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	02/05/2026

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY. Based on record review, staff interview, resident interview, observation of the 100-hall medication cart, and policy review, the facility failed to administer an as needed seizure medication for a resident having a seizure. This affected one (#17) of three residents reviewed for as needed seizure medications. The facility census was 64. Findings include:Review of Resident #17's medical record revealed an admission date of 08/06/25. Diagnoses included epilepsy, intractable without status epilepticus, type two diabetes mellitus, moderate persistent asthma, anxiety, orthostatic hypotension and peripheral vascular disease.Review of Resident #17's quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #17 had intact cognition with a Brief Interview for Mental Status (BIMS) score of 14. Furthermore, Resident #17 was noted to take anticonvulsant medication.Review of Resident #17's current physician orders revealed an order for Divalproex Sodium oral tablet delayed release 500 milligrams (mg) with instructions to give three tablets by mouth every morning and at bedtime for seizures. An order for Levetiracetam oral tablet 1000 mg with instructions to give one and a half tablets by mouth two times a day for seizures. An order for Levetiracetam oral tablet 750 mg with instructions to give one tablet by mouth every morning and at bedtime for seizures. An order for Primidone oral tablet 50 mg with instructions to give one tablet by mouth three times a day for anticonvulsant. An order for Topiramate oral tablet 200 mg with instructions to give one tablet by mouth every morning and at bedtime for seizures. An order for Midazolam nasal solution 5 mg/0.1 milliliter (ml) with instructions to give one spray in the left nostril as needed for a seizure lasting greater than two minutes, may repeat dose in alternate nostril if seizure continues. Do not repeat dose if the resident is having trouble breathing or sedation.Review of Resident #17's care plan dated 01/28/26 revealed Resident #17 received anticonvulsant medication and was at risk for adverse side effects with interventions that included to administer medications as ordered by the physician and to observe Resident #17 closely for significant side effects of anticonvulsant medication use that included but is not limited to dizziness, nausea, jaundice, and blurred vision.Review of Resident #17's Medication Administration Record (MAR) for the month of January 2026 revealed prior to Resident #17's seizure on 01/29/26, Resident #17 received all her scheduled seizure medications as ordered. On 01/29/26 when Resident #17 had her seizure, the as needed seizure medication was not documented as administered.Interview and concurrent observation on 02/05/26 at 2:40 P.M. of the 100-hall medication cart with Registered Nurse (RN) #112 revealed Resident #17 had four doses of the as needed Midazolam in the medication cart in the event of a seizure. RN #112 stated she had been educated about leaving the keys to the medication cart with another nurse when going on break.Interview on 02/05/26 at 3:03 P.M. with Certified Nursing Assistant (CNA) #163 revealed he had just started his shift and noticed Resident #17's call light was on. CNA #163 stated he answered the call light and (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

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	02/05/2026

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #17 told him she was going to have a seizure. CNA #163 reported after ensuring Resident #17 was safe in her bed he ran to get the nurse and when he could not find the nurse on duty, he ran to the Director of Nursing's (DON) office for help. CNA #163 stated Resident #17 convulsed for approximately 10 to 12 minutes.Interview on 02/05/26 at 3:25 P.M. with the DON verified Resident #17 did not receive the as needed dose of Midazolam when she had the seizure on 01/29/26 due to not having access to the medication cart as the nurse on duty went to break and took the medication cart keys with her. The DON stated CNA #163 came running into her office to get help for Resident #17 at which time she ran back to Resident #17's room with CNA #163 and found Resident #17 convulsing in bed. The DON stated she immediately turned Resident #17 onto her side and stated the resident's airway was clear for the entirety of the seizure, which lasted about five minutes. The DON called the Unit Manager for assistance, the physician was notified and an order was received to send Resident #17 to the hospital. Interview on 02/05/26 at 3:40 P.M. with Resident #17 revealed she had an aura and could tell a seizure was going to start. Resident #17 stated she put on her call light and CNA #163 answered it and which time she told CNA #163 she was about to have a seizure. Resident #17 stated CNA #163 went running for the nurse, and other than that Resident #17 stated she does not remember anything else until waking up when she was being transported out of the facility. Resident #17 stated she was not harmed in any way and had no deficits from the seizure.Review of the facility policy titled Medication Administration dated 01/02/24 revealed medications are administered by nurses as ordered by the physician and in accordance with professional standards of practice.As a result of the incident, the facility took the following actions to correct the deficient practice by 01/31/26:On 01/29/26 Resident #17 was immediately sent to the hospital for evaluation and treatment. The resident returned to the facility with no new orders.On 01/29/26 the problem was identified as Resident #17's Midazolam was unable to be obtained from the medication cart for administration during a seizure as no one was able to access the medication cart.On 01/30/26 an ad hoc Quality Assurance and Performance Improvement (QAPI) meeting was held with a root cause analysis completed. Results of the root cause analysis identified no nursing unit should be left unattended with medication cart key handed off to another nurse when going on break. On 01/30/26 all nurses were educated on the process of handing off the medication cart keys to another nurse when going on break. Review on 02/05/26 of the in-service attendance sign-in sheet dated 01/30/26 verified all facility nurses were educated. On 01/31/26, 02/02/6 and 02/05/26 audits were conducted on each shift and verified all nurses handed the medication cart keys to another nurse when going on break. Audits are to continue three times weekly for one more week, then twice weekly for two weeks, then as needed. All results will be reviewed by the Director of Nursing and reported to QAPI. This deficiency represents non-compliance investigated under Complaint Number 2734255.