

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

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366188	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/25/2025
NAME OF PROVIDER OR SUPPLIER Majestic Care of Toledo Snf		STREET ADDRESS, CITY, STATE, ZIP CODE 131 North Wheeling Street Toledo, OH 43605	
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 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 observation, medical record review, staff interview, and facility policy review, the facility failed to ensure accurate and descriptive wound assessments, timely treatment orders for an identified wound, and ensure wound interventions were in place for a resident with pressure ulcers. This affected one (#24) of two residents reviewed for pressure ulcers. The facility census was 67. Findings include: Review of the medical record revealed Resident #24 was admitted on [DATE]. Diagnoses included end stage renal failure, aphasia following cerebral infarction, dysphagia, and adult failure to thrive. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #24 was severely cognitively impaired. Review of the Nursing Admission/readmission Evaluation dated 09/11/25 at 6:39 P.M. revealed Resident #24 was readmitted from the hospital and returned to the facility with no new bruises or wounds. Preexisting wounds on resident's buttocks and left heel were noted. There was no description or measurement of the wound on 09/11/25. Review of the Skin Condition Evaluation dated 09/12/25 revealed on (re)admission, there was a suspected deep tissue injury (DTI) to the left heel measuring 1.4 centimeters (cm) in length by (x) 3.2 cm in width x 0.0 cm in depth. There was no wound treatment ordered on 09/11/25 or 09/12/25. The first wound treatment to the left heel was initiated on 09/17/25. The physician order dated 09/16/25 revealed an order for bilateral heel protectors on at all times when in bed. The physician order, dated 09/17/25, revealed an order for the left heel, cleanse with wound cleanser/normal saline and leave open to air twice a day. The wound assessment report dated 09/17/25 revealed the DTI pressure ulcer to the left heel measuring 1.3 cm x 3.5 cm x 0.0 cm. The care plan dated 09/18/25 revealed Resident #24 had impaired skin integrity to the left heel pressure ulcer with interventions including bi-lateral heel protectors on at all times when in bed. The wound assessment report dated 09/24/25 revealed a DTI pressure ulcer to Resident #24's left heel measuring 1.6 cm x 2.9 cm x 0.0 cm and noted to be improving without complications. Observation on 09/24/25 at 8:46 A.M. revealed Resident #24 was lying in bed on his back with his eyes closed and heels on the mattress. There were no heel protectors in place. Interview on 09/24/25 at 8:50 A.M. with Licensed Practical Nurse (LPN) #376 verified Resident #24 was in bed and did not have heel protectors on. LPN #376 located the heel protectors in the closet. Interview on 09/24/25 at 10:09 A.M. with the Director of Nursing (DON) verified the Nursing Admission/readmission Evaluation was completed inaccurately. The resident had a new heel wound (not existing) and verified there was no descriptions of the wounds to the left heel and buttocks. Interview on 09/25/25 at 11:34 A.M. with Registered Nurse (RN) #360 verified completing the skin assessment report including wound description with measurements on 09/12/25 and no physician treatment orders for the left heel were in not implemented until five days later on 09/17/25. Review of the policy titled Wound Management Policy dated 05/20/24 revealed upon admission upon admission, resident specific categorical skin risk factors are assessed, documented, care planned, and care plan interventions are operationalized, monitored, and evaluated. Residents with impaired skin integrity are recognized by our care team, treated timely, and healing interventions are exhausted until the skin is healed. The facility will have a system in place to identify impaired skin integrity development early to prevent further damage and treat the condition as soon as it is identified.		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 366188 If continuation sheet Page 1 of 3

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and facility policy review, the facility failed to ensure residents were assessed and monitored for complications before and after hemodialysis treatments and failed to implement physician orders to notify the physician for weight loss in a day or week. This affected one (#24) of one resident reviewed for dialysis. The facility census was 67. Findings include: Review of the medical record revealed Resident #24 was admitted on [DATE]. Diagnoses included end stage renal failure, dysphagia, and adult failure to thrive. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #24 was severely cognitively impaired and received dialysis. Review of the care plan dated 08/19/25 revealed Resident #24 required hemodialysis. Interventions included to weigh daily Monday, Wednesday, and Friday with instructions to notify the physician if weight gain was greater than three pounds in a day of five pounds in a week. Review of the pre/post dialysis communication reports for Resident #24 from 08/18/25 to 09/22/25 revealed the reports were not completed on 08/22/25, 08/27/25, and 09/12/25. The physician orders dated 09/12/25 revealed an order to weigh daily Monday, Wednesday, and Friday. Notify the physician if weight gain was greater than three pounds in a day or five pounds in a week. The Medication Administration Record (MAR) dated September 2025 revealed on 09/17/25, Resident #24 weighed 114.5 pounds and on 09/22/25, Resident #24 weighed 104 pounds (10 pound loss in five days). There was no documentation in the medical record the physician was notified of Resident #24's weight loss of ten pounds in five days on 09/22/25. There was no reweight document on 09/22/25. Interview on 09/23/25 at 4:33 P.M. with the Director of Nursing (DON) verified the pre/post dialysis communication report was not completed on 08/22/25, 08/27/25, and 09/12/25. The DON also verified on 09/22/25, Resident #24 should have been reweighed and if the weight was accurate, the physician should have been notified. Follow-up from surveyor notification on 09/23/25 the facility reweighed Resident #24 with an updated weight of 113.6 pounds. Review of the policy titled Dialysis dated 01/02/24 revealed the facility will assure each resident receives the care and services for the provision of hemodialysis consistent with professional standards including ongoing assessment of the resident's condition and monitoring for complications before and after dialysis treatments and ongoing communication and collaboration with the dialysis facility regarding dialysis care and services.		

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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. Based on record review and staff interview, the facility failed to ensure physician orders were transcribed accurately in the electronic medical record. This affected one (Resident #5) of 20 residents reviewed for medical record accuracy. The facility census was 67. Findings include: Review of Resident #5's medical record revealed an admission date of 02/01/23. Diagnoses included hypertensive heart failure, congestive heart failure, and atrial fibrillation. Review of Resident #5's Medication Administration Record (MAR) dated September 2025 revealed Losartan Potassium (antihypertensive) oral tablet 25 milligrams (mg) was to be administered by mouth one time daily for hypertension. Hold for heart rate greater than 60, systolic blood pressure greater than 110, and diastolic blood pressure greater than 60. The physician order was dated 08/05/25. There was an order for Furosemide (diuretic) 10 mg by mouth one time a day for fluid overload. Hold if heart rate was greater than 60. The physician order was dated 07/28/25. Review of Resident #5's September 2025 MAR revealed the medications were administered per nursing judgement and not as written in the order. Interview with the Director of Nursing (DON) on 09/25/25 at 10:43 A.M. verified Resident #5's medication orders were placed in the electronic medical record inaccurately. The orders should have read the Losartan Potassium should have been held if the heart rate was under (not over) 60, systolic blood pressure was under 110, and the diastolic blood pressure was under 60. The Furosemide should have been held if the heart rate was under 60. The DON revealed no written order was available for the medications and it may have been a verbal order from the physician. The nurses who placed the orders in the medical record inaccurately used the greater than and less than signs.		