Printed: 05/05/2026
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
	366039	A. Building B. Wing	09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Majestic Care of Point Place	6101 N Summit St Toledo, OH 43611

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** THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NONCOMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY. Based on medical record review, staff interviews, review of a self -reported incident, review of facility investigation, review of in-service records, and policy review, the facility failed to ensure supervision and a safe environment was provided to prevent the elopement of a resident.Actual harm occurred on 07/29/25, when Resident #47 eloped from the facility through an unalarmed and unlocked exit door in the dining room. Resident #47 fell, sustaining an acute mildly displaced fracture of the right distal fibula at the ankle. This affected one (Resident #47) of three residents reviewed for elopement. The facility census was 65. Findings include:Review of the medical record for Resident #47 revealed an admission date of 10/13/22, with diagnoses including Alzheimer's disease, dementia, and depression. Review of the most recent quarterly Minimum Data Set (MDS) assessment, dated 07/07/25, revealed Resident #47 had severely impaired cognition and required assistance for all functional abilities. Review of the elopement risk assessments dated 02/21/25, 02/27/25, 04/02/25, 06/04/25, 06/30/25, 07/03/25, and 07/29/25 revealed Resident #47 was at risk for elopement. Review of the Morse fall assessment risk, dated 02/21/25, 03/18/25, and 04/02/25, revealed Resident #47 was at high risk for falling. Review of the care plan date 05/09/25 revealed Resident #47 was an elopement risk due to diagnoses of dementia. Interventions included assess for unmet needs when wandering/exit seeking, elopement risk assessment quarterly and as needed, place resident profile in elopement book, redirect resident when wandering or exit seeking - engage in conversation, Secure Care (alarming bracelet device to prevent elopement) to left ankle, check placement every shift and function daily, distract from wandering by offering pleasant diversions, structured activities, food, conversation, television, and book. Review of the care plan dated 06/08/25 revealed Resident #47 is at risk for falls or fall related injury related to dementia and depression. Interventions included encourage and assist to wear appropriate nonskid footwear when up and when in bed, ensure wheelchair is close to bed - Resident #47 frequently transfers herself, follow facility fall protocol, keep call light and frequently used personal items within reach, keep pathways clear and well lit, therapy to screen quarterly and as needed, notify therapy of changes in gait or balance and therapy to treat as ordered, assist with toileting, and assist with transfers. Review of the facility's Self-Reported Incident (SRI) number 236677 revealed Resident #47 was not in her room when facility staff performed their rounds on 07/29/25 at 3:00 A.M. At this time the nurse was notified, and a search began for Resident #47. Resident #47 was located at 3:15 A.M. laying in the grass on facility property to the rear of the facility. Facility staff assisted Resident #47 back into the facility, where she was assessed and neuro-checks (frequent assessment of neurological function) were initiated. At this time, Resident #47 verbalized her right ankle and knee was painful. The facility notified the physician and an order for X-rays were obtained. The facility also notified Resident #47's emergency contact. (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	Resident #47 had a Secure Care Bracelet (an alarming device when exiting the facility) in place prior to the elopement, and its functionality was tested, and it was determined to be functional. X-rays were obtained and it was discovered Resident #47 had a mildly displaced fracture of the distal fibula of her right leg. At this time, Resident #47 was transported to the hospital emergency room (ER) for evaluation. Review of the SRI revealed Resident #47 was last seen in her room by staff on 07/29/25 at approximately 2:00 A.M. by Certified Nursing Assistant (CNA) #175. It was determined Resident #47 exited the facility through a door that was not locked due to no power supply. An investigation conducted by Maintenance Director #137 on 07/29/25 determined that the main power supply to the door had failed. Maintenance Director #137 was able to replace the rechargeable battery in the door and return it to functionality until it was able to be repaired by the vendor. Review of the SRI revealed the door vendor was at the facility on 07/30/25 and determined the cause of the power failure to this door was due to the power supply to the door, located in the facility attic, was beginning to be dislodged. During an interview on 09/04/25 at 10:43 A.M., Maintenance Director #143 revealed all exit doors are locked with electronic locks, and each has a backup battery. The backup batteries are rechargeable and recharge with there is a power supply to the door. When the batteries are fully charged, they can provide power to the door for up to 24 hours. During the thunderstorm on 07/26/25, the facility lost power from 1:50 P.M. until 9:15 P.M., and when the power returned to the facility, he checked all doors to make sure they were properly functioning and had returned to electrical power from backup battery power. He stated that when doors are on backup battery power, the door will beep approximately every 30 seconds and there were no doors beeping. When Maintenance Director #143 returned to the facility on [DATE] at approximately 7:30 A.M., he noted the panel for the exit door located in the left rear corner of the main dining room was not lit up. At this time, he replaced the backup battery and the panel illuminated properly and he contacted the vendor who services the door and scheduled a service appointment on 07/30/25. He stated that when the vendor who services the door was at the facility on 07/30/25, it was determined the power supply had become interrupted and was supplying intermittent power to this door from the storms earlier in the week and drained the back up battery. Review of the Facility Investigation, dated 07/29/25, revealed Resident #47 exited the facility through the door located in the left rear corner of the facility's main dining room. The door alarm failed due to unknown storm damage. Resident #47 was propelling herself in her manual wheelchair through the grass, when she attempted to walk, her foot became stuck, and she fell to the ground. During an interview on 09/04/25 at 1:20 P.M., the Administrator stated Maintenance Director #143 would continue to check all exit doors weekly to ensure they are locked appropriately. Review of the facility policy titled, Wandering and Elopement, dated 01/02/24, revealed the facility ensures residents who exhibit wander behavior and/or are at risk for elopement receive adequate supervision to prevent accidents and receive care in accordance with their person-centered plan of care. Under the category of procedure for locating a missing resident, the policy indicated: any staff member becoming aware of a missing resident will alert personnel using approved protocol. The designated facility staff will look for the resident. Appropriate reporting requirements for the state survey agency should be conducted. As a result of the incident, the facility implemented the following corrective actions to correct the deficient practice by 07/30/25: On 07/29/25 at 3:00 A.M., Resident #47 was observed missing, and the facility missing resident protocol was implemented. Upon observation that Resident #47 was not in her room, CNA #175 notified LPN #208 that Resident #47 was not in her room and staff began searching for Resident #47. On 07/29/25 at 3:15 A.M., Resident #47 was found, by Licensed Practical Nurse (LPN) #208 and returned to the inside of the facility. On 07/29/25 at 3:20 A.M., (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Majestic Care of Point Place		STREET ADDRESS, CITY, STATE, ZIP CODE 6101 N Summit St Toledo, OH 43611	

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F 0689 Level of Harm - Actual harm Residents Affected - Few	a head-to-toe assessment was performed by LPN #208 and which revealed Resident #47's right ankle and right knee were swollen and painful and she had a bruise on her right palm. On 07/29/25 at 3:25 A.M., a headcount was performed, and all residents were accounted for. On 07/29/25 at 3:30 A.M., Resident #47's physician was notified, and an x-ray was ordered. On 07/29/25 at 3:30 A.M., Resident #47 was placed on every 15-minute checks. On 07/29/25 at 3:33 A.M., the on-call nurse manager, LPN #138, was notified. On 07/29/25 at 3:35 A.M., Resident #47's emergency contact was notified. On 07/29/25 at approximately 7:30 A.M., Maintenance Director #143 replaced the battery in the door Resident #47 exited through, returning it to full functionality. On 07/29/25, the inter-disciplinary team members met to review residents' current care plan and update as needed, interventions, and elopement assessment also completed. On 07/29/25, x-ray was completed, and results were received revealing a mildly displaced fracture of the distal fibula on Resident #47's right leg. Resident #47's emergency contact and Nurse Practitioner (NP) #301 were notified and Resident #47 was taken to the emergency room for treatment. On 07/29/25 at 5:15 P.M., Resident #47 was transported to the ER. Resident #47 revealed she returned to the facility with a soft cast and orders to follow up with an orthopedic surgeon. On 07/29/25, Director of Nursing Services (DNS) completed new Elopement Evaluations for all current residents and elopement evaluation scores have been reviewed to identify any residents at risk for elopement. On 07/29/25, all at risk for elopement residents care plans were reviewed and interventions reviewed for accuracy. All resident elopement binders, located at the front desk and nursing stations, were reviewed to ensure accuracy. All residents with Secure Care bands in place had placement and expiration date verified. On 07/29/25, all doors with Secure Care system tested by Maintenance Director #143, to ensure all exit doors were locked appropriately. On 07/29/25, Director of Nursing Services (DNS) or designee educated all staff on the elopement policy, and any employees unable to be educated on this date will receive education prior to their next worked shift. On 07/30/25, ICU Security Solutions was at facility and checked all security doors and alarms and made repairs from storm earlier in the week. On 07/30/25, an elopement drill was conducted on all three shifts. On 07/29/25, Director of Nursing Services (DNS) or designee educated all staff on the elopement policy, and any employees unable to be educated on this date will receive education prior to their next worked shift. Review of the staff in-service dated 07/29/25 revealed staff members were educated on exit-seeking behaviors, staff responsibilities, and what to do if an elopement occurs while you're working, review of staff sign-in sheets revealed all staff were provided education on elopements on 07/29/25 or prior to their next worked shift. Interviews on 09/04/25 and 09/08/25 with CNA #141, CNA #143, CNA #155, Director of Housekeeping #188, LPN #132, LPN #300, Registered Nurse (RN) #103, RN #113, RN #124, and RN #195 revealed they were educated on the facilities elopement policies and procedures and possessed appropriate knowledge in what do to in the event of an elopement. Review of two additional residents (#12 and #33) revealed no concerns with supervision and elopements. This deficiency represents non-compliance investigated under Complaint Number 2601843.