
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)
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. Based on observation, staff and resident interviews, review of open and closed medical records, review of the facility water temperature logs and policy review, the facility failed to ensure shower water temperatures in the East Hall shower room were adequately warm. This affected four (#19, #24, #55 and #63) of four residents reviewed for comfortable and homelike environment. The facility identified 15 (#4, #11, #14, #26, #28, #29, #30, #31, #37, #39, #41, #47, #48, #50 and #56) additional residents who used the East-hall shower room. The facility census was 52.Findings include:1. Review of the medical record for Resident #19 revealed an admission date of 02/27/25 with diagnoses of congestive heart failure, weakness, and parkinsonism. Review of the significant change comprehensive Minimum Data Set (MDS) assessment, dated 02/18/26, revealed Resident #19 had impaired cognition and was dependent on staff for showers/bathing.Interview on 04/16/26 at 11:11 A.M. with Resident #19 revealed he rarely used the shower. Resident #19 stated the water in the shower room was too cold, but staff provided bed baths for him.2. Review of the medical record for Resident #24 revealed an admission date of 08/25/25 with diagnoses of Parkinson's disease, asthma, and depression. Review of the quarterly MDS assessment, dated 04/02/26, revealed Resident #24 had intact cognition and required partial/moderate assistance for shower/bathing.Interview on 04/16/26 at 10:50 A.M. with Resident #24 confirmed she received a shower. Resident #24 stated the water was chilly but bearable. Resident #24 stated she had refused showers in the past because the water was cold.3. Review of the medical record for Resident #55 revealed an admission date of 02/27/26 with diagnoses of congestive heart failure, anxiety, and atrial fibrillation. Review of the MDS assessment, dated 03/06/26, revealed Resident #55 had intact cognition and was dependent on staff for showers/bathing.Interview on 04/16/26 at 11:14 A.M. with Resident #55 revealed the East Hall shower room was so cold she felt like she had icicles coming off her body. Resident #55 stated she avoided showers because it was so cold. Resident #55 stated she received bed baths in her room.4. Review of the closed medical record for Resident #63 revealed an admission date of 03/10/26 with diagnoses of chronic obstructive pulmonary disease (COPD), anxiety, Type II diabetes mellitus, and restless legs. Resident #63 discharged from the facility on 03/26/26. Review of the admission comprehensive MDS assessment, dated 03/17/26, revealed Resident #63 had intact cognition and required substantial/maximal assistance for showering/bathing.Review of Resident #63's shower sheet, dated 03/23/26, revealed a written statement water in the shower room was too cold so [Resident #63] wanted to wash up at the sink.Interview on 04/14/26 at 10:04 A.M. with Medical Records (MR) #164 verified the statement written on Resident #63's shower sheet dated 03/23/26 related to the shower water being too cold to shower.Interview on 04/14/26 at 3:29 P.M. with Certified Nursing Assistant (CNA) #149 revealed water in the East Hall shower room was cold and residents complained about it. Interview on 04/15/26 at 11:25 A.M. with CNA #119 revealed she assisted Resident #63 with showers. CNA #119 confirmed Resident #63 used the East Hall shower room. Interview on 04/16/26 10:35 A.M. with Licensed Practical Nurse (LPN) #101 revealed she was aware the East Hall showers had cold water and stated the stall closest to the door was cold and the stall farthest from the door was barely warm. Observations on 04/16/26 from 10:39 A.M. until 10:47 A.M., with Maintenance Director (MD) #161, of the East Hall shower room water temperatures revealed stall number one (closest to the door) had a temperature of 83 degrees Fahrenheit (F) after running for six minutes, and stall number two had a temperature of 88 degrees F after running for five minutes. Additional observation revealed the sink in the East Hall shower room reached a temperature of 90 degrees F after three minutes. Concurrent interview with MD #161 verified the low water temperatures and stated he intended to keep hot water temperatures between approximately 109 degrees F and 115 degrees F. MD #161 stated cold shower water temperatures were never reported to him as a concern. MD #161 confirmed the water temperatures did not meet the minimum (continued on next page)

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 04/24/2026

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	requirement of 105 degrees F and further stated the water pressure was low and a shower at those temperatures would be cold.A follow-up interview on 04/16/26 at 1:28 P.M. with MD #161, and concurrent review of the facility's water temperature logs from 02/02/26 through 03/11/26, revealed the East Hall shower room water temperatures should be monitored weekly, and no water temperatures were logged. Additionally, no water temperatures were recorded between 03/11/26 and 03/30/26. Further review revealed the East Hall shower room water temperature was 112 degrees F on 03/31/26 and was 109 degrees F on 04/06/26. MD #161 stated he began his position at the facility mid-March 2026. Review of the facility policy titled, Water Supply Management, Water Temperature Control, and Water System Maintenance, revised 02/26/26, revealed water temperatures were maintained within state-allowed limits. The deficiency represents non-compliance investigated under complaint number 2975430.

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 04/24/2026

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on open and closed medical record review, staff interviews, and review of facility policy and procedures, the facility failed to ensure a baseline care plan was developed and provided to Resident #63's representative and further failed to ensure a baseline care plan for Resident #30 addressed the resident's care needs. This affected two (#63 and #30) of two residents reviewed for baseline care plans. The facility census was 52.Findings include:1. Review of the closed medical record for Resident #63 revealed an admission date of 03/10/26 with diagnoses of chronic obstructive pulmonary disease, anxiety, Type II diabetes mellitus, heart disease and restless legs. Resident #63 discharged from the facility on 03/26/26. Review of the admission comprehensive Minimum Data Set (MDS) assessment, dated 03/17/26, revealed Resident #63 required substantial/maximal assistance for toileting hygiene, showering/bathing and upper body dressing and was dependent for lower body dressing and personal hygiene. Additionally, Resident #63 required substantial/maximal assistance for rolling to the left and right, lying to sitting, sitting to standing, and chair to bed transfers and toilet transfers. Walking was not attempted due to medical condition or safety concerns. Review of the Nursing Admission/readmission Evaluation, dated 03/10/26, revealed Resident #63 needed physical assistance for ambulation, transfers, toileting and bathing. Additionally, Resident #63 used a walker and manual wheelchair for mobility. Further review revealed no baseline care plan was initiated. Interview on 04/15/26 at 8:38 A.M. with MDS Coordinator (MDSC) #127 confirmed no baseline care plan was initiated for Resident #63. Additionally, MDSC #127 stated she developed Resident #63's activities of daily living (ADLs) comprehensive care plan on 03/24/26. MDSC #127 further confirmed, along with concurrent review of Resident #63's comprehensive care plan, that monitoring for diabetes mellitus was not initiated until 03/24/26. MDSC #127 verified the first care area was initiated on 03/23/26 and no care plan was in place from Resident #63's admission on [DATE] until 03/23/26. 2. Review of the medical record for Resident #30 revealed an admission date of 04/01/26 with diagnoses including peptic ulcer, schizoaffective disorder, bipolar disorder, rheumatoid arthritis, anxiety disorder, chronic obstructive pulmonary disease, and lung cancer. Review of the social services progress review for the MDS assessment, dated 04/02/26, revealed Resident #30 was cognitively intact, had adequate vision and hearing, was able to be understood, and did not display any behaviors nor refusals of care. Review of the baseline care plan dated 04/01/26 for Resident #30 revealed she did not have a care plan for the administration of oxygen. Observation on 04/14/26 at 8:15 A.M. of Resident #30 revealed she was wearing an oxygen nasal cannula connected to an oxygen concentrator running at four liters-per-minute (lpm). Interview on 04/16/26 at 12:45 P.M. with the Administrator confirmed Resident #30 did not have a care plan developed to include the administration of oxygen and this resident utilized oxygen as needed. (continued on next page)

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	04/24/2026

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility procedures regarding the 72-hour care conference revealed the baseline care plan would be initiated by the nurse conducting the admission assessment. Review of facility policy titled Comprehensive Care Plan, dated 11/01/24, revealed care plans would include objectives to meet residents' medical needs. The deficiency represents non-compliance investigated under complaint number 2975430.

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 04/24/2026
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)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, staff interviews and review of facility policy, the facility failed to ensure dependent residents received appropriate bathing, showers, grooming and fingernail care. This affected four (#14, #57, #62 and #63) of five residents reviewed for activities of daily living (ADLs). The facility census was 52. Findings include:1. Review of Resident #14's medical record revealed an admission date of 05/06/21 with diagnoses including, malignant neoplasm of bronchus or lung, metabolic encephalopathy, schizophrenia, dementia, pulmonary embolism, malnutrition, pain, esophagitis, intellectual disability, anemia, and anxiety disorder. Review of the Minimum Data Set (MDS) assessment, dated 02/18/26, revealed Resident #14 was severely cognitively impaired, utilized a wheelchair for mobility, required substantial to maximal assistance with ADLs, was incontinent of bowel and bladder, received a mechanically altered diet, was at risk for pressure ulcer development, and received Hospice care. Review of a physician order dated 01/21/25 revealed Resident #14 admitted to Hospice services. Review of the plan of care, dated 12/03/25, revealed Resident #14 had an ADL self-care performance deficit related to (r/t) decline in functional mobility, diagnosis of lung cancer, dementia, hypertension, schizophrenia, dysphagia, anemia, low back pain, restlessness/agitation, anxiety, tremor, constipation, esophagitis, use of psychotropic medications, incontinence, and weakness. Resident #14 received end of life care through Hospice. Interventions included the following: assist with bathing as needed; provide the resident with short, simple instructions such as hold your washcloth in your hand, put soap on your washcloth, and wash your face to promote independence; partial to maximum assistance; provide supportive care; assistance with mobility as needed; document assistance as needed; and showers on Wednesday and Friday during day shift. Review of skin observation shower sheets revealed bed baths were provided to Resident #14 on 03/20/26, 03/24/26, 03/26/26, 04/03/26, 04/07/26 and 04/10/26. Further review revealed no documentation of the resident having his hair washed, fingernails clipped or beard groomed. None of the skin observation shower sheets documented resident refusals of care. Review of the electronic medical record (EMR) shower task charting revealed Resident #14 was provided with a bed bath on 03/31/26 and 04/10/26. Showers were documented on 03/17/26, 03/20/26 and 04/07/26. No refusals of care were documented. Observation on 04/14/26 at 5:33 A.M., during concurrent interview with Certified Nursing Assistant (CNA) #105 and CNA #136, revealed Resident #14 had greasy long hair, unkept facial hair/beard growth and long jagged fingernails. CNA #105 and CNA #136 verified the findings and stated Hospice was responsible for washing the resident's hair and providing showers. Interview on 04/15/26 at 1:00 P.M. with Hospice CNA (HCNA) #201 revealed the facility CNAs were to provide Resident #14 with showers and grooming. HCNA #201 verified Resident #14 had long greasy hair, unkept beard growth, and long jagged fingernails. 2. Review of the medical record revealed Resident #57 was admitted to the facility on [DATE]. Diagnoses included malignant neoplasm of colon, anemia, muscle weakness, cognitive communication deficit, colostomy, depression and moderate protein calorie malnutrition. Review of the admission MDS assessment, dated 02/24/26, revealed Resident #57 had a Brief Interview for Mental Status (BIMS) score of four, indicating severe cognitive impairment. Resident #57 was dependient on others for toileting hygiene, showering, upper and lower body dressing and personal hygiene. Review of the admission care plan dated 02/17/26 revealed Resident #57 required assistance with ADLs with the goal of staff assistance with daily care needs. (continued on next page)

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 04/24/2026
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)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 04/13/26 at 9:55 A.M. with Resident #57 revealed the resident requested to shower more than once a week. Resident #57 stated he was unsure when his shower days were but knew he had only been getting showered once a week. Review of the facility Skin Observation Shower Sheets ([NAME]) for Resident #57 revealed shower days were scheduled for Mondays and Thursdays. Further review of the [NAME] for Resident #57 revealed showers sheets were completed on the following days: 02/19/26, 03/05/26, 03/09/26, 03/12/26, 03/19/26, 03/26/26, 03/30/26, 04/02/26 and 04/06/26. Review of the nurse aide task checklist for Resident #57 revealed showers were completed on the following days: 03/19/26, 03/30/26, 04/02/26, 04/06/26, 04/09/26 and 04/16/26. Further review of nurse aide task checklist revealed Resident #57 refused a shower on 03/26/26. No other refusals were noted in the nurse aid task checklist or on the [NAME]. Interview on 04/16/26 at 2:03 P.M. with the Interim Director of Nursing (IDON) confirmed the facility's expectation was for staff to complete shower sheets for each scheduled shower day, whether the resident refused to be showered or accepted a shower or bed bath. A follow- up interview on 04/16/26 at approximately 3:00 P.M. with IDON verified the facility had no evidence Resident #57 received scheduled showers on 02/23/26, 02/26/26, 03/02/26, 03/16/26, 03/23/26, 04/09/26 and 04/13/26. 3. Review of the closed medical record for Resident #62 revealed he was admitted on [DATE] and discharged on 03/05/26. His diagnoses included chronic obstructive pulmonary disease, arthritis, cutaneous abscess of right lower extremity, bacteremia, hypertension, difficulty walking, and gastro-esophageal reflux disease. Review of the admission MDS assessment, 02/12/26 revealed Resident #62 revealed was cognitively intact and did not display any behaviors nor refusals of care at the time of the assessment. He utilized a wheelchair and was dependent for mobility. Resident #62 required maximal to dependent levels of assistance with ADLs. Interview on 04/15/26 at 2:00 P.M. with the Administrator revealed shower sheets were completed for each resident when bathing occurred. Continued interview revealed Resident #62 was scheduled for bathing on Wednesdays and Fridays. Review of shower sheets for Resident #62 revealed bathing occurred on 02/20/26, 02/28/26 and 03/04/26 (three of eight opportunities). Review of the nursing progress notes for Resident #62 from 02/05/26 to 03/05/26 revealed no evidence he refused bathing. Interview on 04/15/26 at 3:35 P.M. with the Administrator confirmed the only shower sheets completed for Resident #62 were on 02/20/26, 02/28/26 and 03/04/26. Continued interview confirmed there was no documentation indicating Resident #62 refused bathing or received showers as scheduled. 4. Review of the closed medical record for Resident #63 revealed an admission date of 03/10/26 with diagnoses of chronic obstructive pulmonary disease, anxiety, Type II diabetes mellitus, and restless (continued on next page)

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 04/24/2026
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)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	legs. Resident #63 discharged from the facility on 03/26/26. Review of the admission comprehensive MDS assessment, dated 03/17/26, revealed Resident #63 had intact cognition and required substantial/maximal assistance for showering/bathing. Review of the shower sheets from 03/10/26 through 03/26/26 revealed no evidence of showers from 03/10/26 through 03/15/26. Interview on 04/14/26 at 9:52 A.M. with CNA #126 confirmed paper shower sheets should be completed for all residents, whether the shower was refused or not. Interview on 04/14/26 at 9:59 A.M. with Registered Nurse (RN) #158 confirmed staff should complete paper shower sheets for all residents' showers, bed baths, or refusals of care. Interview on 04/14/26 at 10:04 A.M. with Medical Records (MR) #164 revealed Resident #63 was to receive showers on Mondays and Thursdays. MR #164 confirmed Resident #63 should have received a shower on 03/12/26 (Thursday) and the facility had no evidence the shower was provided for the resident. Interview on 04/16/26 at 2:03 P.M. with the IDON confirmed the facility's expectation was for staff to complete shower sheets for each scheduled shower day, whether the resident refused to be showered or accepted a shower or bed bath. Follow-up interview on 04/16/26 at 2:12 P.M. with the IDON confirmed no additional shower sheets were available between 03/10/26 and 03/15/26 and, therefore, the facility could not provide evidence Resident #63 was offered a shower and/or bed bath during that time. Review of the facility policy titled, Activities of Daily Living, dated 01/02/24, revealed care and services would be provided for the following ADLs: bathing, dressing, grooming and oral care. This deficiency represents non-compliance investigated under Master Complaint Number 2979608 and Complaint Numbers 2975430, 2796491 and 2799367.

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 04/24/2026
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)
F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, staff interview and review of facility policy, the facility failed to ensure timely assessment and preventative interventions were implemented for a diabetic foot ulcer. This affected one (#47) of one resident reviewed for diabetic foot care. The facility census was 52. Findings include:Review of Resident #47's medical record revealed an admission date of 05/20/20 with diagnoses including schizoaffective disorder, Type II diabetes mellitus, history of diabetic ulcers, dementia, peripheral vascular disease, hypertension, chronic pain syndrome, insomnia, and hypothyroidism.Review of the Minimum Data Set (MDS) assessment, dated 03/12/26, revealed Resident #47 was assessed with moderately impaired cognition, no recorded resistive behaviors, required setup or clean-up assistance with eating, was dependent for activities of daily living (ADLs), required substantial to maximal assistance with bed mobility and was not at risk of developing pressure ulcers with a diabetic foot ulcer present.Review of a physician order dated 06/15/22 revealed to encourage offloading heel boots/protectors every shift. Further review revealed an order dated 11/19/25 for a weekly skin observation on every day shift, every Wednesday.Review of the care plan, initiated on 10/26/23 and revised on 04/22/25 and 03/19/26, revealed Resident #47 had potential for impairment to skin integrity related to decline in functional mobility, incontinence, peripheral vascular disease, diabetes mellitus Type II and diabetic foot ulcer. Interventions included the following: encourage and assist to off-load heels as tolerated; encourage and assist with turn and repositioning as tolerated; low air loss mattress to bed; monitor/document location, size and treatment of skin injury; report abnormalities, failure to heal, signs/symptoms of infection and maceration to the physician; and treatment to foot ulcer per orders.Further review of the care plan revealed on 10/30/23, the plan was revised to address Resident #47's diabetes mellitus Type II with long term insulin use. Interventions included: diabetes medication as ordered by doctor; monitor/document for side effects and effectiveness; educate resident/family/caregiver that diabetes is a chronic disease and compliance was essential to prevent complications of the disease, review complications and prevention with the resident/family/caregiver, elicit a verbal understanding from the resident/family/caregiver; nails should always be cut straight across, never cut corners, file rough edges with emery board; identify areas of non-compliance or other difficulties in resident's diabetic management; modify the problem area so that it may be more manageable for the resident/family; provide and document teaching to resident/family/caregiver; address identified roadblocks to compliance; monitor compliance with diet and document any problems; monitor/document/report to physician (MD) as needed (PRN) signs and symptoms of hypoglycemia; monitor/document/report to MD PRN signs and symptoms of hyperglycemia; monitor/document/report to MD PRN for signs and symptoms of infection to any open areas; and refer to podiatrist/foot care nurse to monitor/document foot care needs and to cut long nails. Review of a skin risk assessment, dated 01/16/26, revealed Resident #47 was at risk for skin breakdown due to age greater than [AGE] years old and dementia or Alzheimer's disease. Review of the weekly skin observation documentation revealed Resident #47 had no new skin alteration on 02/19/26. Further review of the medical record revealed no evidence that the next scheduled skin observation was completed on Wednesday, 02/25/26. Review of a change in condition evaluation form dated 02/26/26 at 4:28 P.M. and completed by Licenses Practical Nurse (LPN) #130 revealed Resident #47 had a skin wound or ulcer that started on 02/26/26 during the afternoon to the left great toe and second toe. The wound was described as a new onset grade two or higher pressure ulcer/injury, or progression of pressure ulcer/injury despite interventions. Apparently, minor recent wound was now developing redness, swelling, or pain. In addition, a wound/scab was described to the left heel. Narrative documentation noted LPN #130 was notified by the aide to come and observe Resident #47's left great and second toe and heel. LPN #130 observed the left great toe with a black scab and left (continued on next page)

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 04/24/2026
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)
F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	second toe and heel scarred. A new order was initiated to apply betadine every (q) shift until assessed by the Nurse Practitioner (NP) with bilateral arterial doppler of lower extremities. The resident representative was notified on 02/26/26 with no time listed. No wound measurements were documented. Review of the skin condition evaluation dated 03/03/26 at 3:48 P.M. revealed Resident #47 had an in-house acquired diabetic foot ulcer to the left great toe measuring five centimeters (cm) long by (x) four cm wide with undetermined depth, 20 percent (%) of the wound was covered with epithelialization tissue and 80% of the wound was filled with eschar. No exudate was identified. A second area identified as a diabetic foot ulcer was noted to the left heel measuring one cm x one cm x undetermined depth. The wound tissue was noted with 50% of the wound covered with epithelialization and 50% of the wound was filled with eschar. No exudate was identified. Review of a late entry progress note, dated 02/27/26 at 9:30 A.M. and entered on 03/06/26 at 9:32 A.M., revealed Certified Nurse Practitioner (CNP) #01 documented that Resident #47 was resting in bed during exam. The resident was seen for a routine visit. Nursing reported concern for new foot ulcer to her left toe. The left great toe with scab, left heel dry/cracked. Skin was appropriate for ethnicity, warm and dry. CNP #01 ordered betadine twice daily (BID), notify provider of any changes and pending order for arterial doppler to rule out (r/o) vascular cause.Review of the Arterial Bilateral Lower Extremity Duplex Scan Doppler Studies, dated 02/27/26, revealed mild diffuse femoral arterial disease. There was no focal critical stenosis or occlusion. Review of an interdisciplinary team (IDT) note dated 03/02/26 at 1:08 P.M. revealed the IDT met to review and discuss the resident's skin integrity. A root cause analysis was completed and determined that Resident #47's socks were improperly sized and too small for her feet, contributing to the diabetic foot ulcer. The interventions implemented included: replacement of socks, new treatment orders, care plan would be updated as indicated and resident plan of care continued to be ongoing. Review of a progress note dated 03/04/26 at 1:00 P.M. revealed CNP #01 saw Resident #47. The resident was resting in bed during the exam. Resident #47 was seen for a follow-up visit and was recently diagnosed with a foot ulcer. The arterial doppler was negative for acute findings. Left great toe with scab, left heel dry/cracked and skin was pink, warm and dry. Diabetic foot ulcer noted to left great toe, no change from previous visit. Continue betadine treatment every shift.Additional review of the physician orders revealed on 03/05/26, the treatment was modified to the left heel diabetic foot ulcer, to include cleanse with normal saline, pat dry then apply skin prep, monitor for signs and symptoms of infection, notify MD of any changes and apply every shift for wound care. An additional physician order was initiated on 03/20/26 to elevate/float heels when resting in bed every shift for diabetic foot ulcer. Review of a nursing progress note dated 04/01/26 at 4:13 P.M. revealed Assistant Director Of Nursing (ADON) #153 spoke with Resident #47's Power Of Attorney (POA) regarding the resident's sore on her left great toe. ADON #153 informed the POA that the provider was in today to observe the sore and changed the treatment plan as well, adding an antibiotic to treat cellulitis that had started in the toe. The POA was also concerned about the resident's heel, as the resident was complaining of it feeling sore from time to time. It was explained that the resident's foot could be offloaded, as well as a tent placed over the top of the foot, to keep the sheet and/or covers off the area to promoted healing. Further review of the physician orders revealed on 04/01/26, wound treatment was changed to include: left great toe, cleanse with normal saline, pat dry, apply hydrogel, cover with border gauze, monitor for signs and symptoms of infection and notify MD/NP with concerns, change every day shift for wound care and every 24 hours as needed for dislodgement/soilage. In addition, doxycycline hyclate oral tablet 100 milligrams (mg), give one tablet by mouth two times a day for cellulitis of the great toe for seven days. Review of skin condition evaluation dated 04/07/26 at 2:59 P.M. revealed Resident #47 had a diabetic foot ulcer to the left heel. It was described as boggy with fragile skin that was at risk for breakdown with normal color. The left great toe measured one cm x 1.4 cm x undetermined depth with 10% granulation to the wound bed and non-attached edge appearing as cliff. No exudate was identified. Review of a physician order dated 04/11/26 revealed Resident #47's antibiotic was changed to cephalexin tablet (continued on next page)

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 04/24/2026
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)
F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	500 mg, give one tablet by mouth two times a day for wound infection for seven days. Observation on 04/13/26 at 8:10 A.M. revealed Resident #47 was in bed. Both feet had socks on and were resting on the mattress. No pressure relief boots or elevation were in place. In addition, no tent was observed to keep bed linen off of Resident #47's lower extremities. Continued observation on 04/13/26 at 9:14 A.M. revealed Resident #47 remained in bed with bilateral feet with socks on and resting on the mattress. No pressure relief boots or elevation were in place and no tent was observed to keep bed linen off the lower extremities. Observation on 04/13/26 at 11:37 A.M. revealed Certified Nursing Assistant (CNA) #149 and CNA #159 provided care to Resident #47, which included transferring the resident to the wheelchair using a standing lift. Resident #47 had socks on both feet and slip on shoes. The resident's feet were resting on the floor. Concurrent interview with CNA #149 and CNA #159 verified Resident #47 did not have heel elevation or pressure relief boots in place when she was in bed. CNA #159 stated she had not observed pressure relief boots in place at any time. Observation on 04/13/26 at 2:11 P.M. of Resident #47's left foot, with LPN #145, revealed the resident was seated in a wheelchair in her room with bilateral shoes to her feet. LPN #145 removed Resident #47's left sock and exposed a dressing to the left great toe. The dressing was dated 04/12/26 at 11:00 A.M. The dressing was removed and a moderate amount of yellow/green drainage was observed. Interview on 04/16/26 at 1:37 P.M. with the Director of Nursing (DON), and concurrent review of Resident #47's medical record, verified there was no evidence a weekly skin assessment was completed on 02/25/26. Interview on 04/16/26 2:20 P.M. with the DON and ADON #153, and concurrent review of Resident #47's medical record, verified no weekly skin assessment was completed on 02/25/26. Further interview confirmed that upon discovery of the toe wound on 02/26/26, LPN #130 did not document a description or obtain measurements of the toe wound. The DON and ADON #153 verified no description or measurements of the wound were obtained until 03/03/26. Review of facility policy, Wound Management, effective 05/30/24, revealed residents with impaired skin integrity were recognized by the facility team, treated timely and interventions to heal were not exhausted until the skin was healed. The facility would have a system in place to monitor the resident's skin for early symptoms of the development of a new skin impairment. Preventative skin monitoring may identify a new symptom or risk factor. The resident's care team will assess the skin, care plan any new care initiative, monitor the care initiative and evaluate care initiatives for effectiveness. The facility would have a system in place to identify impaired skin integrity development early to prevent further damage and treat the condition as soon as it was identified. This deficiency represents non-compliance investigated under Complaint Number 2796491.

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 04/24/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** Based on observation, open and closed medical record review, staff interview, resident interview, review of the facility elopement investigation files and review of facility policies, the facility failed to ensure adequate supervision was provided for residents assessed to be at risk for elopement. This affected one (#29) of one resident reviewed for elopement. Additionally, the facility failed to ensure smoking materials were properly stored. This affected one (#56) of two residents reviewed for smoking. Lastly, the facility failed to ensure neurological assessments were thoroughly completed following falls. This affected one (#63) of two residents reviewed for falls. The facility census was 52. Findings include:1. Review of the medical record for Resident #29 revealed he was admitted on [DATE] with diagnoses including traumatic subdural hemorrhage, Type II diabetes mellitus, alcohol use with withdrawal, dysphagia, cognitive communication deficit, slurred speech, anxiety, and unsteadiness on his feet. Review of the annual Minimum Data Set (MDS) assessment, dated 03/20/26, for Resident #29 revealed he had moderate cognitive impairment, did not exhibit aggressive behaviors, refusals of care, nor wandering behaviors. Further review of the point of care documentation during the lookback period revealed Resident #29 exhibited wandering behaviors on 03/19/26. Review of care plans dated 03/15/25 and 05/16/25 for Resident #29 revealed he exhibited exit-seeking behaviors and was an elopement risk. Interventions included application of, and checking the placement and function of, his wander management device, redirection, and providing structured activities. Review of physician orders for Resident #29 revealed two physician orders, each dated 08/04/25, for a wander management device to be placed on his left ankle, and a functional test of the device to occur every day shift. Review of the elopement risk assessments for Resident #29, completed between 03/15/25 and 03/29/26, revealed he was at risk for elopement. Review of the facility incident report dated 03/29/26 revealed Resident #29 had an elopement incident on 03/29/26. Review of the elopement investigation file for the incident on 03/29/26 revealed a written and signed statement from Dietary [NAME] (DC) #169 indicating she arrived at the facility at 5:22 A.M. and observed Resident #29 outside the employee access door walking toward the smoking area. DC #169 stated another staff member opened the employee access door and was looking for Resident #29 when she arrived at the facility. Review of a progress note documented on 03/29/26 at 5:29 A.M., written by Licensed Practical Nurse (LPN) #143, revealed Resident #29 was observed in the hallway at 5:15 A.M. Sometime after 5:15 A.M. door alarms were activated and Resident #29 was found outside. Resident #29 was returned inside, assessed, and found to be physically unharmed. Review of the elopement investigation file for Resident #29, dated 04/17/26, revealed a written and signed statement from Registered Nurse (RN) #106 indicating the front door alarm was activated at (continued on next page)

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 04/24/2026
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)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5:22 P.M. on 04/17/26. Continued review revealed staff began looking for Resident #29 first in his room then expanded the search to both inside and outside the facility. RN #106 stated Resident #29 was found on the lawn across a two-lane street adjacent to the facility property. Resident #29 was returned to the facility, assessed, and found to be physically unharmed. Further review of the investigation file revealed a written timeline of events by the Administrator indicating she received a phone call from RN #106 at 5:23 P.M. indicating Resident #29 had eloped, and another phone call from RN #106 at 5:34 P.M. indicating Resident #29 had been found. Observation on 04/20/26 at 9:00 A.M. revealed a staff member stationed outside Resident #29's door. Observation on 04/20/26 at approximately 9:10 A.M. revealed the location where Resident #29 was found when he eloped from the facility on 04/17/26 was west of the facility, across a two-lane street with a grassy median approximately 210 yards away from the front door of the facility. Additionally, the location where Resident #29 was found was approximately 35 yards south of a four-lane state route with a speed limit of 55 miles per hour. Interview on 04/20/26 at 9:30 A.M. with the Administrator revealed Resident #29 had successfully eloped from the building on 04/17/26 and was placed on one-on-one (1:1) staff observation. Continued interview revealed Resident #29 would remain on 1:1 observation until he could move to his new facility, which had been secured. The Administrator stated the current facility staffing was not adequate to provide continued supervision levels necessary to ensure the safety of Resident #29. A follow-up interview on 04/20/26 at 12:00 P.M. with the Administrator revealed the initial intervention for Resident #29's elopement that occurred on 03/29/26 was to relocate him to the memory care unit; however, there was an incident between Resident #29 and another resident on the memory care unit and Resident #29 was relocated back to his original room the same day and placed on 15-minute checks. It was determined the facility would seek alternative placement for the resident. The Administrator stated Resident #29 was back to his baseline with decreased exit-seeking behaviors and she discontinued the 15-minute checks at midnight on 04/08/26 without any additional interventions implemented. Review of facility policy titled Elopement Risk Management Guide, dated 04/15/24, revealed the facility would ensure the safety and wellbeing of their residents. 2. Review of the medical record for Resident #56 revealed he was admitted to the facility on [DATE] with diagnoses including cerebral infarction due to thrombosis, dilated cardiomyopathy, hypertension, subcortical and intraventricular intracerebral hemorrhage, hemiplegia affecting the left side, and wheezing. Review of the quarterly MDS assessment, dated 03/09/26, for Resident #56 revealed he was cognitively intact and did not display any behaviors at the time of the assessment. He refused care on one to three days of the assessment period. Resident #56 utilized a manual wheelchair with supervision assistance and required maximal assistance with transfers and activities of daily living (ADLs). Review of the care plan for Resident #56 revealed a focus area for smoking with interventions dated 01/21/26 to orient resident to smoking policies, procedures and times. Review of the smoking assessment dated [DATE] for Resident #56 revealed he was safe to smoke (continued on next page)

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 04/24/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	with supervision. Review of progress notes for Resident #56 revealed documentation dated 04/13/26 at 12:26 P.M. created by Licensed Practical Nurse #145 indicating a vape pen was found in Resident #56's bed and the nurse practitioner (NP) was notified. Observation on 04/14/26 at 10:52 A.M. of Resident #56's room revealed he was not in his room and there was a red vape pen on his bed. Interview on 04/14/26 at 10:54 A.M. with Certified Nursing Assistant (CNA) #149 verified a red vape pen was on Resident #56's bed. Interview on 04/14/26 at 11:18 A.M. with Assistant Director of Nursing (ADON) #153 and Licensed Practical Nurse (LPN) #145 confirmed the red vape pen found in Resident #56's bed was not allowed to be stored in his room and should have been secured with all other smoking supplies. LPN #145 confirmed the red vape pen had been temporarily relocated to her locked medication cart. Interview on 04/14/26 at 2:00 P.M. with Resident #56 revealed he was aware of the facility's rules regarding smoking and all smoking materials. He indicated smoking materials, including vape pens, were required to be stored in a locked box maintained by the facility. Review of facility policy titled, Smoking, dated 02/14/25, revealed smoking included the use of electronic cigarettes, smoking was only permitted in designated areas at designated times, and smoking supplies would be stored by the facility. 3. Review of the closed medical record for Resident #63 revealed an admission date of 03/10/26 with diagnoses of chronic obstructive pulmonary disease, anxiety, Type II diabetes mellitus, heart disease and restless legs. Resident #63 discharged to another facility on 03/26/26. Review of the admission comprehensive MDS assessment, dated 03/17/26, revealed Resident #63 had intact cognition required substantial/maximal assistance for toileting hygiene and showering/bathing, upper body dressing, and was dependent for lower body dressing and personal hygiene. Additionally, Resident #63 required substantial/maximal assistance for rolling to the left and right, lying to sitting, sitting to standing, and chair to bed transfers and toilet transfers. Walking was not attempted due to medical condition or safety concerns. Review of the incident log from 01/15/26 through 04/20/26 revealed Resident #63 had an unwitnessed fall on 03/22/26. No additional fall incidents were identified for the resident. Review of the Neurological Assessment Flow Sheet, completed 03/22/26 at 9:30 P.M. through 03/24/26 at 4:15 A.M. revealed hand grasps and motor functions were not completed during the assessments on 03/22/26 at 9:30 P.M., 03/22/26 at 9:45 P.M., on 03/22/26 at 10:00 P.M., on 03/22/26 at 10:15 P.M., on 03/22/26 at 11:15 P.M., on 03/23/26 at 12:15 A.M., on 03/23/26 at 1:15 A.M., and on 03/23/26 at 5:15 A.M. Further review of the assessments during these dates and times revealed Resident #63 was alert and his pupils were equal and reactive to light. Interview on 04/16/26 at 3:03 P.M. with the Administrator, and concurrent review of the neurological assessment flowsheet verified the assessments were completed inaccurately and should have included an assessment of hand grasps and motor functions for all assessment timepoints. (continued on next page)

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 04/24/2026
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)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The deficiency represents non-compliance investigated under Complaint Number 2975430.

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 04/24/2026
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)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on closed medical record review, staff interviews and review of facility policy, the facility failed to ensure complete and accurate documentation in the medical record. This affected one (#59) of three residents reviewed for accurate medical records. The facility census was 52. Findings include:Review of the closed medical record for Resident #59 revealed an admission date of 11/21/25 and a discharge date of 02/10/26. Diagnoses included traumatic subdural hemorrhage, intracranial abscess and granuloma and dependence on respirator (ventilator) status. Review of the quarterly Minimum Data Set (MDS) assessment, dated 02/06/26, revealed Resident #59 had impaired cognition. Further review revealed a Discharge Return Anticipated MDS was completed on 02/10/26. Review of the facility's Admission, Discharge, and Transfer Report, from 02/01/26 through 02/28/26, revealed Resident #59 was discharged to the hospital on [DATE]. Interview on 04/15/26 at 12:10 P.M. with the Interim Director of Nursing (IDON) and Assistant Director of Nursing (ADON) #153 revealed the IDON had worked at the facility for approximately two weeks and ADON #153 had worked at the facility for approximately three weeks. Continued interview with the IDON and ADON #153 revealed they were unfamiliar with Resident #59 and the circumstances of the discharge. Concurrent review of Resident #59's progress notes from 02/05/26 through 02/11/26 with the IDON and ADON #153 verified there was no information regarding the resident's discharge contained in the electronic medical record (EMR) and the 02/10/26 MDS was completed as a Discharge Return Anticipated. ADON #153 stated a change in condition assessment and alert charting should have been completed if Resident #59 left the facility emergently. ADON #153 confirmed there was no evidence of alert charting or a change in condition in Resident #59's EMR. The IDON and ADON #153 verified there was no information contained in Resident #59's medical record regarding the reason for the resident's discharge. A follow-up interview on 04/15/26 at 12:15 P.M. with the IDON revealed the Administrator explained Resident #59 had a scheduled surgical appointment at the hospital on [DATE] and discharged to another long-term care facility from the hospital. Review of facility policy titled, Documentation in the Medical Record, dated 01/02/24, revealed the facility would ensure each medical record would present an accurate representation of the resident's experience and progress through complete and accurate documentation. This deficiency represents non-compliance investigated under complaint number 2799367.

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 04/24/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, medical record review, policy review and review of the Centers for Disease Control and Prevention (CDC) guidelines, the facility failed to implement and monitor Legionella control measures. This had the potential to affect all residents. Additionally, the facility failed to ensure enhanced barrier precautions (EBP) were implemented. This affected three (#1, #3 and #47) of three residents reviewed for transmission-based precautions (TBP). The facility census was 52. Findings include:1. Review of the facility's Legionella Water Management Plan, dated 12/01/25, revealed the Legionella prevention and monitoring tasks were to include flushing hot and cold water for three to five minutes each in empty rooms and in less frequently used outlets, including soiled utility rooms, medication rooms, shower stalls, private room showers and all eyewash stations. Furthermore, the Legionella Water Management Plan included a prevention task of cleaning and disinfecting or replacement of shower heads on a six-month cycle. Review of the facility documentation revealed no evidence the prevention and monitoring tasks of flushing water in less frequently used outlets/empty rooms or shower head cleaning or replacement was completed. Interview on 04/15/26 at 9:40 A.M. with Maintenance Director (MD) #161 revealed the facility performed flushing of less frequently used water outlets and this was tracked through The Equipment Lifecycle System (TELS); however, he was unaware he needed to maintain documented evidence that the task was completed. Additionally, MD #161 verified the shower heads were not cleaned/disinfected or replaced every six months as indicated in the facility's Legionella Water Management Plan. Review of the CDC guidelines titled, Toolkit for Controlling Legionella in Common Sources of Exposure (Legionella Control Toolkit), dated 02/17/26, revealed recommendations to store hot water at temperatures above 140 degrees Fahrenheit (F) and flushing low-flow piping at least weekly and flush infrequently used fixtures (for example, eye wash stations and emergency showers) regularly as-needed to maintain quality parameters within control limits. 2. Review of the medical record for Resident #1 revealed she was admitted on [DATE] with diagnoses including subsequent encounter of bladder injury, septic shock, ascites, Type II diabetes mellitus, polyneuropathy, irritable bowel syndrome, cystocele, peritonitis, and stage three chronic kidney disease. Review of the admission Minimum Data Set (MDS) assessment, dated 03/19/26, revealed Resident #1 was cognitively intact and did not display any behaviors nor refusals of care at the time of this assessment. She required maximal assistance to full dependence with activities of daily living (ADLs), bed mobility, and transfers. Resident #1 utilized a wheelchair and was dependent for mobility. Review of the care plan for Resident #1 revealed interventions initiated on 03/12/26 for impaired skin integrity related to her abdominal wound, heels, sacrum, and panniculitis. Interventions included wound care as ordered. Review of the physician orders for Resident #1 revealed an order dated 03/15/26 for EBP to be utilized during wound care for infection control. (continued on next page)

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 04/24/2026
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)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation on 04/15/26 at 9:15 A.M. of Licensed Practical Nurse (LPN) #158 providing wound care to Resident #1's abdomen and closed-suction bulb drain site revealed she did not don a gown, did not disinfect the bedside tabletop prior to utilizing it for wound care supplies, nor did she complete hand hygiene between a glove change. Interview on 04/15/26 at 9:30 A.M. with Assistant Director of Nursing (ADON) #153 and LPN #158 confirmed the above observations and verified a gown should have been worn during wound care, the bedside table should have been disinfected before placing clean wound supplies on the table, and hand hygiene should have been performed between each glove change. 3. Review of the medical record for Resident #3 revealed he was admitted on [DATE] with diagnoses including acquired deformity of head, disorders of the meninges, cognitive communication deficit, chronic respiratory failure with hypoxia, and tracheostomy status. Review of the quarterly MDS assessment, dated 03/03/26, revealed Resident #3 was cognitively impaired and did not display any behaviors nor refusals of care at the time of this assessment. He was dependent for all care, transfers, and mobility. Resident #3 required oxygen therapy, suctioning and tracheostomy care. Review of the care plan for Resident #3 revealed focus areas for the management of his tracheostomy and altered respiratory status. Interventions included the use of EBP dated 05/22/25. Review of the physician orders dated 02/07/26 revealed Resident #3 had orders for EBP to be utilized every shift for infection control and tracheostomy care every 12 hours. Observation on 04/16/26 at 9:20 A.M. of Registered Nurse (RN) #106 performing tracheostomy care for Resident #3 revealed she did not perform hand hygiene prior to entering the room nor between glove changes, did not don a gown and did not disinfect the bedside tabletop prior to using it for sterile tracheostomy care supplies. Interview on 04/16/26 at 9:40 A.M. with RN #106 confirmed the above observations and verified she should have performed hand hygiene prior to entering the room and between glove changes, worn a gown and disinfected the bedside tabletop before placing sterile supplies on it. 4. Review of Resident #47's medical record revealed an admission date of 05/20/20. Diagnoses included schizoaffective disorder, Type II diabetes mellitus, dementia, peripheral vascular disease, hypertension, chronic pain syndrome, insomnia, and hypothyroidism. Review of the MDS assessment, dated 03/12/26, revealed Resident #47 was assessed with moderately impaired cognition and was not at risk for developing pressure ulcers with a diabetic foot ulcer present. Review of a progress note dated 02/26/26 at 4:25 P.M. revealed Resident #47's left great toe had a black scab and the left second toe and heel scarred. Review of the physician orders revealed wound treatment was initiated on 02/26/26 and included Betadine Swabsticks External Swab 10 percent (%) (povidone-iodine), apply to left great and second toe topically every shift. Further review revealed on 03/05/26 the treatment was modified to the left heel to include cleanse with normal saline, pat dry then apply skin prep every shift for wound care. (continued on next page)

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 04/24/2026
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)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Lastly, on 04/01/26, wound treatment was changed to include left great toe, cleanse with normal saline, pat dry. apply hydrogel and cover with border gauze. Change every day shift for wound care and every 24 hours as needed for dislodgement/soilage. Observation on 04/13/26 at 8:32 A.M. revealed Resident #47 was seated in bed and eating the breakfast meal. No EBP were observed to be in place. Observation on 04/13/26 at 11:37 A.M. revealed Certified Nursing Assistant (CNA) #149 and CNA #159 provided Resident #47 with assistance with activities of daily living (ADLs), including transfer to the wheelchair using a standing lift. No personal protective equipment (PPE) was donned by CNA #149 and CNA #159 prior to providing care for Resident #47. Interview on 04/13/26 at 11:42 A.M. with LPN #145 verified Resident #47 had a current wound. LPN #145 confirmed there was no instruction signage or PPE accessible before entering Resident #47's room and the resident should have EBP in place. Interview on 04/13/26 at 2:11 P.M., during observation of Resident #47's left foot wound, with LPN #145 verified a second time that Resident #47 should be on EBP and they were not in place. Interview on 04/14/26 at 7:05 A.M. with ADON #153 verified EBP were not in place for Resident #47 until yesterday and the resident had been treated for a wound since 02/26/26. Review of the facility policy titled, Contact Precautions (EBP), revised 03/05/25, revealed an order for EBP would be obtained for resident's with any of the following: wounds (chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds and chronic venous stasis ulcers) and/or indwelling medical devices (central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes) even if the resident was not known to be infected or colonized with a multidrug-resistant organism (MDRO). Implementation of EBP included making gowns and gloves available immediately near or outside of the resident's room and face protection may also be needed if performing activity with risk of splash or spray. High-contact resident care activities included dressing, bathing, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use (central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes, and wound care (any skin opening requiring a dressing). Review of the facility policy titled, Handwashing-Hand Hygiene, dated 03/05/25, revealed hand hygiene would occur after removing gloves. This deficiency represents non-compliance investigated under Complaint Number 2796491.