

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365830	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/11/2025
NAME OF PROVIDER OR SUPPLIER Majestic Care of Bryan		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0689 Level of Harm - 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 medical record review, review of hospital records, review of investigation statements, review of interdisciplinary investigation notes, staff and resident interviews, review of a mechanical lift owner's manual, review of a mechanical lift sling owner's manual, review mechanical lift safety inspections, and review of facility policy, the facility failed to ensure Resident #02 was safely transferred using a mechanical lift resulting in an avoidable fall. This resulted in Actual Harm on 08/07/25 when Resident #02 was not safely transferred resulting in a mechanical lift tipping and the resident suffering an avoidable fall sustaining a right hip fracture requiring surgical repair. This affected one (#02) of four residents reviewed for accidents. Additionally, the facility failed to ensure safe sling utilization while using a mechanical lift to transfer a resident, which placed the resident at risk for more than minimal harm. This affected one (#12) of four residents reviewed for accidents. Furthermore, the facility failed to ensure timely assessment and initiation of safety interventions for residents who displayed exit seeking behavior, and failed to ensure a door exit alarm was responded to timely, which placed the resident at risk for more than minimal harm. This affected one (#54) of four residents reviewed for accidents. The facility census was 77.1. Review of the medical record for Resident #02 revealed she was admitted to the facility on [DATE]. Her diagnoses included morbid obesity, spinal stenosis, asthma, mitral valve insufficiency, depression, anxiety, unspecified convulsions, and difficulty walking. Review of the quarterly Minimum Data Set 3.0 (MDS) dated [DATE] for Resident #02 revealed she was cognitively intact. Resident #02 displayed no behaviors at the time of the review. She was incontinent, dependent for care with personal and toileting hygiene, bathing, bed mobility, transfers, and required oxygen therapy. Review of the care plan for Resident #02 revealed she required the use of a mechanical lift for all transfers. Review of a progress note dated 08/07/25 at 3:54 P.M. for Resident #02 revealed Licensed Practical Nurse (LPN) #288 was alerted by a Certified Nurse Assistant (CNA) that a mechanical lift used to transfer Resident #02 from her wheelchair to her bed had tipped over while in use and Resident #02 was on the floor. After immediate assessment by LPN #288, Resident #02 was taken to the local emergency room via emergency squad due to Resident #02 complaining of severe pain, rated nine out of ten, to her right hip. Review of a progress note dated 08/07/25 at 11:01 P.M. for Resident #02 revealed LPN #263 received notification from the emergency room that Resident #02 was admitted with a diagnosis of hip fracture and would have surgery in the morning. Review of a progress note dated 08/08/25 at 9:51 A.M. for Resident #02 revealed the interdisciplinary team met regarding Resident #02's fall from the mechanical lift and the lift involved in the fall had been removed from service. (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 0689 Level of Harm - Actual harm Residents Affected - Few	Review of hospital records dated 08/12/25 revealed Resident #02 sustained a right hip fracture on 08/07/25 after falling from a mechanical lift and underwent surgical repair of the fracture on 08/08/25. Further review of progress notes from physical and occupational therapy revealed Resident #02 expressed fear and/or anxiety related to being transferred in a mechanical lift on 08/16/25, 08/20/25, 08/21/25, 09/03/25, 09/05/25, 09/08/25, 09/10/25, 09/12/25, 09/15/25, 09/22/25, 9/30/25, 10/02/25, and 10/06/25. Review of interdisciplinary team meeting notes regarding Resident #02's fall from a mechanical lift revealed on 08/07/25 at 3:54 P.M. CNA #266 and CNA #269 were transferring Resident #02 using a mechanical lift. The lift tipped to one side and Resident #02 fell to the floor. Resident #02 was assessed by LPN #288 at 3:55 P.M. Due to severe pain verbalized by Resident #02, Emergency Medical Services (EMS) was contacted via 911 call, and Resident #02 was transferred to the emergency room via EMS at 4:05 P.M. At 4:15 P.M. the mechanical lift was removed from service and inspected. The mechanical lift was noted to be rated for up to 450 pounds and Resident #02's weight was 289 pounds. Upon inspection of the mechanical lift it was noted the lift wobbled when weight was applied and the legs closed slightly. Review of a statement from CNA #266 dated 08/07/25 revealed she was assisting CNA #269 with a mechanical lift transfer of Resident #02 when the lift tipped over while lifting Resident #02 out of her wheelchair. Review of a statement from CNA #269 dated 08/07/25 revealed she was assisting CNA #266 with a mechanical lift transfer of Resident #02 when the lift began to tip, attempts to prevent the lift from tipping were unsuccessful, and Resident #02 fell to the floor while attached to the mechanical lift. Interview on 12/08/25 at 9:34 A.M. with Resident #02 revealed she sustained a fall from a mechanical lift while being transferred from her wheelchair to her bed. Resident #02 could not recall the exact date of the fall and stated she broke her right hip when she landed on the frame of the mechanical lift. Interview on 12/09/25 at 11:46 A.M. with Regional Nurse Consultant #304 revealed the facility's maintenance staff performed internal monthly safety inspections on all mechanical lifts and had an external company perform safety inspections twice per year. Interview on 12/09/25 at 3:45 P.M. with Resident #02 revealed she was afraid to use the mechanical lift when she returned to the facility after her fall from the lift. Interview with Maintenance Director (MD) #244 on 12/10/25 at 12:00 P.M. revealed he completed mechanical lift safety inspections monthly and if any safety issues were noted, the lift was immediately taken out of service by placing the lift in a locked room inaccessible to staff. Interview on 12/11/25 at 8:20 A.M. with the Director of Nursing (DON) revealed on 08/07/25 at approximately 3:55 P.M. she received a call that Resident #02 had fallen during a mechanical lift transfer. The DON stated she went to Resident #02's room and found Resident #02 on the floor, in the tipped mechanical lift sling attached to the lift, being assessed by LPN #288. Resident #02 was complaining of pain to her right hip and leg, emergency services were summoned, and Resident #02 was taken to the emergency room via squad. (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Interview on 12/11/25 at 10:30 A.M. with the Administrator revealed the mechanical lift that tipped while transferring Resident #02 on 08/07/25 had not received an external inspection since 01/20/22. The Administrator confirmed the facility did not have the outside company inspect the mechanical lift following the incident involving Resident #02 on 08/07/25. Interview on 12/11/25 at 10:43 A.M. with CNA #266 and CNA #269 revealed on 08/07/25 at approximately 3:50 P.M. Resident #02 indicated she wanted to get back into her bed. Both CNAs stated they were assisting with the mechanical lift transfer, and the lift did not appear to be malfunctioning until they began to raise Resident #02 from her wheelchair and the lift tipped over. Interview on 12/11/25 at 10:43 A.M. with CNA #269 revealed she observed Resident #02 experienced increased anxiety when using the mechanical lift, which required additional patience and reassurance, after Resident #02 returned from the hospital. Review of the manufacturer's manual for the mechanical lift that tipped while transferring Resident #02 on 08/07/25 revealed institutional maintenance inspection safety checks of the caster base, mast, boom, swivel bar, and actuator assembly should be completed monthly. Review of the facility's internal safety inspection logs for the mechanical lift that tipped while transferring Resident #02 on 08/07/25 revealed it was inspected each of the prior 12 months by MD #244. The facility's mechanical lift safety inspection included inspection and testing of the caster base, shifter handle, mast, boom, swivel bar, lift pump assembly, all lift surfaces, battery, remote controls, control panel, and electrical cords. Review of a monthly safety inspection form for a mechanical lift completed by MD #244 revealed MD #244 completed a thorough inspection and testing of the caster base, shifter handle, mast, boom, swivel bar, lift pump assembly, all lift surfaces, battery, remote controls, control panel, and electrical cords. Review of external safety inspection documentation for the mechanical lift that tipped while transferring Resident #02 on 08/07/25 revealed the last inspection was completed on 01/20/22. Further review of the external inspection documentation revealed the lift was not inspected by the outside company following the incident involving Resident #02 on 08/07/25. Review of facility policy dated 01/02/24 and titled Transfers and Mechanical Lifts revealed the facility would ensure residents would be transferred safely to prevent the risk of injury and promote a secure experience for the resident. Additionally, the policy stated staff would perform mechanical lift transfers in accordance with manufacturer's instructions. 2. Review of the medical record for Resident #12 revealed she was admitted on [DATE]. Her diagnoses included congestive heart failure, epilepsy, hypertension, history of traumatic brain injury, and depression. Review of the quarterly Minimum Data Set 3.0 (MDS) dated [DATE] for Resident #12 revealed she was cognitively intact, experienced bilateral lower extremity functional deficits, and was dependent for care with activities of daily living and transfers. Resident #12 was incontinent of bowel and had an indwelling urinary catheter. Review of the Care Plan for Resident #12 revealed she required the use of a mechanical lift for all transfers. Observation on 12/08/25 at 11:55 A.M. of a mechanical lift transfer from bed to wheelchair for Resident #12 performed by LPN #228 and CNA #290 revealed CNA #290 secured the purple mechanical (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	lift sling hooks on the lift boom on her side and LPN #228 secured the black sling hooks onto the lift boom on her side. CNA #290 began lifting Resident #12. Interview at the time of this observation prompted CNA #290 to stop the lift process and she confirmed the sling hooks, for safety purposes, should have been on the same color on both sides of the lift boom to ensure Resident #12 was evenly lifted. LPN #228 stated she did not understand the new mechanical lift slings and adjusted her sling hooks to purple. Continued observation of this mechanical lift transfer revealed once Resident #12 was raised from her bed, LPN #228 lined the receiving wheelchair up facing toward the mechanical lift. CNA #290 advised LPN #228 the wheelchair needed to be facing sideways with the mechanical lift. LPN #228 again expressed confusion and proceeded to follow CNA #290's instruction. Concurrent interview with LPN #228 revealed she did not recall being trained on the use of the new mechanical lift slings. Review of training records for LPN #228 revealed she was re-trained on mechanical lift use and slings on 10/09/25. Interview on 12/10/25 at 11:41 A.M. with the Director of Nursing revealed the mechanical lift and sling training that occurred in October 2025 for all nursing staff included the correct use of lifts and slings. The training elements utilized were videos from the mechanical lift manufacturer, a lecture session, live demonstration from management, and a hands-on skills check-off by each nursing staff member. Review of the mechanical lift sling owner's manual revealed sling hook strap colors should be matched on each side when attached to the mechanical lift boom to ensure the resident is lifted evenly. Review of facility policy dated 01/02/24 and titled, Transfers and Mechanical Lifts, revealed the facility would ensure residents would be transferred safely to prevent the risk of injury and promote a secure experience for the resident. Additionally, the policy stated staff would perform mechanical lift transfers in accordance with manufacturer's instructions. 3. Record review for Resident #54 revealed this resident was admitted to the facility on [DATE] with the following diagnoses: vascular dementia (dementia related to changes in blood flow), type 2 diabetes mellitus (high sugar), repeated falls, anxiety, major depressive disorder, and obstructive and reflux uropathy (inability to urinate). Review of the MDS assessment dated [DATE] revealed Resident #54 had impaired cognition. Review of the progress note dated 11/12/25 at 12:25 P.M. revealed that writer received a report that Resident #54 was attempting to leave out of the back door by the vending machines. Further review revealed Resident #54 had to be redirected. Review of the Elopement Risk Assessment for Resident #54 dated 12/03/25 revealed a score of zero. A score of zero indicated that the resident was not at risk for elopement. Further review revealed Resident #54 was marked as No for, 'had this resident displayed exit-seeking behavior.' Review of the care plan dated 12/03/25 revealed Resident #59 had impaired cognition and required assistance with decision making and monitoring for changes. Additional review revealed no care planning or interventions for exit seeking behavior. (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of Interdisciplinary Team (IDT) notes dated 02/10/25 to 12/09/25 for Resident #54 revealed no IDT note charted regarding elopement. Interview with the Director of Nursing (DON) on 12/09/25 at 2:10 P.M. verified they were told that Resident #54 was found attempting to exit the door. The DON further stated Resident #54 reported they were hearing a sound outside and wanted to turn it off. The DON verified the elopement risk assessment for Resident #54 was completed incorrectly. The DON further verified the IDT team did not review the incident and the care plan for Resident #54 was not updated regarding the exit seeking behavior but should have been. Review of policy titled Elopement and Wandering dated 01/02/24 revealed the facility shall establish and utilize a systematic approach to monitoring risk for elopement or unsafe wandering, monitor for effectiveness, and modify interventions when necessary, and alarms should be responded to in a timely manner. 4. Observation on 12/09/25 at 11:15 A.M. revealed the door alarm at the end of the 200 hall was set off. Continued observation at 11:23 A.M. revealed no employee came to check the alarm. Surveyor was required to walk to the front desk to inform staff the alarm was going off before staff responded. Observation on 12/09/25 at 2:00 P.M. revealed the door alarm at the end of the 200 hall was set off. Further observation on 12/09/25 at 2:08 P.M. revealed the DON walked down to the door to check the alarm. Further observation revealed one staff member sitting at the front desk at the other end of the hallway who did not check the alarm. Interview with the DON on 12/09/25 at 2:10 P.M. verified the alarm was going off. The DON verified alarms should be responded to in a timely manner, in no more than two minutes, but they expect staff to respond to door alarms immediately.		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, staff interview, and review of the facility menu with spread sheets, the facility failed to ensure residents on a mechanically altered diet received the same portions as the residents who received a regular diet. This had the potential to affect the 24 residents (#9, #10, #11, #13, #15, #17, #18, #21, #22, #23, #27, #30, #35, #38, #39, #53, #54, #57, #60, #63, #64, #66, #76 and #84) who received mechanically altered diet. The facility census was 77. Findings Include: Observations on 12/09/25 at 11:17 A.M. of the texture modification process for the pureed turkey meat found ten, three ounce (3 oz) #10 scoops of turkey were added to the food processor. Dietary Staff (DS) #235 then added turkey gravy and slices of bread to thin, blend, and thicken the processed meat. Observations on 12/09/25 at 11:22 A.M. of the food temperatures and portion sizes found a 3 oz scoop was used for the pureed turkey and the mechanical soft turkey while a four ounce (4 oz) scoop was used for the residents who received a regular textured diet. Coinciding interview with the Dietary Manager (DM) #291 verified the portion size of 3 oz for the mechanical soft diet and puree diets were smaller than the portions for those who received a regular diet. DM #291 stated it did not seem correct, but it was what the menu called for. DM #3291 stated she would bring it to corporate attention. DM #291 stated the menus were created and provided to them by corporate and they followed them as written. Observation on 12/09/25 at 11:35 A.M. of the lunch tray line meal service preparation revealed 3 oz scoops were placed in the pureed turkey and mechanical soft turkey while a 4 oz scoop was placed in the regular turkey. Observation on 12/09/25 at 11:38 A.M. of the tray line lunch plating process revealed the regular meals were provided with a 4 oz scoop of turkey. Observation on 12/09/25 at 11:39 A.M. of plating of a mechanical soft lunch meal found a 3 oz scoop was used and 3 oz of turkey was plated. 3 oz of mechanical soft turkey was not equivalent to the regular textured meal of 4 oz of turkey. Observation on 12/09/25 at 11:41 A.M. found a second mechanical soft plate was put together and 3 oz of turkey were provided. All the observed regular lunches continued to be plated with 4 oz of turkey. Observation on 12/09/25 at 11:53 A.M. found a pureed diet was plated. A 3 oz scoop was used and 3 oz of the pureed turkey added to the plate. 3 oz was not equivalent to the regular textured meal of 4 oz of turkey. Review of the facility's lunch menu spreadsheet for Tuesday 12/09/25 revealed Regular herb roasted turkey 4 oz, Mechanical Soft herb roasted turkey one #10 scoop, and Pureed herb roasted turkey one #10 scoop. Review of the facility's posted scoop size conversion chart revealed a #10 scoop had a 3 oz capacity.		

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide doctor's orders for the resident's immediate care at the time the resident was admitted. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, resident interview, and staff interview, the facility failed to ensure wound care orders were in place for a resident's wounds upon admission. This affected one resident (#83) of four residents reviewed for wound care and treatment. The facility census was 77. Findings Include: Review of Resident #83's medical record revealed an admission date of 12/01/25 and a discharge date of 12/08/25. Diagnoses included rheumatoid arthritis, type II diabetes, chronic pain, nicotine dependence, severe protein calorie malnutrition, and cognitive communication deficit. Review of Resident #83's admission Skin assessment dated [DATE] revealed Resident #83 had a sacrum area crusted measuring 5 centimeters (cm) by 4 cm into the second layer of skin and a right gluteal fold area 1.5 cm by 1 cm into the second layer of skin. The assessment indicated the physician was notified however, no treatment orders were found. Further review of Resident #83's medical record found no evidence of an admission treatment order being written to address the two wounds identified on Resident #83's admission skin assessment. Interview on 12/08/25 at 10:16 A.M. with Resident #83 found her to be alert and aware. Resident #83 reported she just admitted to the facility a week ago and she was discharging herself today because she was not happy with the care here. Resident #83 reported she came to the facility with scabbed wound on her bottom and it had been getting better at home. Resident #83 stated there were no treatments done for the wound since she got there. Resident #83 reported the scab came off because of the lack of care and it was now open and was hurting her. An observation of Resident #83's wound was not able to be made as she was actively in the process of discharging from the facility. Interview on 12/11/25 at 8:07 A.M. with the Administrator verified there were no orders in place for Resident #83's wound treatment in Resident #83's record. The Administrator stated she would contact the physician directly to check if there had been an order written. Interview on 12/11/25 at 10:31 A.M. with Registered Nurse (RN) #229 verified she was the admitting nurse who had completed Resident #83's admission skin assessment on 12/01/25. RN #229 verified Resident #83 had two wounds on her bottom which needed a treatment ordered. RN #229 reported she had called the physician and left a message regarding the two wounds and let the Unit Manager, Licensed Practical Nurse (LPN) #297, know. RN #229 stated she had not worked on Resident #83's hall since the initial assessment and follow-up would have fallen on the Unit Manager LPN #297. Interview on 12/11/25 at 12:32 P.M. with the Administrator verified the physician had no notes pertaining to Resident #83.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, resident interview, and staff interview, the facility failed to ensure residents who were identified as at risk for constipation had interventions implemented when they went longer than three days without a bowel movement. This affected one Resident (#5) of three residents reviewed of constipation. The facility census was 77. Findings Include: Review of Resident #5's medical record revealed an admission date of 05/14/21. Diagnoses included spinal stenosis, history of stroke, hemiplegia and hemiparesis, bipolar disorder, fibromyalgia, constipation, and anxiety disorder. Review of Resident #5's Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating Resident #5 was cognitively intact. Resident #5 was dependent on staff for toilet use, bathing, dressing, bed mobility and transfers. Resident #5 displayed no behaviors during the review period. Resident #5 was occasionally incontinent of urine and always incontinent of bowel. Review of Resident #5's physician orders revealed an order dated 11/02/23 for bisacodyl EC delayed release 5 milligrams (mg) give two tablets in the morning for constipation. An order dated 12/11/24 for docusate sodium 100 mg one capsule three times a day for constipation. An order dated 11/01/23 Dulcolax suppository 10 mg insert suppository rectally every 24 hours as needed for constipation. An order dated 11/01/23 for fleet enema 7-19 grams (GM) per 118 milliliter (ml) insert one unit rectally every 24 hours as needed for constipation. An order dated 04/11/24 for milk of magnesia oral suspension 1200 mg per 15 ml give 30 ml every 24 hours as needed for constipation. Review of Resident #5's Medication Administration Record (MAR) from 11/01/25 to 12/08/25 revealed all Resident #5's scheduled medications for constipation were administered as ordered. However, there were no as needed (PRN) medications administered. Review of Resident #5's bowel tracking for the last 30 days revealed Resident #5 had no bowel movement documented from 11/27/25 to 12/03/25, for a total of six days with no bowel movements. No PRN interventions were found as being implemented in the medication administration record to address Resident #5's six days of constipation. Review of Resident #5's progress notes revealed no documentation of interventions being implemented for lack of bowel movements from 11/27/25 to 12/03/25. Interview on 12/10/25 at 9:58 A.M. with Resident #5 found him to be alert and aware. Resident #5 verified he had gone a few days, like four or five days, without having a bowel movement a week or so ago. Resident #5 stated he had issues with constipation for quite some time since he was on pain medications. Resident #5 stated he did not have any pain or discomfort when he was last constipated and had bowel movements since. Resident #5 stated he received his scheduled medications for constipation but was not aware of any additional medications being given when he was constipated. Interview on 12/10/25 at 11:06 A.M. with Licensed Practical Nurse (LPN) #224 verified Resident #5 had no documented bowel movements for six days, 11/27/25 to 12/03/25, and there were no as needed (PRN) interventions implemented after three days of no bowel movements as there should have been.		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observations, and resident, staff and physician interviews, the facility failed to timely implement physician's orders for Resident #3's pressure ulcer dressing change and failed to ensure the physician/provider was notified regarding the presence of eschar to Resident #7's heel ulcer and the potential need to change the treatment plan. This affected two (#3 and #7) out of three residents reviewed for pressure ulcer care. The current census is 77. Findings include: 1. Review of Resident #3's medical records revealed the resident was admitted to the facility on [DATE]. Diagnoses for Resident #3 include pressure ulcer stage 4 on right buttock, pressure ulcer stage 3 on left buttock, heart disease, diabetes type two, spondylosis of lumbosacral region, and dysphagia. Review of Resident #3's admission orders dated 11/03/25 for wound care revealed the staff were ordered to cleanse with normal saline, pat dry, apply Hydrogel to wound, and cover with gauze. Review of Resident #3's wound care physician documentation dated 12/03/25 revealed the order given for the wound was changed to cleanse wound, apply skin protectant Cavilon advance to peri-wound area, wet gauze with normal saline and pack wound bed, cover with gauze pads and secure with medical tape. Review of Resident #3's Treatment Administration Records revealed the 12/03/25 order entered into the records was soak wound with wound cleanser solution, pat dry, apply calcium alginate to wound bed and cover wound followed by an Optilock and secure with pink tape. Review of Resident #3's progress notes dated 12/03/25 at 1:06 P.M. entered late into the record on 12/09/25 at 11:09 A.M., revealed the nurse documented Resident #3 returned from the wound care appointment with new orders. Per the note the orders were reviewed with the facility's wound care supplier and the physician and the orders were adjusted to comply with the facility's policy. Per the note the outside wound care clinic was updated on the facility's policy. Interview on 12/08/25 at 1:33 P.M. with Resident #3 revealed the resident was alert and oriented and had concerns regarding his wound care. Resident stated he has a very large pressure ulcer on one side of his buttocks. Per Resident #3 the nurses were providing care but were not following his wound physician's orders to do a wet-to-dry dressing change. Resident #3 stated he was told by the wound nurse it was against a regulation and facility policy to do a wet to dry dressing change at the facility. Resident #3 stated he was concerned the wound would not heal as fast as it could if the nurses were following the actual wound dressing order. Interview on 12/09/25 at 8:48 A.M. with the Director of Nursing (DON) stated there was no actual facility policy in regards to the facility not being able to follow the outside wound physician orders and provide a wet-to-dry. Per the DON, the facility staff were educated by the medical supplier regarding wet-to-dry dressing changes and stated the wound nurse obtained an order to change the outside provider's order in accordance with the guidance given from the medical supplier. The DON verified the wound care order from the wound physician was discontinued and a new order was obtained from the medical director. (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Majestic Care of Bryan		STREET ADDRESS, CITY, STATE, ZIP CODE 1104 Wesley Avenue Bryan, OH 43506	
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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 12/10/25 at 3:45 P.M. with the Medical Director (MD) revealed the facility's physician was contacted by a nurse and he was told the wound care dressing order from Resident #3's wound care physician was being questioned by staff. Per MD, the nurse informed him the medical supplier consultant was educating the staff the type of dressing change could be considered 'cytotoxic'. MD stated he was informed by the nurse the wound care physician was refusing to change the dressing change order so he gave a new order for a new dressing change to the nurse. MD verified he did not contact the wound care physician and consult on the rationale for the new order. Interview on 12/11/25 at 11:00 A.M. with Licensed Practical Nurse, (LPN) #297 revealed the nurse was acting as wound nurse and monitoring all wounds in the facility at the time of the survey. LPN #297 stated she received the new wound order from Resident #3's wound care physician. LPN #297 verified she did not enter the wound care physician's actual order into the treatment records at the time she received due to the medical supplier consultant advising her not to follow the wound care physician's order and to obtain a new order without the wet-to-dry aspect with a different type of solution to be used. LPN #297 stated she contacted the wound care physician on 12/03/25 and was told by the wound clinic the physician did not want to change the order and stated the order sent back to the facility should be followed. LPN #297 stated she called the Medical Director, (MD) and obtained a new order for Resident #3's dressing change. LPN #297 stated she did inform the resident the order from the wound care physician was against the facility's policy but stated there was no actual policy against the dressing change. Observation on 12/11/25 at 1:30 P.M. with LPN #297 performing wound care for Resident #3 revealed the nurse notified Resident #3 they would be completing the previous wound care physician's order, a wet-to-dry dressing. During the observation LPN #297 was observed following the original wound care physician's orders for the dressing change to Resident #3's wound. 2. Review of the medical record of Resident #07 revealed an admission date of 08/12/25. Diagnoses included dementia, Parkinsonism, and diabetes mellitus type two. Review of the admission MDS assessment dated [DATE] revealed Resident #7 had no pressure injuries upon admission and required touch assistance for lower body dressing and putting on or taking off footwear. Review of the medical record revealed a deep tissue injury was noted on 10/27/25 on the right inner heel. The physician and family were notified. Skin prep was ordered on 10/29/25 to be applied to the area every shift. Review of a Skin Condition Evaluation dated 11/13/25 revealed the area to be classified as an unstageable pressure injury measuring 4 centimeters (cm) by 3.1 cm and covered with eschar. Review of the record revealed no indication the physician had been notified of the presence of eschar and no treatment change had been ordered. Review of a Wound Consultant report dated 12/03/25 revealed Resident #07 had been recommended to use skin prep to the right inner heel. Observation on 12/09/25 at 2:30 P.M. with the Director of Nursing (DON) of Resident #07's wound revealed the area to be 3.5 cm by 4 cm, covered 100 percent with eschar and left open to air. Interview on 12/11/25 at 12:20 P.M. with Certified Nurse Practitioner (CNP) #310 revealed she was aware of the wound on Resident #07's right heel but was not aware it was covered with eschar. (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 12/11/25 at 12:30 P.M. of Resident #07's foot with CNP #310 and DON revealed the eschar was present. Interview at the time revealed CNP #310 had not been notified of the eschar. CNP #310 stated she was not wound certified and had not examined Resident #07's foot since 10/30/25. CNP #310 stated she would have deferred to the wound treatment consultant the facility had in place. Interview on 12/11/25 at 12:40 P.M. with Licensed Practical Nurse (LPN) #297, designated by the facility as the current wound nurse, revealed she had last seen the wound on 11/13/25 along with Wound Care Consultant #311 and the skin prep order had not been altered so did not question it.		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and policy review, the facility failed to ensure catheter drainage bags were maintained below the level of the bladder to allow proper gravity drainage for one resident (#54) of one resident reviewed for catheter care. The facility census was 77. Findings Include: Record review for Resident #54 revealed the resident was admitted to the facility on [DATE] with multiple diagnoses including dementia, diabetes mellitus (high sugar), and obstructive and reflux uropathy (inability to urinate normally due to blockage). Record review for Resident #54 revealed the resident had impaired cognition and required partial to moderate assistance with indwelling catheter care. Review of physician orders for Resident #54 revealed order dated 07/24/25 for a suprapubic (catheter inserted directly into the bladder with surgery) catheter. Review of the care plan dated 12/03/25 directed staff to keep the suprapubic catheter drainage bag and tubing below the level of the bladder for gravity drainage. Interview with Resident #54 on 12/08/25 at 9:50 A.M. revealed the resident wore a leg bag at all times, including during the night. Further interview revealed the resident did not want to wear the leg bag. Observation of Resident #54 on 12/09/25 at 7:05 A.M. revealed the Resident #54 lying in bed with a leg bag attached. The head of the bed was flat, and the leg bag was at the level of the bladder, not below it. Observation and staff interview on 12/09/25 at 7:15 A.M. with Licensed Practical Nurse (LPN) #289 revealed Resident #54 had a leg bag in place. LPN #289 verified the leg bag was not below the level of the bladder while the resident was lying in bed. LPN #289 further stated Resident #54 always wore a leg bag. Interview with the Director of Nursing (DON) on 12/09/25 at 2:15 P.M. verified Resident #59 always used a leg bag. When asked whether a leg bag could be kept below the level of the bladder while the resident was in bed, the DON stated it was not possible. The DON verified the use of the leg bag at all times was not care planned. Review of the policy titled, Indwelling Catheter, dated 01/02/24, revealed the catheter must be secured to facilitate the flow of urine, prevent kinks, and must be positioned below the level of the bladder.		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, resident interview, and staff interview, the facility failed to ensure resident's diet orders were followed as written. This affected one (Resident #9) of four residents reviewed for nutrition. The facility census was 77. Findings Include: Review of Resident #9's medical record revealed an admission date of 10/01/25. Diagnoses included abnormal weight loss, anxiety disorder, asthma, heart failure, osteoarthritis, cognitive communication deficit, and dysphagia. Review of Resident #9's Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 14 indicating Resident #9 was cognitively intact. Resident #9 required moderate assistance with toilet use, bathing, parts of dressing, and transfer. Resident #9 displayed no behaviors during the review period. Resident #9 received a mechanically altered diet. Review of Resident #9's care plan revised 10/17/25 revealed supports and interventions for self-care deficit, risk for alteration in mood, oral/dental health problems related to chewing and potential for nutritional risk. Interventions for nutritional risk included to document food and fluid intake, honor food preferences, provide and serve diet as ordered, and provide and serve supplements as ordered. Review of Resident #9's physician orders revealed an order dated 10/07/25 for a regular diet, pureed texture, thin consistency, double eggs with breakfast, ice cream and magic cups with lunch and dinner and cottage cheese with lunch. Observation on 12/08/25 at 11:23 A.M. of Resident #9 found Certified Nursing Assistant (CNA) #283 delivered Resident #9's lunch tray. Resident #9 was observed opening the lids and smelling the items. Resident #9 was provided what appeared to be pureed green beans, mashed potatoes, and pureed peaches. No protein was found on the tray, and no ice cream or magic cup supplements were provided. Resident #9 stated he was missing some items from his lunch. Interview on 12/08/25 at 11:30 A.M. with CNA #283 verified Resident #9 had not been provided a magic cup supplement, ice cream, his cottage cheese or other protein. Interview on 12/08/25 at 11:32 A.M. with Dietary Staff (DS) #248 revealed Resident #9 did not like meat (beef or pork) with any of his meals and verified Resident #9 had not been provided the pureed pasta with red meat sauce like the other residents because of the beef content. CNA #248 requested a magic cup frozen supplement since it had not been provided on his tray. CNA #248 then delivered the supplement but Resident #9 continued to not have the additional ice cream or cottage cheese as ordered. Interview on 12/09/25 at 10:05 A.M. with Dietary Manager (DM) #291 verified Resident #9 did not eat meat (pork or beef) and was to be provided an alternate protein with each meal. DM #291 reported Resident #9 enjoyed and they provided such items as eggs, pureed grilled cheese, cottage cheese, or yogurt. DM #291 verified the kitchen also supplied Resident #9's ice cream and magic cups with his meals which were kept in the kitchen freezer.		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation of medication administration, and review of facility policy, the facility failed to ensure a seizure medication was administered as ordered which resulted in a significant medication error. This affected one (Resident #20) of nine residents observed for medication administration. The facility census was 77. Findings include: Review of the medical record for Resident #20 revealed she was admitted to the facility on [DATE] with diagnoses including congestive heart failure, type two diabetes mellitus, hyperlipidemia, and unspecified convulsions. Review of the annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #20 was cognitively intact and displayed no behaviors at the time of the review. Review of admission paperwork for Resident #20 revealed a past medical history including seizures. Review of physician orders for Resident #20 revealed an order dated 11/04/25 for 300 milligrams (mg) of oxcarbazepine to be administered by mouth every evening at bedtime for seizure disorder and an order for 600 milligrams (mg) of oxcarbazepine to be administered by mouth every morning for seizure disorder. Observation on 12/10/25 at 8:00 A.M. of medication administration by Licensed Practical Nurse (LPN) #258 for Resident #20 revealed she administered 300 mg of oxcarbazepine to Resident #20 instead of the ordered 600 mg dose. Interview on 12/10/25 at 9:20 A.M. with the Director of Nursing and LPN #258 confirmed Resident #20 received an incorrect dose of 300 mg of oxcarbazepine at 8:00 A.M. and should have received 600 mg. Review of facility policy dated 01/02/24 titled, Medication Administration revealed medication would be administered as ordered by the physician.		