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	12/18/2025

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 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. Based on observation, record review, staff interview, and policy review, the facility failed to ensure appropriate incontinence care. This affected one (#03) of three residents reviewed for incontinence. The facility census was 63. Review of the medical record for Resident #03 revealed an admission date of 06/02/17 with a readmission date of 11/04/22, diagnoses included pneumonia, protein-calorie malnutrition, chronic obstructive pulmonary disease, Alzheimer's disease, anxiety, dysphagia, and depression.Review of the 5-day Minimum Data Set (MDS) assessment, dated 12/10/25, revealed Resident #03 had severely impaired cognition, required substantial/maximal assistance for rolling from left to right and for toileting hygiene, was always incontinent of bowel and bladder, and had a feeding tube.Observation on 12/17/25 at 12:20 P.M. of incontinence care provided by Certified Nurse Assistant (CNA) #123 for Resident #03 revealed CNA #123 performed hand hygiene, put on gloves, and used a cloth washcloth to cleanse and rinse Resident #03 who had been incontinent of urine. CNA #123 cleansed Resident #03's perineal area from back to front (the anus toward her pubic area), then used a clean cloth to rinse Resident #03's perineal area, again wiping from back to front. CNA #123 then applied barrier cream to Resident #03's sacrum and placed a clean brief on Resident #03. Interview on 12/17/25 at 12:35 P.M. with CNA #123 confirmed she cleaned Resident #03 from back to front. CNA #123 confirmed she should have cleansed and rinsed Resident #03 from front to back (the pubic area toward the anus). Review of the policy, Perineal Care, dated 12/12/23, revealed perineal care should be provided to all incontinent residents in order to promote cleanliness and prevent infection to the extent possible. Further review revealed female residents should be cleansed from front to back (from pubic area toward anus). This deficiency identified non-compliance investigated under Complaint Number 2680650 and Complaint Number 2668243.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, staff interviews, and review of facility policies, the facility failed to ensure infection prevention measures were correctly utilized when providing care to residents. This affected three (Residents #03, #22, and #71) of six resident reviewed for infection control. The facility census was 63. 1. Review of the medical record for Resident #22 revealed she was admitted on [DATE]. Diagnoses included hemiparesis to the right side following a stroke, type two diabetes mellitus, dysphagia, aphasia, hypertension, neurogenic bladder, colostomy, and stage three pressure ulcer. Review of the Minimum Data Set 3.0 assessment dated [DATE] for Resident #22 revealed the resident was unable to communicate and was severely cognitively impaired, displayed no behaviors at the time of the assessment and was dependent for all care. Resident #22 was at risk for pressure ulcers and three were present on admission to her right heel, scapula, and sacrum. Review of a physician order for Resident #22 dated 09/25/25 revealed a wound treatment was ordered twice daily to her sacrum. The wound order stated to cleanse the sacral wound with wound cleaner, pat dry, apply skin-prep around the wound, allow the kin prep to dry, pack wound with gauze moistened with pure hypochlorous acid solution, and cover with a dry dressing. Observation on 09/30/25 at 11:45 A.M. of sacral wound care for Resident #22 revealed Licensed Practical Nurse (LPN) #169 performed hand hygiene and applied clean gloves. LPN #169 removed the old dressing from Resident #22's sacrum, disposed of the dressing in the trash and removed her gloves. LPN #169 put on new clean gloves, obtained scissors from her pocket, picked up a gauze, cut the gauze with the scissors, moistened the gauze with hypochlorous acid solution, and then placed the moistened gauze in Resident #22's sacral wound. Subsequent interview with LPN #169 and Infection Control LPN #146, who was also present during this observation verified LPN #169 did not perform hand hygiene before putting on new clean gloves and did not clean the scissors prior to using them to cut the gauze. Infection Control LPN #146 stated LPN #169 should have performed hand hygiene between glove changes and should have cleansed the scissors from her pocket prior to cutting the gauze that was placed in Resident #22's sacral wound. Review of facility policy dated 05/30/24 and titled Wound Management revealed the resident care team would act to prevent infection while managing resident wounds. 2. Review of the medical record for Resident #03 revealed an admission date of 06/02/17 with a readmission date of 11/04/22, diagnoses included pneumonia, protein-calorie malnutrition, chronic obstructive pulmonary disease, Alzheimer's disease, anxiety, dysphagia, and depression. Review of the 5-day MDS assessment, dated 12/10/25, revealed Resident #03 had severely impaired cognition, required substantial/maximal assistance for rolling from left to right and for toileting hygiene, was always incontinent of bowel and bladder, and had a feeding tube. Review of a physician order for Resident #03, dated 12/11/25, revealed staff should practice Enhanced Barrier Precautions (EBP) when engaging in high contact resident care activities. EBP includes the practice of wearing personal protective equipment (gown and gloves) when providing care. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 12/17/25 at approximately 12:18 P.M. revealed an EBP sign posted on Resident #03's door stating personal protective equipment (PPE), including disposable gowns and gloves must be worn when providing high contact resident care. Observation on 12/17/25 at 12:20 P.M. of incontinence care provided by Certified Nurse Assistant (CNA) #123 for Resident #03 revealed CNA #123 performed hand hygiene, put on gloves, and used a cloth washcloth to cleanse and rinse Resident #03 who had been incontinent of urine. After CNA #123 completed incontinence care, CNA #123 used the same gloves to apply barrier cream to Resident #03's sacrum and placed a clean brief on Resident #03. Continued observation revealed CNA #123 removed her gloves, proceeded to move Resident #03's pillows and reposition Resident #03. CNA #123 then determined she needed an additional pillow and left the room, obtained another pillow, returned to the room, and continued to reposition Resident #03. Interview on 12/17/25 at 12:35 P.M. with CNA #123 revealed she should have worn a disposable gown while providing incontinence care to Resident #03. CNA #123 further confirmed she did not wash her hands after removing the gloves after providing incontinence care and before repositioning Resident #03, and confirmed she should have. CNA #123 further confirmed she should have washed her hands prior to leaving Resident #03's room to obtain another pillow. Review of the policy, Handwashing-Hand Hygiene, dated 03/01/25, revealed care team members must wash their hands for twenty seconds using antimicrobial or non-antimicrobial soap and water under the following conditions: before and after direct contact with residents; after removing gloves; and after handling items potentially contaminated with blood, body fluids, or secretions. 3. Review of the medical record for Resident #71 revealed an admission date of 10/30/25 with diagnoses of Huntington's disease, dysphagia, and gastrostomy status. Review of the comprehensive admission MDS assessment, dated 11/06/25, revealed Resident #71 was rarely/never understood, and had a feeding tube. Review of the current care plan, revised 11/13/25, revealed Resident #71 was at risk for complications due to tube feeding related to dysphagia. Interventions included EBP. Review of the physician order dated 10/30/25 revealed staff were required to wear enhanced barrier precautions when engaging in high contact resident care activities. Observation on 12/17/25 at 4:21 P.M. revealed Resident #71 had an EBP sign on her door and PPE, including disposable gowns and gloves, available outside the room. Observation on 12/17/25 at 4:26 P.M. revealed Registered Nurse (RN) #133 washing her hands and preparing a syringe and plastic water beaker to provide water flushes to Resident #71. RN #133 donned disposable gloves and accessed Resident #71's g-tube medication port to administer medications and water flushes. Interview on 12/17/25 at 4:34 P.M. with RN #133 confirmed she did not wear a disposable gown while accessing Resident #71's g-tube. RN #133 confirmed Resident #71 had an EBP sign posted on her door. RN #133 stated she was unclear whether EBP PPE was required when accessing Resident #71's g-tube. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 12/18/25 at 11:05 A.M. Infection Preventionist #146, confirmed staff should wear EBP, including a gown and gloves, when administering medications through a g-tube for Resident #71. Review of the undated policy Enhanced Barrier Precautions, revealed the facility would implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms. Review of the Enhanced Barrier Precaution sign revealed staff should wear gloves and a gown when providing high-contact resident care activities. This deficiency identified non-compliance investigated under Complaint Number 2680650.