STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365830	A. Building B. Wing	06/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Majestic Care of Bryan	1104 Wesley Avenue Bryan, OH 43506

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 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Let each resident or the resident's legal representative access or purchase copies of all the resident's records. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview, and policy review, the facility failed to ensure residents received timely copies of their medical records. This affected two (#75 and #77) of three residents reviewed for medical record requests. The facility census was 64.1. Review of the medical record for Resident #75 revealed an admission date of 10/10/25 with diagnoses of heart failure, anxiety, edema, depression, and hypertension. Resident #75 discharged to the community on 04/02/26. Review of the quarterly Minimum Data Set (MDS) assessment, dated 01/30/26, revealed Resident #75 had severely impaired cognition. Review of the comprehensive admission MDS assessment, dated 10/2025, revealed Resident #75 had intact cognition. Interview on 06/24/26 at approximately 4:00 P.M. with Licensed Social Worker #306 revealed she completed the cognitive assessment for Resident #75 on 01/30/26 and Resident #75 refused to participate with the assessment; therefore, LSW #306 had to mark the results accordingly. Review of an Authorization for Use or Disclosure of Protected Health Information form, signed by Resident #75 on 02/05/26 revealed a request for a copy of the entire medical record for personal use. Review of an email correspondence from the facility's corporate office, dated 02/11/26, revealed the records were attached and should be provided to Resident #75. Additionally, review of an Authorization for Use or Disclosure of Protected Health Information form, signed by Resident #75 on 05/02/26 revealed a request for a copy of the entire medical record for personal use. Review of the facility's email correspondence revealed the request was emailed on 04/02/26. Further review of the facility's email correspondence revealed the facility attempted to contact Resident #75 on 04/06/26, and left a voicemail on 04/07/26 indicating the records were available for pickup. Interview on 06/29/26 at 3:40 P.M. with the Administrator confirmed the Authorization for Use or Disclosure of Protected Health Information form, signed by Resident #75 on 05/02/26 was misdated and Resident #75 should have used the date 04/02/26. Further interview confirmed copies of Resident #75's medical record were not available within two working days of either request. 2. Review of the medical record for Resident #77 revealed an admission date of 02/27/26 with a discharge to the hospital on [DATE]. Diagnoses included epilepsy, anxiety, and depression. Review of the 5-day MDS assessment, completed 03/05/26, revealed Resident #77 had intact cognition. Review of an Authorization for Use or Disclosure of Protected Health Information form, signed by Resident #77's Power of Attorney on 03/26/26 revealed a request for a copy of the entire medical record for treatment, payment or other healthcare operations and for personal use. Review of the facility's records revealed Resident #77's records were available for pickup on 04/03/26. Interview on 06/29/26 at 3:40 P.M. with the Administrator confirmed copies of Resident #77's medical record were not available within two working days of the request. Review of the policy Release of Information, effective 05/01/25, revealed no guidance regarding the time the facility would require to provide copies of the medical record. This deficiency represents non-compliance investigated under Complaint Number 2968730.

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of Self-Reported Incidents (SRIs), staff interviews, record review, and policy review, the facility failed to ensure allegations of abuse and injuries of unknown origin were thoroughly investigated. This affected two (#80 and 81) of nine residents reviewed for self-reported incidents. Additionally, the facility failed to ensure residents were timely assessed after alleging abuse. This affected one (#80) of nine residents reviewed for self-reported incidents. The facility census was 64. Findings include:1. Review of the medical record for Former Resident (FR) #80 revealed an admission date of [DATE] and a discharge with family on [DATE]. Diagnoses included cerebral ischemia, heart disease, anxiety, and malaise.Review of the 5-day Minimum Data Set assessment (MDS), dated [DATE], revealed FR #80 had impaired cognition, was dependent on staff for all mobility, and required substantial/maximal assistance for toileting hygiene, bathing, and dressing. Further review revealed FR #80 had no hallucinations or delusions during the lookback period, and rejected care one to three days.Review of a nursing progress note, dated [DATE] at 11:38 P.M., revealed FR #80 was yelling, hitting, and kicking while two aides were providing care. After FR #80 was changed, FR #80 then called the aides back in and told them that two people were in there and attacked her sexually.Review of the EIDC (Enhanced Information Dissemination Collection) website revealed SRI #274124 was created [DATE] at 12:24 P.M. and closed on [DATE] at 8:42 P.M. Interview on [DATE] at 11:04 A.M. with the Administrator and concurrent review of the facility's investigation into SRI #274124, revealed there was no evidence FR #80 was assessed by the nurse at the time of the allegation. The facility completed a full skin assessment of FR #80 during their investigation, initiated on [DATE] at 12:24 P.M. Continued interview and review of the facility staff schedules for [DATE] revealed the two Certified Nursing Assistants (CNAs) assigned to the hall were CNA #207 and CNA #208. The Administrator confirmed Licensed Practical Nurse (LPN) #209 wrote the progress note on [DATE] at 11:38 P.M. Further, the Administrator confirmed no interviews with CNA #207, CNA #208 and LPN #209 were included in the investigation into Resident #80's allegation of sexual abuse. Continued interview with the Administrator indicated CNA #207 and CNA #208 were suspended during the investigation. Interview on [DATE] at 12:05 P.M. with Staff Scheduler #304, and concurrent review of the staff schedules dated [DATE] through [DATE], revealed CNA #207 worked on [DATE] and [DATE] and CNA #208 worked on [DATE].Follow-up interview with the Administrator on [DATE] at 4:55 P.M. regarding CNA #207 and CNA #208 working while the investigation remained open revealed the staff were allowed to return to work as the investigation was concluded after the facility interviewed FR #80 and her family member on [DATE], and interviewed residents and staff on [DATE]. The Administrator stated the SRI remained open until [DATE] because staff acknowledgements of the abuse policy were outstanding.Review of the policy, Abuse, Mistreatment, Neglect, Exploitation and Misappropriation, effective [DATE], revealed the Procedure to Protect the Resident included assessment of the involved resident and immediate removal of Care Team Members from the facility and the schedule pending the outcome of the investigation. Further review revealed the person investigating the incident should generally take the following actions: interview the resident, the accused, and all witnesses.2. Review of the medical record for Former Resident (FR) #81 revealed an admission date of [DATE] and a discharge upon death on [DATE]. FR #81 was under the care of hospice. Diagnoses included Alzheimer's disease, osteoarthritis, venous thrombosis and embolism, and anemia.Review of the comprehensive significant change MDS assessment, dated [DATE], revealed FR #81 had impaired cognition and was dependent on staff for mobility and transfers. All other mobility assessments were marked not applicable. Review of the care plan initiated [DATE], with revisions, revealed FR #81 had an activities of daily life (ADL) self-care performance deficit related to cognitive losses, range of motion deficit to both upper extremities with active range of motion deficits. Nonambulatory. Interventions included an update [DATE] for (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assistance of one to two staff for toileting and bed mobility, assist of two staff with mechanical lift for transfers.Review of FR #81's nursing progress note dated [DATE] revealed the physician was rounding in the facility when FR #81 complained of right ankle pain. Swelling of +1 was noted to the right ankle. FR #81 reported pain started that afternoon. No known injury. Received an order for an x-ray.Review of a nursing progress note dated [DATE] revealed the x-ray results indicated right ankle healilng fractures of the distal tibia and fibula.Review of SRI #269494, initiated [DATE], revealed a potential injury of unknown origin was reported for FR #81. Interview on [DATE] at 10:40 A.M. with the Administrator, and concurrent review of the facility's investigation into SRI #269494, revealed staff and residents were interviewed regarding abuse and safety concerns. Non-interviewable residents had full-body skin assessments. The facility determined abuse did not occur. Continued interview with the Administrator revealed the facility's investigation contained no interviews with staff regarding circumstances which could have led to the fracture, or staff who were familiar with FR #81 to determine when the area was first observed. The Administrator further confirmed the investigation contained no evidence FR #81's record was reviewed for previous skin assessments or potential falls. The Administrator confirmed the investigation into an injury of unknown origin did not show evidence the facility attempted to determine the source/cause of the injury.Review of the policy, Abuse, Mistreatment, Neglect, Exploitation and Misappropriation, effective [DATE], revealed the Procedure to Investigate (an alleged incident) included the guidance: if there are not direct witnesses, the interviews may be expanded. For Injuries of Unknown Source, the investigation may generally involve talking with Care Team Members working on both the shift on duty when the injury was discovered and prior shifts as well.This was an incidental finding identified during the complaint investigation completed on [DATE].

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, record review and policy review, the facility failed to ensure fall interventions were in place and fall interventions were reviewed and revised as needed, and failed to accurately document the use of fall interventions. This affected one (#31) of three residents reviewed for falls. Additionally, the facility failed to implement their policy regarding post-fall procedures when a fall was reported by family. This affected one (#77) of three residents reviewed for falls. Finally, the facility failed to show evidence of investigations into a fall with injury. This affected two (#31 and #76) of three residents reviewed for falls. The facility census was 64. 1. Review of the medical record for Resident #31 revealed an admission date of 10/10/22 with diagnoses of cerebellar ataxia, dysphagia, traumatic brain injury, and neuromuscular dysfunction of bladder. Review of the quarterly Minimum Data Set (MDS) assessment, dated 04/28/26, revealed Resident #31 had impaired cognition and required substantial/maximal assistance for bed mobility, and was dependent for all other mobility. Resident #31 used a manual wheelchair and needed setup or clean-up assistance to wheel 50 feet with two turns. Resident #31 had one fall since the previous assessment with no injury. Review of Resident #31's physician orders revealed an order initiated 02/24/25 for dycem mat (non-slip plastic) to the wheelchair to aid in resident safety. Check placement every shift, and an order initiated 05/20/26 for a mechanical lift to be used for all transfers. Review of Resident #31's care plan, initiated 03/24/25, with revisions, revealed Resident #31 was at risk for falls or fall related injury due to limited mobility, diplegia of upper limbs, contractures, dysarthria, and deformities of lower legs. Interventions included: dycem mat to wheelchair to aid in resident safety. Check placement every shift (initiated 03/24/25), replace dycem to wheelchair seat as needed (initiated 03/24/25), and resident specific stand-up lift with sling to be used for all transfers (initiated 05/12/25). Review of the Morse Fall Scale, completed 04/06/26, revealed Resident #31 was at high risk for falls. Observation on 06/23/26 at 11:34 A.M. revealed Certified Nursing Assistant (CNA) #203 and CNA #307 in Resident #31's room preparing to transfer Resident #31 from the bed to the wheelchair with a mechanical lift. Concurrent interview with CNA #203 confirmed no dycem was in Resident #31's wheelchair. Resident #31 was appropriately transferred using a sling pad to the wheelchair and was placed in the wheelchair with the sling pad between his body and the wheelchair cushion. Interview on 06/23/26 at 11:49 A.M. with CNA #203 and concurrent review of Resident #31's care plan revealed Resident #31 no longer used a stand-up lift for transfers as it was no longer safe. CNA #203 further confirmed the dycem mat was not in the wheelchair and further determined if the mat was in the wheelchair, Resident #31 could still slip from the wheelchair as he was sitting on top of the sling pad. Review on 06/23/26 at 2:55 P.M. of Resident #31's Treatment Administration Record (TAR) for June 2026 revealed Licensed Practical Nurse (LPN) #205 charted on the TAR to indicate Resident #31's dycem mat was in the wheelchair. Interview on 06/23/26 at 3:11 P.M. with LPN #205 confirmed she did not check to verify Resident #31's dycem mat was in place before charting it was in place. Concurrent observation in Resident #31's room revealed the dycem mat was under some items on a shelf near the window. Interview on 06/24/26 at 11:10 A.M. with the Administrator revealed the clinical team discussed falls every workday morning. Concurrent review with Resident #31's care plan confirmed the dycem mat to the wheelchair, under the sling pad, was no longer an effective intervention. Review of Resident #31's care plan on 06/25/26 revealed the intervention for the dycem mat was removed. Follow-up interview on 06/29/26 at 3:30 P.M. with the Administrator confirmed the intervention for the dycem mat was removed from Resident #31's care plan by MDS Coordinator #100. Further interview, along with review of the current physician order dated 02/24/25 confirmed the order for dycem mat in the wheelchair remained active. The Administrator confirmed the order and the care plan did not coordinate and the Administrator could not confirm whether staff (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	were educated to place the dycem mat in the wheelchair per physician orders, or to no longer implement it because it was removed from the care plan. Review of the policy, Fall Prevention, dated 01/02/24, revealed each resident's risk factors and environmental hazards will be evaluated when developing the resident's comprehensive plan of care. Interventions will be monitored for effectiveness and the plan of care will be revised as needed. 2. Further review of Resident #31's record revealed a nursing Change in Condition note dated 05/17/26 indicating Resident #31 was found lying on the floor face down with head under the bed. Resident #31 was noted to have a laceration to the left eyebrow and swelling to left eye. The note included a recommendation to send Resident #31 to the emergency department for further evaluation. Further review revealed vital signs were obtained on 05/16/26 at 7:27 P.M. Review of the late entry nursing progress note dated 05/17/26 at 7:31 A.M. revealed at 11:50 P.M. Resident #31 returned from the hospital via stretcher with two sutures to the left eyebrow. Review of the facility's Risk Management documentation, identified as the facility's investigation into the fall, revealed Resident #31 was found on the floor in his room on 05/16/26 at 7:23 P.M. Resident #31 was lying face down with head under the head of the bed and was noted to have a laceration and discoloration and swelling around left eye. Resident #31 stated he fell from the wheelchair. Further review revealed a Mental Status assessment indicated Resident #31 was oriented to time, place, person, and situation. Also under the Mental Status assessment, a box was checked indicating intervention(s) in place at time of incident. No additional investigation information was provided regarding the fall, including witness statements. Review of an interdisciplinary team (IDT) progress note, dated 05/29/26, stated: IDT met regarding resident fall. Resident was found laying face down with head under the head of the bed. Noted to have a laceration to left eye and discoloration and swelling around left eye. Resident sent to ER (emergency room) for eval (evaluation) and tx (treatment). No fx (fracture) noted. Education to call for assistance provided to resident, therapy eval (evaluation). All appropriate parties notified. Care plan reviewed and updated as appropriate. Interview on 06/25/26 at approximately 8:30 A.M. with the Interim Director of Nursing (IDON) confirmed no additional information or evidence of investigation was available regarding the circumstances of Resident #31's fall on 05/16/26. Concurrent review of the facility's fall policy revealed the facility would obtain witness statements in case of injury. 3. Review of the medical record for Former Resident (FR) #76 revealed an admission date of 08/13/25 with diagnoses of Alzheimer's disease, tremor, macular degeneration and dementia. Resident #76 discharged to the hospital on [DATE] and subsequently transferred to another long-term care facility in the area. FR #76 resided in the dementia unit. Review of the quarterly MDS assessment, dated 01/27/26, revealed Resident #76 had impaired cognition and required no assistive devices for walking. Resident #76 required supervision/touching assistance for all mobilities. Resident #76 had two or more falls with no injuries since the previous assessment. Review of the care plan initiated 11/03/25 revealed FR #76 required supervision and assistance as needed for ambulation and setup to supervision for eating. Further review revealed no indication or intervention FR #76 required 1:1 observation and no indication FR #76 could not be left alone. Review of progress notes dated 01/07/26 and 01/12/26 revealed FR #76 ambulated the halls independently. Review of the Morse Fall Scale, completed 01/24/26, revealed FR #76 was at high risk for falling. Review of an occupational therapy (OT) progress note dated 02/16/26 revealed FR #76 worked with OT for sitting balance and increasing her ability to sit unsupported. Review of a nursing progress note dated 02/23/26 revealed FR #76 was in the dining room when the nurse, who was in the nurse's station across the hall from the dining room, heard a loud sound and heard a coffee cup hit the floor. The nurse found FR #76 on the floor on her left side, and by the time the nurse got to the resident, FR #76 had turned herself onto her back. FR #76 was assessed and sent to the hospital for a suspected fracture of the left hip. Review of the facility's Risk Management documentation, identified as the facility's investigation into the fall, revealed FR #76 had an unwitnessed fall on 02/23/26 at 3:15 P.M. in the secured unit's dining room. FR #76 was unable to provide a description of the cause of the fall. Review of the late entry IDT (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	progress note dated 02/24/26 at 6:05 P.M. revealed staff and residents were interviewed, FR #76 was not incontinent prior to the fall, FR #76 was clothed and with appropriate footwear at the time of the fall, and determined the root cause of the fall was impaired cognition and loss of balance. The IDT note did not include an update on FR #76's status from the hospital. The facility did not provide records regarding the hospital assessment of FR #76. Interview on 06/25/26 at approximately 8:30 A.M. with the IDON confirmed the facility could provide no evidence an investigation into the circumstances of FR #76'S fall was completed. Further interview, along with concurrent review of the policy, confirmed the facility could provide no evidence staff interviews were obtained, as indicated in the IDT progress note dated 02/24/26, in the case of a fall with injury. 4. Review of the medical record for FR #77 revealed an admission date of 02/27/26 with a discharge to the hospital on [DATE]. Diagnoses included stroke, epilepsy, anxiety, hypertension and type 2 diabetes mellitus. Review of the 5-day MDS assessment, completed 03/05/26, revealed Resident #77 had intact cognition and had one fall in the previous two to six months prior to admission. No falls in the previous month and no falls with fracture in the past six months. Further review revealed Resident #77 used a walker, had no impairments to upper or lower extremities, and was dependent on staff for all mobility including bed mobility and transfers. Walking was not attempted due to medical condition or safety concerns. Review of the care plan initiated 02/27/26 and not revised revealed FR #77 was at risk for falls or fall related injury due to a history of falls, use of blood glucose lowering medications, use of antihypertensive medications, poor safety awareness, deconditioning, and gait/balance problems. Interventions included: encourage and assist to wear appropriate non-skid footwear, keep call light and frequently used personal items within reach, assist with toileting, and assist with transfers. Review of the Morse Fall Scale assessment, completed 02/27/26, revealed FR #77 was at high risk for falling (score 50.0). Review of a nursing progress note, written by Registered Nurse (RN) #204, dated 03/21/26, revealed FR #77's family member reported FR #77 reported falling out of bed one night and getting himself up off the floor and back into bed, but could not recall what night. FR #77's family member stated FR #77 had left shoulder pain increasing since the alleged fall. An x-ray was ordered. Review of the x-ray results, dated 03/21/26, revealed FR #77 had osteoarthritis of the shoulder and AC (acromioclavicular) joint space; no evidence of a fracture or dislocation. Interview on 06/23/26 at 1:05 P.M. with RN #204, and concurrent review of the progress note dated 03/21/26, revealed she somewhat recalled the situation with FR #77's reported fall from 03/21/26 and stated she could not recall if she interviewed FR #77 about the alleged fall. RN #204 further stated if a resident reported a fall she would typically interview them and initiate a Risk Event in the electronic medical record. Interview on 06/23/26 at 3:11 P.M. with Licensed Practical Nurse (LPN) #205 revealed the fall protocol would be initiated when a resident reported a fall to nursing staff. Interview on 06/24/26 at 2:57 P.M. with the IDON confirmed the facility's post-fall protocol was not initiated for FR #77 after the fall was reported to staff. The IDON confirmed there was no evidence a physical assessment was completed, no neurological checks were initiated, no fall assessment was completed, and no incident was created. Further, the IDON confirmed the facility could provide no evidence an investigation into the incident was completed. Review of the policy, Fall Prevention, dated 01/02/24, revealed the guidance: when any resident experiences a fall, the facility will: assess the resident; completed a post-fall assessment; complete an incident report; notify physician and family; review the resident's care plan and update as indicated; document all assessments and actions; and obtain witness statements in the case of injury. This deficiency represents non-compliance investigated under Complaint Number 2968730 and Complaint Number 2804252.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, staff interview, and facility policy, the facility failed to perform hand hygiene and failed to use proper technique during foley catheter care. This affected one (#51) resident out of one resident observed for foley catheter care. The census was 64. Findings include: Observation on 06/23/26 at 10:04 A.M. revealed Licensed Practical Nurse (LPN) #101 was assisting with wound care for Resident #51. After removing her gloves, LPN #101 immediately donned a new pair of gloves without performing hand hygiene between glove changes. LPN #101 verified that hand hygiene had not been performed at the time of the observation.Observation on 06/23/26 at 10:17 A.M. revealed LPN #100 was completing periˆcare along with Foley catheter care for Resident #51. LPN #100 placed a dirty, soapy washcloth into the wash basin containing clean water, then removed another washcloth from the same basin to wipe the resident's perineal area. LPN #100 verified water in basin was contaminated at the time of observation.Observation on 06/23/26 at 10:20 A.M. revealed Licensed Practical Nurse (LPN) #100 was completing wound care for Resident #51. After removing her gloves, LPN #100 immediately donned a new pair of gloves without performing hand hygiene between glove changes. LPN #100 verified that hand hygiene had not been performed at the time of the observation.Review of facility policy, Handwashing-Hand Hygiene, dated 03/05/25, revealed hand hygiene needs to be completed after removal of gloves and after the removal of gloves.This deficiency represents non-compliance under Complaint Number 2968730.