STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365740	A. Building B. Wing	01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Majestic Care of Clyde	700 Helen Street Clyde, OH 43410

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, review of facility self-reported incident (SRI) #267409, staff interviews, and review of facility policy, the facility failed to ensure adequate supervision was provided to ensure a resident on the secured memory care unit was free from sexual abuse. This affected one resident (#68) of three residents reviewed for abuse. The facility census was 64.Findings Include:Review of the medical record for Resident #68 revealed an admission date of 06/08/21 and a discharge date of 11/22/25 with diagnoses including vascular dementia, major depressive disorder, age-related osteoporosis, idiopathic peripheral autonomic neuropathy, abnormalities of gait and mobility, generalized muscle weakness, oropharyngeal dysphagia, constipation, iron deficiency anemia, sexual dysfunction, bunions of right foot, and anxiety. Review of the most recent quarterly Minimum Data Set (MDS) assessment, dated 09/15/25, identified Resident #68 was rarely/never understood. Further review of this MDS assessment revealed Resident #68 was dependent for ambulation.Review of the medical record for Resident #68 revealed she had a guardian. Resident # 68 lived on the secured memory care unit at the facility. Review of the medical record for Resident #67 revealed an admission date of 05/26/22 and a discharge date of 12/09/25 with diagnoses including atherosclerotic heart disease of native coronary artery, schizoaffective disorder, type two diabetes mellitus (DM2), anemia, other sexual disorders, trans ischemic attack (TIA), dysphagia, dementia, urge incontinence, other abnormalities of gait and mobility, lipoprotein deficiency, generalized muscle weakness, deficiency of other specified B group vitamins, metabolic encephalopathy, pure hypercholesterolemia, nicotine dependence, constipation, pulmonary embolism, hypothyroidism, other signs and symptoms involving cognitive functions and awareness, and cognitive communication deficit. Review of the most recent quarterly MDS assessment dated [DATE] revealed Resident #67 has severely impaired cognition. Further review of this MDS assessment revealed Resident #67 was independent for ambulation.Review of the medical record for Resident #67 revealed he had a guardian. Review of facility SRI #267409 revealed that on 11/11/25 at approximately 10:30 A.M., Resident #68 was in her wheelchair in the common area of the memory care (MC) unit, and Resident #67 had his hand down the front of her shirt. The residents were immediately separated, and Resident #67 was placed on one to one (1:1) monitoring that continued until his discharge on [DATE]. Resident #67 presents with a six out of 15 on brief interview of mental status (BIMs) assessment demonstrating a severe cognitive deficit; care plan review identifies a history of sexual behaviors and poor impulse control. Resident #68 presents with a zero out of 15 on BIMs assessment demonstrating a severe cognitive deficit, care plan review identifies a history of sexual behaviors and poor impulse control. The facility determined sexual abuse was unsubstantiated as the evidence of sexual abuse is inconclusive. The SRI documented both involved residents present with a severe cognitive impairment and did not act willfully, both residents also have a history of sexual behaviors and poor impulse control. Interview on 01/07/26 at 7:15 A.M. with the Administrator and the (continued on next page)

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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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Director of Nursing (DON), both familiar with SRI #267409, confirmed Resident #67 ' s hand was inside the front Resident #68 ' s shirt while both were in the common area of the MC unit. Interview on 01/08/26 at 10:11 A.M. with the DON revealed Resident # 68 would become combative if she did not want another person in her space and the incident that occurred between her and Resident #67 there was no combative behavior from Resident #68. The DON stated the incident between Resident #68 and Resident #67 was consensual as Resident #68 was hypersexual at baseline. The DON further explained Resident #68 was not upset during or after the incident with Resident #67 and did not remember the incident approximately less than five minutes after it occurred. Telephone interview on 01/08/26 at 10:35 A.M. with Certified Nursing Assistant (CNA) #172 revealed she was returning to the unit and saw Resident #68 and Resident #67 in the common area of the MC unit and Resident #67 was standing over Resident #68 who was in her wheel chair. Resident #67 had one hand holding Resident #68's shirt open and the other hand was down her shirt. The CNA stated she reported it to the DON right away and does not feel this was a consensual incident. The CNA did state Resident #68 will say no or have a mean look or become combative if someone is in her space or touched her and she did not want it, but the CNA could not recall if Resident #68 behaved like that at the time of the incident. Review of the facility policy titled, Abuse, Mistreatment, Neglect, Exploitation, and Misappropriation, dated 07/01/25, revealed residents/patients have the right to be free from abuse, neglect, exploitation, and misappropriation of resident/patient property. Sexual abuse is a non-consensual sexual contact of any type with a resident/patient. This citation represents non-compliance investigated under Complaint Number 2671084.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure proper sanitation practices were maintained in the kitchen and failed to ensure canned food items were stored in accordance with facility policy and acceptable food safety standards. This deficient practice had the potential to affect all residents, as all residents were identified as receiving meals prepared by the facility kitchen. The facility census was 64. Findings Include: Observation of the kitchen on 12/30/25 at 6:57 A.M. revealed the facility kitchen floor was coated with unidentified brown and white substances and contained miscellaneous unidentified food and non-food debris. Concurrent interview with with Dietary Aide #143 confirmed the presence of the unidentified brown and white substances and miscellaneous unidentified food and non-food debris on the kitchen floor.Observation on 12/30/25 at 7:00 A.M. of the facility dry storage room revealed the following dented canned food items: two six-pound ten-ounce, cans of pineapple tidbits with large dents on the sides of the cans; one 98-ounce can of collard greens with a large dent in the top ring of the can; and one 110-ounce can of baked beans with a large dent in the top ring of the can.Interview on 12/30/25 at 7:02 A.M. with Dietary Aide #143 confirmed the dents observed on the canned food items.Review of the facility policy titled Kitchen Sanitation, dated 12/01/25, revealed the facility policy required that good sanitary food handling practices be maintained at all times and that sanitary conditions be maintained in food storage, preparation, and serving areas. The policy further required that equipment and areas be kept clean, organized, and free of contamination, spills, mold, or build up. Dented cans or contaminated food items must be separated, labeled Dented Cans - Do Not Use, and disposed of accordingly.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on review of the facility electronic medical record (EMR), observation, interview, and review of facility policy, the facility failed to ensure proper infection control practices were maintained for a resident on isolation precautions. This deficient practice affected one resident (Resident #8) and had the potential to affect 23 additional residents (#1, #2, #3, #5, #6, #9, #17, #22, #23, #25, #29, #32, #33, #34, #36, #38, #43, #45, #48, #49, #57, #59, and #65) who resided in the facility. The facility census was 64. Findings Include: Review of the Electronic Medical Record (EMR) for Resident #8 revealed an admission date of 05/24/25 with diagnoses that included cerebral infarction, aphasia, hemiplegia and hemiparesis following cerebral infarction, dysphagia, asthma, neuralgia and neuritis, lumbar disc displacement, hypertension, bicuspid aortic valve, nonrheumatic aortic valve stenosis, heart disease, obesity, bipolar disorder, cardiac arrhythmia, nicotine dependence, syncope and collapse, presence of a prosthetic heart valve, other psychoactive substance use, radiculopathy, depression, cardiac murmur, ascending aortic aneurysm, and mixed hyperlipidemia. Review of the most recent quarterly Minimum Data Set (MDS) assessment, dated 11/20/25, revealed Resident #8 had a Brief Interview of Mental Status (BIMS) score of 03, indicating severe cognitive impairment. Review of the Electronic Medical Record EMR revealed Resident #8 tested positive for SARS CoV-2 (COVID-19) on 12/24/25 and had a physician order for droplet precautions 12/24/25 through 01/04/25. Observation on 12/30/25 at 8:43 A.M. of the wall outside Resident #8's room revealed signage indicating the resident was on contact precautions and droplet precautions. Review of the facility Contact Precaution signage revealed all individuals were required to perform hand hygiene before entering and upon exiting the room. The signage further required staff and providers to don gloves and a gown prior to room entry, discard gloves and gown prior to room exit, and use dedicated or disposable equipment, or clean and disinfect reusable equipment before use on another individual. Review of the facility Droplet Precaution signage revealed that, in addition to contact precaution requirements, individuals were required to ensure their eyes, nose, and mouth were fully covered with appropriate face protection prior to room entry and to remove face protection before exiting the room. Observation on 12/30/25 at 8:44 A.M. revealed Licensed Practical Nurse (LPN) #157 entered Resident #8's room to obtain vital signs and administer medications while wearing only a surgical mask and gloves and without wearing a gown or eye protection as required by the posted precaution signage. Interview on 12/30/25 at 8:47 A.M. with LPN #157 confirmed she provided care to Resident #8 without wearing the appropriate personal protective equipment (PPE) as outlined in the facility's Contact and Droplet Precaution signage. LPN #157 stated she did not believe PPE was required while providing care to Resident #8. LPN #157 further confirmed there was signage posted outside the resident's room indicating contact and droplet precautions. Review of the facility policy titled Infection Prevention and Control Program, dated 10/01/25, revealed residents with infections or communicable diseases were to be placed on transmission-based precautions in accordance with current CDC guidelines. Review of the facility policy titled Personal Protective Equipment, (PPE) dated 01/02/24, revealed the facility required the appropriate use of PPE to prevent the transmission of pathogens to residents, visitors, and staff.