

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366039	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/18/2025
NAME OF PROVIDER OR SUPPLIER Majestic Care of Point Place		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident interview, staff interview, and policy review the facility failed to ensure a residents were care planned for hearing aids which resulted in the facility failing to ensure resident hearing aids were maintained and in good working order. This affected one (#61) of two residents reviewed for comprehensive care planning. The facility census was 63. Review of Resident #61's medical record revealed an admission date of 02/14/25. Diagnoses included chronic obstructive pulmonary disease, diabetes mellitus, atrial fibrillation, dementia, Parkinson's, and transient ischemic attack. Review of Resident #61's significant change Minimum Data Set (MDS) dated [DATE] revealed the resident had an intact cognition, had moderate hearing loss and required the use of hearing aids. Review of Resident #61's most recent care plan revealed the care plan failed to address hearing loss nor the need for hearing aids. Review of Resident #61's physician order dated 02/14/25 revealed the resident should be seen by the audiologist. Interview with Resident #61 on 09/29/25 at 10:03 A.M. revealed he was unable to wear his hearing aids because they needed new batteries. Resident #61 stated he had let the nurses know that he needed new batteries for his hearing aids. Interview with Nurse #206 and MDS Coordinator #163 on 09/30/25 at 9:33 A.M. revealed the resident's family had requested the resident to be seen by the audiologist. Nurse #206 and MDS Coordinator #163 were unaware Resident #61 needed new batteries for his hearing aids. Interview with Certified Nursing Assistant (CNA) #158 on 09/30/25 at 10:34 A.M. verified she was unaware the resident required hearing aids. Review of the facility policy titled Comprehensive Care Plan revised 05/16/25 revealed the comprehensive care plan will be developed within 7 days after the completion of the comprehensive MDS assessment. All Care Assessment Areas (CAAs) triggered by the MDS will be considered in developing the plan of care.		

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident interview, staff interview, and policy review revealed the facility failed to ensure one Resident (#18) was showered and received haircuts timely. This had the ability to affect all residents. The facility census was 63. Review of Resident #18's medical record revealed an admission date of 08/25/22. Diagnoses included vascular dementia, convulsion, chronic kidney disease, and transient ischemic attack. Review of Resident #18's quarterly Minimum Data Set (MDS) dated [DATE] revealed the resident had a moderately intact cognition. He required supervision or touching assistance for showers. Review of the most recent care plan revealed Resident #18 required minimal assistance with activities of daily living related to dementia and a history of falls. Nail care was to be completed on bath days and as necessary. Supervision and touch assist was required for shower and bathing. Review of Resident #18's skin observation shower sheets revealed the resident received a shower on 09/10/25 and not another shower until 09/20/25. Review of Resident #18's shower/bathing task in the electronic medical record revealed the resident received no shower from 08/31/25 until 09/07/25. The resident received a shower on 09/10/25 and not again until 09/20/25. Review of Resident #18's progress notes from 08/31/25 through 09/20/25 revealed no documentation associated to showers nor shower refusals. Review of the shower schedule revealed Resident #18 was to receive a shower every Wednesday and Saturday. Observation of Resident #18 on 09/29/25 at 9:10 A.M. revealed the resident had long, unkempt hair. Interview with Resident #18 at the time of the observation revealed the resident failed to receive showers timely and would like to be showered regularly. Resident #18 also stated he was in need of a haircut. Interview with Certified Nursing Assistant (CNA) #123 on 09/30/25 at 1:40 P.M. revealed she worked first shift, but the second shift staff failed to complete showers timely. Review of the facility policy titled Activities of Daily Living (ADLs) dated 12/12/23 revealed a resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.		

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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. 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.		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on record review and staff interview, the facility failed to timely respond to pharmacist recommendations. This affected one (#63) of five residents reviewed for pharmacist recommendations. The facility census was 63. Review of the medical record for Resident #63 revealed an admission date of 02/06/25 with diagnoses of type II diabetes mellitus, hypertensive heart disease, and congestive heart failure. Review of the quarterly Minimum Data Set (MDS) assessment, dated 12/08/25, revealed Resident #63 had intact cognition and received hypoglycemic medications. Review of the pharmacy recommendation to prescriber, dated 08/10/25, revealed a recommendation to check Resident #63's hemoglobin A1c (HbA1c) laboratory value. Further review revealed the physician responded 08/15/25 with a statement ok to draw lab. Review of the laboratory test results for Resident #63 revealed a HbA1c test was drawn 10/02/25. Interview on 12/17/25 at 2:59 P.M. with the Director of Nursing (DON) confirmed no HbA1c was drawn for Resident #63 between 08/15/25 and 10/02/25. The DON further stated Resident #63's HbA1c laboratory test should have been completed within seven days of the physician signing the recommendation on 08/15/25.		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 menu spreadsheet, the facility failed to provide appropriate portions and all menu items for residents on a pureed diet. This affected two (#4 and #64) of two residents identified on a pureed diet. The facility census was 63. Observation in the kitchen on 09/30/25 at 4:05 P.M. revealed [NAME] #195 preparing pureed meals for the evening meal. [NAME] #195 used an 8-ounce scoop to portion out turkey and dumplings for preparation. Concurrent interview with [NAME] #195 confirmed he only needed one 8-ounce scoop for two pureed portions of turkey and dumplings. [NAME] #195 stated only two residents, Resident #4 and Resident #64, were on pureed diets. Continued observation revealed [NAME] #195 prepared pureed turkey and dumplings and pureed green beans. [NAME] #195 placed a 4-ounce portion of pureed turkey and dumplings and a 4-ounce portion of pureed green beans onto Resident #4's plate and Resident #64's plate. Concurrent interview with [NAME] #195 confirmed the two items on the plate were the only items residents on a pureed diet would receive, except for dessert. Observation on 09/30/25 at 5:05 P.M. revealed Certified Nursing Assistant (CNA) #114 pulling Resident #4's meal tray from the cart and preparing to take it to his room. Concurrent interview with CNA #114 revealed there were only two items on Resident #4's plate, a main dish and the vegetable. CNA #114 identified Resident #4 also had nutrition supplements on his tray, but did not have a bread serving. Observation on 09/30/25 at 5:07 P.M. revealed Medical Records (MR) #172 passing meal trays. MR #172 removed Resident #64's tray from the tray cart on the hall. Concurrent interview with MR #172 confirmed no bread was on Resident #64's meal tray. Interview on 09/30/25 at approximately 5:09 P.M. with [NAME] #195 and Dietary Manager (DM) #186 confirmed [NAME] #195 provided a 4-ounce pureed portion of turkey and dumplings to Resident #4 and Resident #64. Further interview and concurrent review of the menu spreadsheet revealed residents on a pureed diet should have received a portion size of two #10 scoops (a total of six and a half ounces) rather than the four ounces provided. Additional interview with review of the menu spreadsheet revealed residents on a pureed diet should receive one slice of pureed white bread. [NAME] #195 and DM #186 confirmed no pureed bread was prepared or provided to Resident #4 and Resident #64.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and policy review the facility failed to accurately and timely document in the medical records. This affected one Resident (Resident #37) out of ten residents reviewed for documentation. Additionally, the facility failed to transcribe physician orders. This affected four residents (#04, #37, #05, and #63) out of six reviewed for physician orders. The facility census was 63. 1. Review of the medical record for Resident #04 revealed an admission date of 07/27/22, diagnoses included hemiplegia and hemiparesis following cerebral infarction affecting left side, gastrostomy status, and acquired absence of left leg above the knee. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment, dated 08/19/25 revealed Resident #04 had moderate cognitive impairment and required staff assistance for all activities of daily living (ADL's), was always incontinent for bowel and bladder. Review of the provider notes revealed Resident #04 had left shoulder pain related to a fall with an order for Lidocaine External Patch 4% apply to left shoulder topically every morning and at bedtime for pain remove every 12 hours. On 09/30/25 the order was corrected to Lidocaine External Patch 4% apply to left shoulder topically in the morning for pain on for 12 hours, off for 12 hours. Interview on 09/30/25 at 1:36 P.M. with Director of nursing (DON) revealed that the order for Lidocaine External Patch dated 07/31/25 was inaccurately ordered. 2. Review of the medical record for Resident #05 revealed she was admitted to the facility on [DATE]. Her diagnoses included chronic obstructive pulmonary disease, type two diabetes mellitus, bipolar disorder, obsessive-compulsive disorder, depression, anxiety, coronary angioplasty implant and graft, toxic liver disease, irritable bowel syndrome, and hepatitis C. Review of the Minimum Data Set 3.0 (MDS) assessment dated [DATE] for Resident #05 revealed she was cognitively intact. Resident #05 displayed no behaviors at the time of the assessment. She was incontinent, used a walker for mobility, and required substantial assistance with toileting hygiene, personal hygiene, dressing, bathing, bed mobility and transfers. At the time of the assessment, Resident #05 had scheduled and as-needed pain regimens in place to manage frequent pain, rated five out of ten, that interfered with her daily activities. Review of the pharmacy recommendations dated 09/15/25 for Resident #05 revealed lidocaine patches should be removed for 12 hours each day, per manufacturer recommendations. This pharmacy recommendation was signed and ordered by the attending provider on 09/16/25 indicating the lidocaine patch be applied for 12 hours then removed and kept off for 12 hours. Review of physician orders dated 09/16/25 for Resident #05 revealed an order for a lidocaine patch to be applied to the left ribs topically every 12 hours as needed for pain. Interview on 09/30/25 at approximately 11:30 A.M. with the DON and Corporate Registered Nurse #206 revealed the lidocaine order for Resident #05 dated 09/16/25, generated from the pharmacy recommendation form dated 09/15/25, was inaccurately transcribed. 3. Review of the medical record for Resident #63 revealed an admission date of 02/06/25 with (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	diagnoses of type 2 diabetes mellitus, hypertensive heart disease, and congestive heart failure. Review of the quarterly MDS assessment, dated 12/08/25, revealed Resident #63 had intact cognition. Review of the current physician orders for Resident #63 revealed an order dated 03/20/25 for Percocet oral tablet 5-325 milligram (mg) (oxycodone with acetaminophen), give two tablets by mouth every four hours as needed for moderate to severe pain, no more than eight tablets in 24 hours. Further review revealed an active order initiated 09/25/25 for Percocet oral tablet 5-325 mg (oxycodone with acetaminophen), give one tablet by mouth every four hours as needed for mild pain. Additional review revealed an active order initiated 09/25/25 for Percocet oral tablet 5-325 mg (oxycodone with acetaminophen), give two tablets by mouth every four hours as needed for severe pain. Interview on 09/30/25 at 4:30 P.M. with the DON confirmed Resident #63 had redundant orders for Percocet; specifically one order to provide two tablets as needed for moderate/severe pain and an additional order to provide two tablets for as needed for severe pain. The DON stated an order was pending to consolidate the three Percocet orders, but the provider had difficulty accessing the electronic medical record and had not revised the order at the time of the interview. Follow-up interview on 12/18/25 at 11:50 A.M. with the DON and concurrent review of the Medication Administration Record (MAR) for September 2025 revealed Resident #63 received Percocet, two tablets, from both active orders on 09/26/25, 09/27/25, 09/29/25 and 09/30/25. Resident #63 did not exceed eight tablets in 24 hours. Review of the policy Medication Administration, dated 01/02/24, revealed the facility would administer medication as ordered by the physician. 4. Review of the medical record for Resident #37 revealed an admission date of 08/07/24, diagnoses included orthopedic aftercare following amputation, major depressive disorder, and chronic pain syndrome. Review of the quarterly MDS 3.0 assessment revealed Resident #37 was cognitively intact and required substantial staff assistance with ADL's. Resident #37 was always incontinent for bowel and bladder. Interview with Resident #37 revealed on 11/26/25 Licensed Practical Nurse (LPN) #160 was changing the wound dressing on her left second toe when she noticed the area to have significant discharge, pain, redness, and swelling. After LPN #160 contacted the physician Resident #37 was sent out to the hospital for further evaluation. No progress note was entered by LPN #160 in regards to the wound or for the send out to the hospital. Resident #37 indicated she was sent out sometime between 12:00 and 1:00 A.M. Review of progress notes for Resident #37 from 11/21/25 through 12/02/25 revealed that on 11/26/25 at 9:50 A.M. a note was entered by LPN #146 stating Resident #37 was sent out to hospital due to wound on left second toe red and swollen. No progress note regarding wound or wound care were entered between 11/21/25 and 11/25/25. (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 12/17/25 at 6:01 A.M. with LPN #160 revealed that on 11/26/25 resident #37 came to her with reports of pain and bleeding from the wound area on her left second toe. When LPN #160 was removing the dressing on Resident #37's left second toe she noted excessive discharge, an odor, all toes and top of foot swollen, and redness covering entire foot and very bottom of left leg. LPN #160 called physician on duty and was ordered to send Resident out to hospital emergency room (ER) for further evaluation. Resident #37 was admitted to hospital with a wound infection LPN #160 further stated she did not put any progress notes in related to resident #37's condition or hospital send out because she was busy and never got around to it. Review of policy titled Documentation In The Medical Record dated 01/02/24 revealed that documentation shall be completed at the time of service, but no later than the shift in which the services provided in the Resident's care service occurred. Additionally, the policy stated that the documentation must record descriptive and objective information based on first-hand knowledge of the assessment, observation, or services provided.		

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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. **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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Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366039	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/18/2025
NAME OF PROVIDER OR SUPPLIER Majestic Care of Point Place		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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.		