STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235132	A. Building B. Wing	03/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Majestic Care of Flushing	540 Sunnyside Dr Flushing, MI 48433

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37771 This Citation pertains to Intake Number MI00126544. Based on observation, interview and record review, the facility 1) Failed to ensure that the family of Resident #2 was notified of an elopement from the facility on 02/19/22 when the resident eloped at night with freezing temperatures and was found in the parking lot of the facility and 2) Failed to document that the physician was notified of the elopement, for one resident (Resident #2) of three residents reviewed for elopement, resulting in the lack of communication for care decisions and coordinated care and the potential for elopements to re-occur. Findings include: Resident #2: A review of Resident #2's medical record revealed an admission on 2/3/22 with diagnoses that included Covid-19, syncope and collapse, muscle weakness, difficulty in walking, other symptoms and signs involving cognitive functions and awareness, glaucoma, and dementia. A review of the Minimum Data Set assessment revealed the Resident had moderately impaired cognition with a Brief Interview for Mental Status (BIMS) score of 8 and had wandering behavior that occurred 1 to 3 days. Further review of the MDS included Balance During Transitions and Walking with the Resident walking Not steady, only able to stabilize with human assistance and Surface-to-surface transfer not steady, only able to stabilize with human assistance. A review of Resident #2's Admission Record, revealed the Resident had a son who was the emergency contact #1 and another son who was the emergency contact #2. Further review of Resident #2's medical record revealed the following: -Progress note, Visit Type: Follow Up, dated 2/11/22, .Patient is alert this morning, She is in no acute distress, She is able to answer questions although unsure how accurate her responses are . Neuro: Moves all 4 extremities, alert and oriented x 1 . Unspecified dementia without behavioral disturbance: She is confused at her baseline ., author Nurse Practitioner. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Progress note, Visit Type: Telehealth, Nurse is requesting a wander guard for patient continues to wander off and is afraid she will either leave facility and/or get hurt. Wander guard order approved. Care team notified, signed date 2/20/2022 10:32 AM. -State of Michigan Probate Court . Report of Physician or Mental Health Professional, . 2. I last examined the individual on 2/7/22. 3. Based on that examination and her/his medical record, the individual suffers from the following physical or psychological infirmities: CVA [stroke], cognitive impairment. 4. These infirmities interfere in the following ways with the individual's ability to receive or evaluate information in making decisions: Patient lack insight into medical decision making . 6. I believe the individual due to these described conditions, is not presently able to make informed decisions in the following areas: (all areas indicated) Determining where to live. Consenting to supportive services. Handling personal financial affairs. Authorizing or refusing medical treatment . signed by Physician MM. Review of the medical record revealed a lack of documentation of the elopement and notification of Physician and family of the elopement. The Administrator (NHA) was asked for Accidents and Incidents forms for Resident #2 but did not receive any forms prior to the exit of the survey. An interview was conducted on 3/7/22 at 12:50 PM with Nurse X regarding Resident #2's elopement from the facility. The Nurse indicated she had gotten report from Nurse BB that Resident #2 had gotten out of the building the night before, on 2/19/22, on second shift (afternoon shift) but did not know the time or how long the Resident had been out. The Nurse indicated that documentation would include a report for the incident, skin assessment, notification of the incident to the Administrator, family, doctor, and Director of Nursing. When asked what charting would be completed, the Nurse indicated a progress note would be done of what happened, how was the Resident found, who was notified and talked to, assessments, vital signs, and any changes in skin. When asked about the wander guard, the Nurse reported she had checked the Resident and she did not have one on, did a text message to get the order for the wander guard placement, had not discussed the elopement with the Physician and the Resident continued to wander and exit seeking to get out of the building. On 3/8/22 at 12:43 PM, an interview was conducted with Confidential Person GG, who wanted to remain confidential, regarding Resident #2's elopement on 2/19/22. The Confidential Person reported the Resident got out on 2/19/22, out the front door, approximately 8:00 PM and was found in the parking lot about 10:00 PM by the next shift coming in. When questioned who had brought the Resident back in, the Confidential Person stated, (Nurse Q) brought her back in. The Confidential Person reported that it was snowy out and very cold temperatures. The Confidential Person reported that (Nurse V) was not made aware of the Resident outside the building and was not told until later. The Confidential Person reported the Administrator, and the Director of Nursing were aware of the elopement but did not investigate what really happened, did not report it to the State Agency and was trying to hide it, charting was not corrected, and the Doctor and family were not notified. On 3/9/22 at 9:45 AM, the Administrator was asked for the investigation report for Resident #2's elopement from the facility. At 10:10 AM, an interview was conducted with the Administrator (NHA), the Director of Nursing (DON) and Corporate Nurse JJ regarding Resident #2's elopement. The investigation report included the following: (continued on next page)

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Description: Administrator and DNS (DON) were notified at 8:21 am of a resident leaving the building. This resident is her our (own) responsible party. Her BIMS is an 8. She was out in the parking lot around 10:00 PM when staff saw her and brought her back in the building. She was wearing PJ pants, a gown, gripper socks and a hat. 2-20-2022- Medical Director was notified. Resident #2's medical record lacked documentation that the Medical Director or attending physician was notified of the elopement. On 3/9/22 at 10:10 AM, the progress note, dated 2/19/22 at 10:29 PM, revealed, Pt was redirected by staff attempting to leave the building. Wander guard in place and functioning pt safe in bed at time of note will cont to [NAME], author Nurse V, was reviewed with the NHA, Corporate Nurse and DON. When queried why the documentation was not correct, the Corporate Nurse stated, He should have written accurate information. The lack of documentation that the Physician and family was notified of the elopement was reviewed. The NHA indicated that the Physician was notified when they got the order for the wander guard and stated, The Resident was her own responsible party. The NHA was asked where the rational for the wander guard was and did not have an answer. A review of the documentation from the Nurse Practitioner that was notified for the wander guard was reviewed that revealed, 'Visit Type: Telehealth, Nurse is requesting a wander guard for patient continues to wander off and is afraid she will either leave facility and/or get hurt. Wander guard order approved. Care team notified, signed date 2/20/2022 10:32 AM. During the interview, the Administrator was asked by this surveyor if the facility had filled out an incident report regarding the elopement, was there any documentation of post elopement nursing assessment, documentation of informing the family or a timeline done of the elopement events, the answer given was no. A review of the facility policy titled, Accidents and Incidents-Investigating and Reporting, revised 7/2017, revealed, Policy Statement: All accidents or incidents involving resident, employees, visitors, vendors, etc., occurring on our premises shall be investigated and reported to the Administrator . 2. The following data, as applicable, shall be included on the Report of Incident/Accident form: a. The date and time the accident or incident took place; . c. The circumstances surrounding the accident or incident; .g. The time the injured person's Attending Physician was notified, as well as the time the physician responded and his or her instructions; h. The date/time the injured person's family was notified and by whom .

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37771 This Citation pertains to Intake Number MI00126544. Based on observation, interview and record review, the facility failed to report immediately to the Administrator allegations of an elopement from the facility and failed to report the elopement to the State Agency for one resident (Resident #2) of three residents reviewed for elopement, resulting in potential neglect of resident safety to go undetected and compromise of residents' health, safety and wellbeing, and potential for elopements from the facility to continue to occur. Findings include: Resident #2: A review of Resident #2's medical record revealed an admission on [DATE] with diagnoses that included Covid-19, syncope and collapse, muscle weakness, difficulty in walking, other symptoms and signs involving cognitive functions and awareness, glaucoma, and dementia. A review of the Minimum Data Set assessment revealed the Resident had moderately impaired cognition with a Brief Interview for Mental Status (BIMS) score of 8 and had wandering behavior that occurred 1 to 3 days. Further review of the MDS included Balance During Transitions and Walking with the Resident walking Not steady, only able to stabilize with human assistance and Surface-to-surface transfer not steady, only able to stabilize with human assistance. On [DATE] at 12:25 PM, an observation was made of Resident #2 in her room lying on the bed. The Resident was dressed in a shirt, pants, and a hat on her head. The Resident did not wake when her name was called. The Resident's lunch tray was on the bedside table, not eaten and the breakfast tray was positioned on top of the hamper and appeared to be partially consumed. On [DATE] at 12:35, an interview was conducted with Nurse W regarding Resident #2's wandering behaviors. The Nurse indicated that the Resident walked unassisted or used a wheelchair that she propelled herself, had a WanderGuard (A device on a wrist or ankle band that sounds an alarm when a resident approached or goes through a door.) on her ankle, and had exit seeking behavior of pushing on the doors to get out of the building. When asked how long the Resident had wandering and exit seeking behaviors, the Nurse stated, She exit seeks all day, and reported the behaviors were since admission. When asked about elopements, the Nurse reported Resident #2 had one last month when she exited the building but did not remember the specific date. On [DATE] at 10:13 AM, an observation was made of Resident #2 in her room. The Resident was dressed in a shirt, pants and had a hat on. The Resident was unable to answer most questions appropriately. When asked if the Resident went outside, the Resident stated, I go outside every day. When asked if she went out of the room or out of the building, the Resident did not answer then stated, I go myself. When asked if she had eaten breakfast, the Resident indicated she didn't know. When asked if she knew what time of day it was, the Resident did not answer. (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 12:43 PM, an interview was conducted with Confidential Person GG, who wanted to remain confidential, regarding Resident #2's elopement on [DATE]. The Confidential Person reported the Resident got out on [DATE], out the front door, approximately 8:00 PM and was found in the parking lot about 10:00 PM by the next shift coming in. When questioned who had brought the Resident back in, the Confidential Person stated, (Nurse Q) brought her back in. The Confidential Person reported that it was snowy out and very cold temperatures. The Confidential Person reported that (Nurse V) was not made aware of the Resident outside the building and was not told until later. The Confidential Person reported the Administrator, and the Director of Nursing were aware of the elopement but did not investigate what really happened, did not report it to the State Agency and was trying to hide it, charting was not corrected, and the Doctor and family were not notified. On [DATE] at 7:16 AM, another call was made to Nurse U and an interview was conducted regarding Resident #2's elopement out of the facility. The Nurse reported she was coming into work in her vehicle and had seen someone by the facility doors and thought it was a staff member trying to get into the building. The Nurse indicated she had parked her vehicle and went in to clock in for her shift then came back out to back into a parking space, other staff were arriving at that time. When she was parking, the headlights shined on the person she had seen when she first arrived at the facility and that person was now in the parking lot when she realized it was Resident #2. The Nurse reported that a third shift CNA was backing her car up and she was afraid they might hit the Resident, but the CNA had stopped in time. She reported she had jumped out of her car and stated, I knew who she was (Resident #2), and escorted her back into the building. The Nurse stated, She (Resident #2) was freezing, and did not have a coat on, was wearing pajamas, socks, and a hat. When she got her to the North Hall, CNA HH took her to her room. The Nurse reported she had texted the Administrator and the Director of Nursing to let them know what happened. I used the numbers that were on the sheet at the nurse's station to contact them. The Nurse was questioned if the Administrator or DON had called back. The Nurse indicated that they did not get back with this nurse until the next day after her shift was over. The Nurse reported she looked for the Resident's Nurse but could not find him. The Nurse indicated she had not talked to her Nurse after finding the Resident and that CNA HH was aware the Resident had been outside. The Nurse stated, It was bitter cold outside, and she didn't have a coat or shoes on, she was in the parking lot and could have gotten hit by a car. She could have died out there. The Nurse reported the Resident had dementia and should not have been outside by herself, and stated, I looked for her Nurse, but I couldn't find him. When asked about the documentation that the Resident had attempted to leave the building, the Nurse stated, That was not the truth. She was outside in the parking lot. I seen her when I first pulled in over by the East doors but didn't know it was her until I seen her in the parking lot. The Nurse reported she had texted the Administrator at 10:09 PM on [DATE] that the Resident in (resident's room number) was outside since 8 or 9 PM and she had no WanderGuard and no shoes on. The Nurse indicated she had not got a call back from the Administrator or from the Director of Nursing that night but had talked to the Administrator about the incident on the following Monday. The Nurse stated, Her hands were the coldest, but had not done a skin assessment and indicated that Nurse BB was her Nurse that night and was aware the Resident had been outside. (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 9:45 AM, the Administrator was asked for the investigation report for Resident #2's elopement from the facility. At 10:10 AM, an interview was conducted with the Administrator (NHA), the Director of Nursing (DON) and Corporate Nurse JJ regarding Resident #2's elopement. A review of Nurse U texting the NHA and DON of the allegations of elopement was reviewed. The DON and the NHA both reported they did not get the text until waking the next morning. The DON stated, They should be calling us not texting. The Administrator stated, I was notified by the DON (Director of Nursing). I did speak with (Nurse, LPN U), she said there was no alarm sounding at the front door; (Nurse U) was coming in (coming into work) and saw her. The Nurse (Nurse, LPN V) said at 9:45 p.m. his meds (medication pass) was done; he heard the door alarm, he didn't know when the alarm went off. I talked with (Nurse, LPN V) on Sunday, he went to the front of the building and went out driving around (looking for the resident). The documents presented as the investigation report did not have any information or documentation of the State Agency notification of Resident #2's elopement from the facility. During the interview done on [DATE] at 10:10 a.m., this surveyor asked the Administrator why she did not report the elopement to the State Agency she stated, I can't answer that. When this surveyor asked the Administrator if the elopement should have been reported to the State Agency, she did not answer, she just looked down. A review of the facility policy titled, Abuse Prevention Program, revised [DATE], revealed, Our residents have the right to be free from abuse, neglect . [Collectively, hereinafter abuse] . Reporting and Response . 3. Employees . Must immediately report any suspected abuse or incidents of abuse to the Administrator . 4. The Administrator must be immediately notified of alleged abuse/neglect or incidents of abuse/neglect. If such incidents occur or are discovered after hours, the Administrator and Director of Nursing Services must be called at home or must be paged and informed of such incident. 5. When an alleged or suspected case of mistreatment, neglect, injuries of unknown source, or abuse is reported, the facility Administrator, DON, or individuals designated will immediately [not to exceed 24 hours if the event does not result in serious bodily injury .] notify the following persons or agencies of such incident: 1. The State licensing/certification agency responsible for surveying/licensing the facility; 2. The Resident's Representative of record; 3. The Resident's Attending Physician and/or the Medical Director . 7. To help with identification of incidents of abuse, the following definitions of abuse are provided: . Adverse event-An adverse event is an untoward, undesirable, and usually unanticipated event that causes death or serious injury, or the risk thereof . Neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or mental illness .

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	235132	A. Building B. Wing	03/10/2022

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37771 This Citation pertains to Intake Number MI00126544. Based on observation, interview and record review, the facility failed to thoroughly investigate allegations of an elopement where Resident #2 had eloped from the facility at night, in cold weather, and was found wandering the parking lot when staff arrived for their shift, for one resident (Resident #2) of three residents reviewed for elopement, resulting in an incomplete investigation, lack of care planning for safety and the potential for injury and continued elopements. Findings include: Resident #2: A review of Resident #2's medical record revealed an admission on [DATE] with diagnoses that included Covid-19, syncope and collapse, muscle weakness, difficulty in walking, other symptoms and signs involving cognitive functions and awareness, glaucoma, and dementia. A review of the Minimum Data Set assessment revealed the Resident had moderately impaired cognition with a Brief Interview for Mental Status (BIMS) score of 8 and had wandering behavior that occurred 1 to 3 days. Further review of the MDS included Balance During Transitions and Walking with the Resident walking Not steady, only able to stabilize with human assistance and Surface-to-surface transfer not steady, only able to stabilize with human assistance. Further review of Resident #2's medical record revealed a lack of documentation of the elopement, skin assessment after elopement, and notification of Physician and family of the elopement. Review of Resident #2's care plan revealed a lack of Focus, Goal and Interventions for elopement and wandering or the use of a WanderGuard. On [DATE] at 12:25 PM, an observation was made of Resident #2 in her room lying on the bed. The Resident was dressed in a shirt, pants and a hat on her head. The Resident did not wake when her name was called. The Resident's lunch tray was on the bedside table, not eaten and the breakfast tray was positioned on top of the hamper and appeared to be partially consumed. On [DATE] at 12:35, an interview was conducted with Nurse W regarding Resident #2's wandering behaviors. The Nurse indicated that the Resident walked unassisted at times or used a wheelchair that she propelled herself, had a WanderGuard (A device on a wrist or ankle band that sounds an alarm when a resident approached or goes through a door.) on her ankle, and had exit seeking behavior of pushing on the doors to get out of the building. When asked how long the Resident had wandering and exit seeking behaviors, the Nurse stated, She exit seeks all day, and reported the behaviors were since admission. When asked about elopements, the Nurse reported Resident #2 had one last month when she exited the building but did not remember the specific date. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 10:13 AM, an observation was made of Resident #2 in her room. The Resident was dressed in a shirt, pants and had a hat on. The Resident was unable to answer most questions appropriately. When asked if the Resident went outside, the Resident stated, I go outside every day. When asked if she went out of the room or out of the building, the Resident did not answer then stated, I go myself. When asked if she had eaten breakfast, the Resident indicated she didn't know. When asked if she knew what time of day it was, the Resident did not answer. On [DATE] at 7:16 AM, another call was made to Nurse U and an interview was conducted regarding Resident #2's elopement out of the facility. The Nurse reported she was coming into work in her vehicle and had seen someone by the facility doors and thought it was a staff member trying to get into the building. The Nurse indicated she had parked her vehicle and went in to clock in for her shift then came back out to back into a parking space, other staff were arriving at that time. When she was parking, the headlights shined on the person she had seen when she first arrived at the facility and that person was now in the parking lot when she realized it was Resident #2. The Nurse reported that a third shift CNA was backing her car up and she was afraid they might hit the Resident, but the CNA had stopped in time. She reported she had jumped out of her car and stated, I knew who she was (Resident #2), and escorted her back into the building. The Nurse stated, She (Resident #2) was freezing, and did not have a coat on, was wearing pajamas, socks, and a hat. When she got her to the North hall, CNA HH took her to her room. The Nurse reported she had texted the Administrator and the Director of Nursing to let them know what happened. I used the numbers that were on the sheet at the nurse's station to contact them. I looked for her Nurse but could not find him. The Nurse indicated she had not talked to her Nurse after finding the Resident and that CNA HH was aware the Resident had been outside. The Nurse stated, It was bitter cold outside and she didn't have a coat or shoes on, she was in the parking lot and could have gotten hit by a car. She could have died out there. The Nurse reported the Resident had dementia and should not have been outside by herself, and stated, I looked for her Nurse, but I couldn't find him. When asked about the documentation that the Resident had attempted to leave the building, the Nurse stated, That was not the truth. She was outside in the parking lot. I seen her when I first pulled in over by the East doors but didn't know it was her until I seen her in the parking lot. The Nurse reported she had texted the Administrator at 10:09 PM on [DATE] that the Resident in (resident's room number) was outside since 8 or 9 PM and she had no WanderGuard and no shoes on. The Nurse indicated she had not got a call back from the Administrator or from the Director of Nursing that night but had talked to the Administrator about the incident on the following Monday. The Nurse stated, Her hands were the coldest, but had not done a skin assessment and indicated that Nurse BB was her Nurse that night and was aware the Resident had been outside. On [DATE] at 9:45 AM, the Administrator was asked for the investigation report for Resident #2's elopement from the facility. At 10:10 AM, an interview was conducted with the Administrator (NHA), the Director of Nursing (DON) and Corporate Nurse JJ regarding Resident #2's elopement. The investigation report included the following: Event [DATE] Description: Administrator and DNS (DON) were notified at 8:21 am of a resident leaving the building. This resident is her our (own) responsible party. Her BIMS is an 8. She was out in the parking lot around 10:00 PM when staff saw her and brought her back in the building. She was wearing PJ pants, a gown, gripper socks and a hat. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[DATE]-a head count was done, and all residents have been accounted for [DATE]- (no time indicated) a skin assessment was completed on (Resident #2) and there are no signs of bruises or skin tears or discoloration to skin observed. [DATE]- resident was placed on 72-hour charting. [DATE]-(no time indicated) Medical Director was notified [DATE]-(no time indicated) a wander evaluation was completed and a WanderGuard was placed at once, Prior to this resident triggered a low risk for elopement, and order was obtained. [DATE]- (no time indicated) All residents have had a new wander/elopement evaluation started. [DATE]- (no time indicated) a room change was done so that this resident can be in a high visible place. [DATE]- (no time indicated) the WanderGuard system was checked and is in working order, by taking a WanderGuard to each door. [DATE]- (no time indicated) care plan has been updated and once the other evaluations have been completed the other care plans will be updated as well (no date/time indicated completion) [DATE]-Resident was interviewed and said she was looking for her grandchildren and wanted to go home. [DATE]-education on elopement was started with all staff and will continue until all have been re-educated. No one will work until the education was completed. [DATE]-Resident is her own responsible party There were no witness statements that were presented to the surveyors. The NHA indicated she had notes on paper from phone calls made to staff. When asked if she had any signed witness statements, the NHA indicated she did not and only had her notes that she wrote. When asked about a timeline of events of the elopement, the NHA indicated the document given as the investigation report. The investigation report lacked documentation of Resident #2's history of behaviors of wandering and exit seeking. There was no documentation of care planning focus, goals and interventions for behaviors of wandering, exit seeking or the use of the WanderGuard. During an interview done on [DATE] at 10:10 a.m., The Administrator stated I was told she (the resident) went out the front door. She was exit seeking that day and night. Her son was at the facility that day; she was looking for Grandbabies. The timeline of events collected by the surveyors were reviewed and the investigation report lacked a definitive time of when the Resident had eloped, which door she eloped from and how long she was outside that indicated an undetermined amount of time the Resident had been outside. The NHA reported she had been told the Resident had left the building out the front door and that she had been exit seeking throughout the day and night. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235132	A. Building B. Wing	03/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Majestic Care of Flushing	540 Sunnyside Dr Flushing, MI 48433

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at approximately 10:50 a.m., prior to observation of the facility grounds, the way the resident went out and door she was brought back through, the Administrator was requested by this surveyor to activate the front door alarm. The Administrator, DON nor this surveyor could hear the alarm with the conference room door shut and when open, the alarm was barley heard. The investigation report lacked documentation that door alarms were evaluated and audible to staff. During an interview done on [DATE] at 10:10 a.m., the Administrator was asked by this surveyor if the facility had filled out a incident report regarding the elopement, was there any documentation of post elopement nursing assessment, documentation of informing the Physician and POA or a time line done of the elopement events, the answer given was no. A review of the facility policy titled, Abuse Prevention Program, revised [DATE], revealed, Our residents have the right to be free from abuse, neglect . [Collectively, hereinafter abuse] .Abuse Identification, Training and Education: .Assessing, care planning, and monitoring residents with needs and behaviors that may lead to conflict or neglect; Assessing residents with signs and symptoms of behavior problems and developing and implementing care plans to address behavioral issues .7. To help with identification of incidents of abuse, the following definitions of abuse are provided: . Adverse event-An adverse event is an untoward, undesirable, and usually unanticipated event that causes death or serious injury, or the risk thereof . Neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or mental illness . Abuse Investigations: 8. Any individual observing an incident of resident abuse or suspecting resident abuse must immediately report such incident to the Administrator or Director of Nursing or designee . 12. A completed copy of the Incident Report and written statements from witnesses, if any, must be provided to the Administrator . 16. The individual conducting the investigation will, at a minimum: Review the resident's medical record to determine events leading up to the incident; Interview the person (s) reporting the incident; Interview any witnesses to the incident; Interview the resident [as medically appropriate]; Interview the resident's Attending Physician as needed to determine the resident's current level of cognitive function and medical condition; Interview staff members [on all shifts] who have had contact with the resident during the period of the alleged incident; Interview the resident's roommate, family members, and visitors; .Review all events leading up to the alleged incident . 17. The following guidelines should be considered when conducting interviews: .Employee witnesses will be required to sign and date any witness report they make . 23. The Administrator will provide a written report of the results of all abuse investigations and appropriate action taken to the state survey and certification agency . within five working days of the reported incident . A review of the facility policy titled, Accidents and Incidents-Investigating and Reporting, revised ,d+[DATE], revealed, Policy Statement: All accidents or incidents involving residents, employees, visitors, vendors, etc., occurring on our premises shall be investigated and reported to the Administrator . 1. The Nurse Supervisor/Charge Nurse and/or the department director or supervisor shall promptly initiate and document investigation of the accident or incident . 8. Incident/Accident reports will be reviewed by the Safety Committee for trends related to accident or safety hazards in the facility and to analyze any individual resident vulnerabilities.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety 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** 37771 This Citation pertains to Intake Number MI00126544. Based on observation, interview and record review, the facility is placed in Immediate Jeopardy for its 1) Failure to accurately assess for elopement risk and assess for injury after an elopement occurred, 2) Failure to prevent an elopement,3) Failure to respond to a door alarm in a timely manner, 4) Failure to follow the elopement protocol, 5) Failure to ensure a safety care plan, and 6) Failure to ensure that door alarms were audible to staff for one resident (Resident#2) of three residents reviewed for the potential for elopement, resulting in an Immediate Jeopardy when Resident #2, who was a cognitively impaired Resident, suffered from dementia and an impaired gait, exited the building on [DATE] at night without staff knowledge for an undetermined amount of time. The Resident was dressed in a hospital gown, pants, a hat and gripper socks. The temperature outside was at or below freezing and there was snow on the ground. The Resident was observed outside the building at approximately 9:55 PM in the parking lot of the facility as staff for the oncoming shift was driving into the parking lot . Facility staff did not respond appropriately to audio alarms and did not search the perimeter of the building timely, implement effective care planning interventions for safety, prevention and monitoring, assess the Resident upon return into the building and ensure door alarms were audible to staff. This deficient practice resulted in the likelihood for serious harm, injury, and/or death. Immediate Jeopardy (IJ): The Immediate Jeopardy began on [DATE]. The Immediate Jeopardy was identified on [DATE]. The Administrator was notified of the Immediate Jeopardy on [DATE] at 3:50 PM and a plan to remove the immediacy was requested. The IJ was abated/removed on [DATE] based on the facility's implementation of the abatement/removal plan, as verified onsite on [DATE]. Findings Include: Resident #2: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of Resident #2's medical record revealed an admission on [DATE] with diagnoses that included Covid-19, syncope and collapse, muscle weakness, difficulty in walking, other symptoms and signs involving cognitive functions and awareness, glaucoma, and dementia. A review of the Minimum Data Set assessment revealed the Resident had moderately impaired cognition with a Brief Interview for Mental Status (BIMS) score of 8 and had wandering behavior that occurred 1 to 3 days. Further review of the MDS included Balance During Transitions and Walking with the Resident walking Not steady, only able to stabilize with human assistance and Surface-to-surface transfer not steady, only able to stabilize with human assistance. Further review of Resident #2's medical record revealed the following: -Progress note, Visit Type: Follow Up, dated [DATE], .Patient is alert this morning, She is in no acute distress, She is able to answer questions although unsure how accurate her responses are . Neuro: Moves all 4 extremities, alert and oriented x 1 . Unspecified dementia without behavioral disturbance: She is confused at her baseline ., author Nurse Practitioner. -Progress note, dated [DATE] at 10:29 PM, Pt (patient) was redirected by staff attempting to leave the building. Wander guard in place and functioning pt safe in bed at time of note will cont (continue) to [NAME] (monitor), author Nurse V. -Progress note, dated [DATE] at 10:18 AM, Obtained order from physician for wander guard. -Progress note, Visit Type: Telehealth, Nurse is requesting a wander guard for patient continues to wander off and is afraid she will either leave facility and/or get hurt. Wander guard order approved. Care team notified, signed date [DATE] 10:32 AM. -Wandering/Elopement Risk Scale document in Resident #2's medical record with a lock date on [DATE] revealed the Resident scored an 8 that indicated Low risk. The section History of Wandering revealed 5. Exit seeking behaviors documented and the section Diagnosis revealed, The resident has: 0. NO diagnosis of dementia/cognitive impairment; diagnosis impacting gait/mobility or strength, was indicated on the form. The response 5. Medical diagnosis of dementia/cognitive impairment; diagnosis impacting gait/mobility or strength was not indicated. -Wandering/Elopement Risk Scale, signed [DATE] at 9:37 AM, . Category: High Risk to Wander. Score: 13 . -Brief Interview for Mental Status (BIMS), dated [DATE], .Summary Score . 5 ., no author signature. -State of Michigan Probate Court . Report of Physician or Mental Health Professional, . 2. I last examined the individual on [DATE]. 3. Based on that examination and her/his medical record, the individual suffers from the following physical or psychological infirmities: CVA [stroke], cognitive impairment. 4. These infirmities interfere in the following ways with the individual's ability to receive or evaluate information in making decisions: Patient lack insight into medical decision making . 6. I believe the individual due to these described conditions, is not presently able to make informed decisions in the following areas: (all areas indicated) Determining where to live. Consenting to supportive services. Handling personal financial affairs. Authorizing or refusing medical treatment . signed by Physician MM. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the medical record revealed a lack of documentation of the elopement, skin assessment after elopement, and notification of Physician and family of the elopement. Review of Resident #2's care plan revealed a lack of Focus, Goal and Interventions for elopement and wandering or the use of a WanderGuard. On [DATE] at 12:25 PM, an observation was made of Resident #2 in her room lying on the bed. The Resident was dressed in a shirt, pants and a hat on her head. The Resident did not wake when her name was called. The Resident's lunch tray was on the bedside table, not eaten and the breakfast tray was positioned on top of the hamper and appeared to be partially consumed. On [DATE] at 12:35, an interview was conducted with Nurse W regarding Resident #2's wandering behaviors. The Nurse indicated that the Resident walked unassisted or used a wheelchair that she propelled herself, had a WanderGuard (A device on a wrist or ankle band that sounds an alarm when a resident approached or goes through a door.) on her ankle, and had exit seeking behavior of pushing on the doors to get out of the building. When asked how long the Resident had wandering and exit seeking behaviors, the Nurse stated, She exit seeks all day, and reported the behaviors were since admission. When asked about elopements, the Nurse reported Resident #2 had one last month when she exited the building but did not remember the specific date. An interview was conducted on [DATE] at 12:50 PM with Nurse X regarding Resident #2's elopement from the facility. The Nurse indicated she had gotten report from Nurse BB that Resident #2 had gotten out of the building the night before, on [DATE], on second shift (afternoon shift) but did not know the time or how long the Resident had been out. The Nurse indicated she got in report that a WanderGuard was on the resident. The Nurse stated, I wanted to visually see it. When I looked for it, it wasn't on her. When asked about one staff to resident monitoring, the Nurse indicated that in the morning, there was no staff assigned one to one and that they were not able to provide that until later in the morning when staff was available. The Nurse indicated she should have had one to one, we were just watching her, she was exit seeking. We didn't have many aides, staff wise. We kept a close eye on her until staff was enough to accompany her. The Nurse reported that the nightshift had not had the Resident with one to one staffing but when she came in to shift, the Resident was at the Nurses station with the Nurse present. When asked if she had done a skin assessment on the Resident, the Nurse stated, No I didn't do any assessments on her. I didn't notice anything different with her, and indicated the assessment would be done by the nurse after she was found outside. The Nurse indicated that documentation would include a report for the incident, skin assessment, notification of the incident to the Administrator, family, doctor and Director of Nursing. When asked what charting would be completed, the Nurse indicated a progress note would be done of what happened, how was the Resident found, who was notified and talked to, assessments, vital signs and any changes in skin. When asked about the WanderGuard, the Nurse reported she had checked the Resident and she did not have one on, did a text message to get the order for the WanderGuard placement, had not discussed the elopement with the Physician and the Resident continued to wander and exit seeking to get out of the building. When asked regarding behaviors prior to the elopement, the Nurse reported the Resident was known to wander, was confused and should not be out unattended. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 3:37 PM, an interview was conducted with Nurse BB was assigned care of Resident #2 on [DATE] and worked the 10:00 PM to 6:00 AM shift. The Nurse indicated she had gotten in report that Resident #2 had attempted to get out of the building, but Nurse V did not report she had eloped outside. The Nurse reported that after approximately two hours into the shift she heard the Resident had been out for a period of time. When asked what the weather was like that night, the Nurse indicated it was cold out and snow was on the ground. When asked if the Resident had a WanderGuard on, the Nurse reported the offgoing nurse reported she had a WanderGuard on but had not checked for one until the morning when giving report to the next shift and stated, I was told she had one on, he passed it on in report that she had one on, but she didn't have one on in the morning when I checked for it. I just assumed she had one on, and reported she had not done an assessment on the resident that night. When asked about the Resident's behaviors of wandering, the Nurse indicated she had been assigned her care a couple times before, and She usually slept through the night, but this night she was out way more. She was up with us the whole night. The Nurse reported the Resident walked unassisted and around the unit by herself. When queried if the Resident was oriented, the Nurse reported she was confused but could answer some questions. When asked if the Resident was safe to be out of the building by herself the Nurse stated, No. On [DATE] at 9:58 AM, an interview was conducted with Certified Nursing Assistant (CNA) KK, regarding recent education or in-services. The CNA indicated they had elopement in-service. When asked why the training had occurred, the CNA stated, I heard (Resident #2) got out to the parking lot. When asked about the elopement, the CNA indicated she didn't remember who had told her and that was all she had heard about it. On [DATE] at 10:13 AM, an observation was made of Resident #2 in her room. The Resident was dressed in a shirt, pants and had a hat on. The Resident was unable to answer most questions appropriately. When asked if the Resident went outside, the Resident stated, I go outside everyday. When asked if she went out of the room or out of the building, the Resident did not answer then stated, I go myself. When asked if she had eaten breakfast, the Resident indicated she didn't know. When asked if she knew what time of day it was, the Resident did not answer. On [DATE] at 10:18 AM, an interview was conducted with the Agency that employed Nurse V who was assigned care of Resident #2 on the afternoon shift on [DATE] when the Resident had eloped. Nurse V was contacted multiple times but did not answer or provide a call back to the surveyor. The Agency indicated that the facility had sent an email regarding Nurse V to not return to work at the facility with a start date on [DATE] and indicated that it did not indicate an elopement of a Resident. The Agency indicated they would attempt to contact the Nurse. On [DATE] at 12:06 PM, an interview was conducted with Nurse X regarding Resident #2's elopement from the facility. The elopement and prior interview was reviewed with the Nurse. When asked about the weather on [DATE], the Nurse indicated she remembered it had been very cold out and snowy, and that she remembered because it was her birthday weekend. When asked if the Administrator had been notified, the Nurse reported the Administrator had been in that morning, was talking to the previous nurses and had an education packet for elopement that she wanted signed. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 12:43 PM, an interview was conducted with Confidential Person GG, who wanted to remain confidential, regarding Resident #2's elopement on [DATE]. The Confidential Person reported the Resident got out on [DATE], out the front door, approximately 8:00 PM and was found in the parking lot about 10:00 PM by the next shift coming in. When questioned who had brought the Resident back in, the Confidential Person stated, (Nurse Q) brought her back in. The Confidential Person reported that it was snowy out and very cold temperatures. The Confidential Person reported that (Nurse V) was not made aware of the Resident outside the building and was not told until later. The Confidential Person reported the Administrator and the Director of Nursing were aware of the elopement but did not investigate what really happened, did not report it to the State Agency and was trying to hid it, charting was not corrected and the Doctor and family were not notified. On [DATE] at 2:17 PM, an interview was conducted with CNA HH, regarding [DATE] and Resident #2's elopement. The CNA indicated it was the end of the shift when the Resident was found and brought back into the facility by Nurse U. The CNA was asked what time they had seen the Resident and reported they had worked with another CNA to do check and change of Residents and had started about 8:00 PM and completed just after 9:00 PM and had seen Resident #2 during that time period. When asked about the Resident's behavior for wandering, the CNA reported the Resident was confused, wanders all over, they redirect her but she keeps wandering . Ever since she came (admitted into the facility) she keeps wandering. The CNA indicated the Resident walked by herself and had a slow shuffling gait. When asked if a door alarm had sounded that night, the CNA stated, The ringer was going off constantly. When asked how long the alarm was going off before they started to check for the Resident, the CNA indicated they were unsure but about five minutes. The CNA indicated they had not checked the door that was alarming and indicated they thought the Nurse had checked it and when he came back, he asked for a search for Resident #2. The CNA indicated that they had looked approximately 10 minutes before Nurse U was bringing her back in. When asked if the CNA remembered if the Resident wore a WanderGuard, the CNA reported the Resident did not have a WanderGuard on prior to the elopement. On [DATE] at 2:45 PM, an interview was conducted with Nurse Y who indicated she had worked on [DATE] when Resident #2 had eloped out of the facility. When asked regarding door alarms sounding that night, the Nurse stated, A buzzer was going off on a door. They go off all the time. The CNA's usually go check, and indicated the CNA's usually turn them off and that she did not check the door alarms that night. The Nurse reported that she had been told that Resident #2 had gotten out and was found in the parking lot. The Nurse indicated that she did not know where the Resident's Nurse (Nurse V) was at the time and had not seen him. When asked about her last elopement training or elopement drills prior to [DATE], the Nurse indicated she did not remember having any. On [DATE] at 3:30 PM, an interview was conducted with Nurse AA who indicated she had worked on [DATE] when Resident #2 had eloped out of the facility. When asked about hearing door alarms around the time the Resident had eloped, the Nurse was unsure if she had heard any door alarms and stated at the end of the shift, she was getting dressing changes completed on Residents, did not hear door alarms or respond to door alarms. The Nurse indicated the Administrator was aware because she came in the morning, at 6:00 AM, she was already there, and had us sign an in-service for missing Residents. When queried regarding the content of the in-service, the Nurse reported with door alarms, they were to do a hall sweep, check the door, check outside around the building, count the residents, call overhead. The Nurse was queried regarding previous elopement training and drills and stated, Not that I remember. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 7:08 PM, an interview on the phone was conducted with CNA II who indicated she had worked the night Resident #2 had eloped from the facility. The CNA reported that she was with other CNAs at the end of the shift taking out the garbage and when they got back to the unit the front door was alarming. The CNA was unsure how long the alarm had been going off and she had gone to check the door with Nurse V checking the door at the same time. The CNA stated she had turned the alarm off and had looked outside the door with the Nurse but did not see anyone. The CNA reported they did not go out and circle the building but had come back inside and went to the unit. The CNA reported that the Nurse had asked where Resident #2 was and they determined she was not on the unit or in her room. The Nurse left and the CNAs started to look for the Resident for approximately 15 minutes when the Resident had returned with Nurse U. The CNA indicated the Resident had non-skid socks on and that it was cold, snowy and dark outside. When queried when she had last seen the Resident, the CNA stated Between 9 and 9:30 at night. The CNA was asked what the Nurse had been doing when they went to take the trash out and indicated she thought he was passing medications. The CNA indicated that in the beginning of the shift, Resident #2 had been looking for her son and trying to go home to babysit the grand kids. The CNA reported that when she saw the Resident with Nurse U, the Nurse had her her arm around her and rubbing her and stated, I remember her rubbing her like she might have been cold. On [DATE] at 7:16 AM, another call was made to Nurse U and an interview was conducted regarding Resident #2's elopement out of the facility. The Nurse reported she was coming into work in her vehicle and had seen someone by the facility doors and thought it was a staff member trying to get into the building. The Nurse indicated she had parked her vehicle and went in to clock in for her shift then came back out to back into a parking space, other staff were arriving at that time. When she was parking, the headlights shined on the person she had seen when she first arrived at the facility and that person was now in the parking lot when she realized it was Resident #2. The Nurse reported that a third shift CNA was backing her car up and she was afraid they might hit the Resident but the CNA had stopped in time. She reported she had jumped out of her car and stated, I knew who she was (Resident #2), and escorted her back into the building. The Nurse stated, She (Resident #2) was freezing, and did not have a coat on, was wearing pajamas, socks and a hat. When she got her to the North hall, CNA HH took her to her room. The Nurse reported she had texted the Administrator and the Director of Nursing to let them know what happened. I used the numbers that were on the sheet at the nurse's station to contact them. I looked for her Nurse but could not find him. The Nurse indicated she had not talked to her Nurse after finding the Resident and that CNA HH was aware the Resident had been outside. The Nurse stated, It was bitter cold outside and she didn't have a coat or shoes on, she was in the parking lot and could have gotten hit by a car. She could have died out there. The Nurse reported the Resident had dementia and should not have been outside by herself, and stated, I looked for her Nurse but I couldn't find him. When asked about the documentation that the Resident had attempted to leave the building, the Nurse stated, That was not the truth. She was outside in the parking lot. I seen her when I first pulled in over by the East doors but didn't know it was her until I seen her in the parking lot. The Nurse reported she had texted the Administrator at 10:09 PM on [DATE] that the Resident in (resident's room number) was outside since 8 or 9 PM and she had no WanderGuard and no shoes on. The Nurse indicated she had not got a call back from the Administrator or from the Director of Nursing that night, but had talked to the Administrator about the incident on the following Monday. The Nurse stated, Her hands were the coldest, but had not done a skin assessment and indicated that Nurse BB was her Nurse that night and was aware the Resident had been outside. On [DATE] at 9:45 AM, the Administrator was asked for the investigation report for Resident #2's elopement from the facility. At 10:10 AM, an interview was conducted with the Administrator (NHA), the Director of Nursing (DON) and Corporate Nurse JJ regarding Resident #2's elopement. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The investigation report included the following: Description: Administrator and DNS (DON) were notified at 8:21 am of a resident leaving the building. This resident is her our (own) responsible party. Her BIMS is an 8. She was out in the parking lot around 10:00 pm when staff saw her and brought her back in the building. She was wearing PJ pants, a gown, gripper socks and a hat. [DATE]-a head count was done, and all residents have been accounted for [DATE]- (no time indicated) a skin assessment was completed on (Resident #2) and there are no signs of bruises or skin tears or discoloration to skin observed. [DATE]- resident was placed on 72-hour charting. [DATE]-(no time indicated) Medical Director was notified [DATE]-(no time indicated) a wander evaluation was completed and a WanderGuard was placed at once, Prior to this resident triggered a low risk for elopement, and order was obtained. [DATE]- (no time indicated) All residents have had a new wander/elopement evaluation started. [DATE]- (no time indicated) a room change was done so that this resident can be in a high visible place. [DATE]- (no time indicated) the WanderGuard system was checked and is in working order, by taking a WanderGuard to each door. [DATE]- (no time indicated) care plan has been updated and once the other evaluations have been completed the other care plans will be updated as well (no date/time indicated completion) [DATE]-Resident was interviewed and said she was looking for her grandchildren and wanted to go home. During an interview done on [DATE] at 10:10 a.m., The Administrator stated I was told she (the resident) went out the front door. She was exit seeking that day and night. Her son was at the facility that day; she was looking for grandbabies. During an interview done on [DATE] at 10:10 a.m., the Administrator stated, I was notified by the DON (Director of Nursing). I did speak with (Nurse, LPN U), she said there was no alarm sounding at the front door; (Nurse U) was coming in (coming into work)and saw her. The Nurse (Nurse, LPN V) said at 9:45 p.m. his meds (medication pass) was done; he heard the door alarm, he didn't know when the alarm went off. I talked with (Nurse, LPN V) on Sunday, he went to the front of the building and went out driving around (looking for the resident). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235132	A. Building B. Wing	03/10/2022

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Majestic Care of Flushing	540 Sunnyside Dr Flushing, MI 48433

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview done on [DATE] at 10:10 a.m., the Director of Nursing/DON stated I got a text message at about 10:30 p.m. that night. I got it off my phone in the AM and called the Administrator. We educated (staff) about giving us phone calls, not text messages. I called the facility to make sure she was safe. The nurse (Nurse, LPN U) was gone by then (went home); they needed to do a head count. At 10:12 a.m. on [DATE], we got an order from the doctor for a wander alarm and moved her closer to the nurses station. A review of Resident #2's care plan revealed a lack of a safety care plan and lack of a wandering/elopement care plan in the medical record. When asked about the lack of care plans the DON and NHA did not have an answer. A review of the medical record revealed a lack of skin assessment completed after the elopement. The NHA indicated she thought that one had been done and was unsure why it was not in the medical record. The timeline of events, collected by the surveyors, were reviewed and the investigation report lacked a definitive time of when the Resident had eloped, which door she eloped from and how long she was outside that indicated an undetermined amount of time the Resident had been outside. The NHA reported she had been told the Resident had left the building out the front door and that she had been exit seeking throughout the day and night. The Wandering/Elopement Risk Scale document in Resident #2's medical record with a lock date on [DATE] revealed the Resident scored an 8 that indicated Low risk. The section History of Wandering revealed 5. Exit seeking behaviors documented and the section Diagnosis revealed, The resident has: 0. NO diagnosis of dementia/cognitive impairment; diagnosis impacting gait/mobility or strength, was indicated on the form. The response 5. Medical diagnosis of dementia/cognitive impairment; diagnosis impacting gait/mobility or strength was not documented. The Resident's diagnoses that included syncope and collapse, muscle weakness, difficulty in walking, other symptom and signs involving cognitive functions and awareness, and dementia was reviewed with the NHA, Corporate Nurse and DON. The Wandering/Elopement Risk Scale was not documented correctly, if the diagnosis section was documented correctly, the score would be 13, with the scoring of 11-above High Risk For Elopement. The NHA and DON did not have a comment regarding the inaccurate Wandering/Elopement Risk Scale document. The progress note, dated [DATE] at 10:29 PM, revealed, Pt was redirected by staff attempting to leave the building. Wander guard in place and functioning pt safe in bed at time of note will cont to [NAME], author Nurse V, was reviewed with the NHA, Corporate Nurse and DON. When queried why the documentation was not correct, the Corporate Nurse stated, He should have written accurate information. When queried why the Nurse was not asked to come in to make correct documentation, the NHA indicated the Nurse was a DNR and was not to return to the facility. The NHA was questioned why Administration did not ensure accurate account of the incident in the medical record, the NHA did not have an answer. The lack of documentation that the Physician and family was notified of the elopement was reviewed. The NHA indicated that the Physician was notified when they got the order for the WanderGuard and stated, The Resident was her own responsible party. The NHA was asked where the rational for the WanderGuard was and did not have an answer. When queried why the elopement was not reported to the State Agency, the NHA indicated the Resident was her own responsible party and stated, We have the right to make bad decisions. When asked who she indicated was making bad decisions, the NHA stated, The Resident made the bad decision of leaving. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at approximately 10:50 a.m., Prior to observation of the facility grounds, the way the resident went out and door she was brought back through, the Administrator was requested by this surveyor to activate the front door alarm. The Administrator, DON nor this surveyor could hear the alarm with the conference room door shut and when open, the alarm was barley heard. Observation of the outside of the facility: Observation done on [DATE] at approximately 12:10 p.m., of the outside route the resident took when she eloped. Done with Corporate Nurse, RN JJ, Administrator, DON and two surveyors. This surveyor and the above persons left the building through the front alarmed door. The front door did alarm, however it was hard to hear from a distance or when unit hallway doors were shut. The alarm went off, but staff did not immediately respond to the alarm. Observation of the facility outside sidewalk and parking lot was done. Loose gravel/stone and broken cement was on both sides of the sidewalk. Several areas of large broken off pieces of cement was noted on the driveway side of the sidewalk. The sidewalk was uneven, and several potholes were observed in the driveway. The driveway was connected to the residential road and a school was directly across from the facility; the speed limit was 25 miles an hour in the road. At the point where the sidewalk turned to the right to go to the back of the facility, there was a very large [NAME] on the ground (trip hazard). There were several uneven drains in the parking lot noted. Corporate Nurse JJ measured the distance from the facility front door to the back door were (Nurse U) brought the resident back into the facility. Two ways were measured, the greatest distance was 359 feet and the least distance was 156 feet. Activation of the East Door on [DATE]: On [DATE] at 12:20 p.m., the Administrator, Corporate Nurse JJ and two surveyors opened the East Door, activating the door alarm. A short hallway from the door lead to the Central Unit main hallway. Nursing Assistant K was in the Central Hall passing meal trays at the time and did not go and answer the door alarm. During an interview done on [DATE] at 12:30 p.m., CNA K was asked by this surveyor if she had heard the door alarm and she stated, I didn't hear it. CNA K was approximately 70 feet from the activated door alarm at the time. The facility door alarms were not loud enough to be heard by staff. On [DATE] at 1:30 PM, an interview was conducted with the NHA regarding elopement drills. The NHA presented elopement drills for first shift on [DATE] at 12:,d+[DATE]:10 PM, second shift on [DATE] at 2:, d+[DATE]:06 and third shift on [DATE] at 5:00 AM to 5:20 AM. There were no elopement drills presented that were done prior to Resident #2's elopement from the facility. When queried regarding the lack of elopement drills, the NHA reported that according to Maintenance, Nursing would do the elopement drills, and indicated there was no documentation on the drills being completed. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 3:03 PM, an interview was conducted with Nurse V regarding Resident #2's elopement from the facility on [DATE]. The Nurse reported that on [DATE], he was passing medication at the end of his shift and indicated the time was approximately 9:55 PM. The Nurse indicated that he was in a Resident's room and when he came out of the room, he realized a door alarm was sounding and had gone to the panel at the Nurses' station to determine which door was sounding, went to the door where CNA II was approaching, the CNA turned off the alarm and he had gone out the door to look but did not see anyone and returned into the building. Upon coming back to the Unit, he realized Resident #2 was not in her room. The Nurse left the Unit and went through the building to where he had parked his car and proceeded to look for the Resident by driving around the building. The Nurse was asked if he or the CNA had done a full sweep of the building grounds when first approaching the alarmed door. The Nurse reported they did not, but went through the building to get his car. The Nurse reported that when he came back to the Unit, the Resident was in bed. The Nurse stated, No one told me she had gotten out of the building. I didn't know that until I talked to the Administrator the next day. The Nurse indicated that the Nurse who found the Resident out in the parking lot had not talked to him regarding finding

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22347 This Citation pertains to Intake MI00126938. Based on observation, interview and record review, the facility failed to ensure that two of two reviewed resident's (Residents #5 and Resident #6), who received tube feedings, had the head of the bed at a 30-to-35 degree angle while the feedings were running, resulting in the likelihood of aspiration pneumonia, hospitalization and antibiotic therapy. Findings Include: Resident #5: Review of the Face Sheet, Minimum Data Set (MDS, assessment tool) dated 3/22, Physician orders dated 3/7/22, Nursing and Physician progress notes dated 3/7/22 through 3/9/22, revealed Resident #5 was [AGE] years-old, admitted to the facility on [DATE] (after hospitalization), was dependent on staff for all Activities of Daily Living (ADL's) and had decreased cognitive ability and was not able to make own decisions. The resident's diagnosis included, Chronic Subdural Hemorrhage (brain bleed), high blood pressure, Dementia, Dysphagia (difficulty swallowing) and had a feeding tube in place for nutrition and hydration. Review of the Physician order dated 3/7/22, revealed Resident #5 was ordered Nepro 1.8 tube feeding formula at a rate of 15 ml's per hour using a feeding pump. The resident was nothing by mouth (NPO, no oral nutrition or hydration). Review of the residents Feeding care plan dated 4/2/21 (prior to being transferred to the hospital), stated Elevate head 30-45 degrees (raise the head of the bed while tube feeding running). Observation made on 3/9/22 at 9:08 a.m., revealed Resident #5 laying almost flat in her bed with her eyes closed. The residents feeding was running at 15 ml's per hour and her bed was observed to be at a 10 degree elevated. During an interview done on 3/9/22 at 9:10 a.m., Physical Therapist/PT T said he had raised the resident's head of her bed to a 30 degree angle as this survey went to get a therapist to measure the angle of the head of the bed. PT T stated, I just put her bed up, it was almost flat. PT T said the bed should not have been less then 30 degrees with the feeding running. During an interview done on 3/9/22 at 9:11 a.m., Nursing Assistant/CNA K who was in the resident's room at the time, stated the bed should be up (when feeding is running). During an interview done on 3/9/22 at 9:12 a.m., CNA U stated It (the residents head of the bed) should be at a higher angel, when feeding was running. Resident #6 (continued on next page)

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	235132	A. Building B. Wing	03/10/2022

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Face Sheet, MDS dated ,d+[DATE], Physician orders and progress notes dated 1/22 through 3/22, and Nursing note's dated 3/22, revealed Resident #6 was a [AGE] year-old, admitted to the facility on [DATE], was totally dependent on staff for all ADL's with decreased cognition. The resident's diagnosis included, Vascular Dementia, Stroke, Heart Failure, Dysphagia (difficulties with swallowing) and had a feeding tube placed for nutrition and hydration. The resident received Hospice services. Review of the Physician order dated 2/15/22, revealed the resident received Jevity 1.5 at 60 ml's an hour per feeding pump. Review of the residents Feeding care plan dated 8/17/20, stated Elevate head 30-45 degrees. Observation made on 3/7/22 at 8:50 a.m., revealed Resident #6's tube feeding was funning at 60 ml's and the head of the bed was 10 degrees. On 3/7/22 at 9:00 a.m., Occupational Therapist/OT H was asked by this surveyor to measure the residents head of his bed; she got a 10 degree angle and stated, It should be at least 30 (degrees). At the time, the residents tube feeding was running at 80 ml's an hour. During an interview done on 3/9/22 at approximately 1:00 p.m., the Director of Nursing was asked by this surveyor what degree angel should the head of the bed be when tube feeding is running and she stated, at least a 30 degree angle. Review of the facility Enteral Nutrition policy dated 11/2018, stated Head of bed elevation (30 to 35 degree elevation),Risk of aspiration, Improper positioning of the resident during feeding.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39083 Based on observation, interview, and record review, the facility failed to maintain a sanitary kitchen and sanitary food contact surfaces resulting in the potential contamination of equipment and food supply. These deficient practices affect all residents who consume food from the kitchen. Findings Include: On 3/10/22 at approximately 9:00 AM to 11:00 AM, the following observations were made in the kitchen: -The waste disposal basin near the dish machine was observed to be clogged and backed up to the flood level rim. The waste disposal was observed to be leaking water on to the floor. Furthermore, the floor tile grout underneath the leaking waste disposal was observed to be worn away, allowing water to collect in the formed tile spacing. According to the 2013 FDA Food Code Section 5-205.15 System Maintained in Good Repair. A PLUMBING SYSTEM shall be: (A) Repaired according to LAW; P and (B) Maintained in good repair. -The air diffuser near the dish washing area was observed to be caked in dust. The air diffuser was directly over clean dishware. According to the 2013 FDA Food Code Section 6-501.12 Cleaning, Frequency and Restrictions. (A) PHYSICAL FACILITIES shall be cleaned as often as necessary to keep them clean. -A package of fish was observed to be stored on the floor of the walk-in freezer. The floor was observed to be soiled with food debris, such as broccoli. According to the 2013 FDA Food Code Section 3-305.11 Food Storage. (A) Except as specified in (B) and (C) of this section, FOOD shall be protected from contamination by storing the FOOD: (1) In a clean, dry location; (2) Where it is not exposed to splash, dust, or other contamination; and (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	(3) At least 15 cm (6 inches) above the floor . -The soap dispenser at the hand sink, located next to the cook line, was observed to not be mounted on the wall, making it difficult to dispense soap to properly wash hands. Additionally, paper towels were not provided at the paper towel dispenser. -The refrigerator dedicated to resident food was observed to have multiple food items that did not contain a resident label or expiration date. Additionally, the refrigerator gasket was observed to be in poor repair. During an interview on 3/10/22 at 1:49 PM, Dietary Manager OO stated that they resumed normal operations in their regular kitchen on 2/22/22 after [cleaning company] cleaned the kitchen of construction debris after work was done on the floor tile and plumbing drains. Dietary Manager OO continued to say that they had to re-sanitize counters and dishware after the fog/disinfect from [cleaning company] because it left a residue. A review of the [cleaning company] invoice, service date 2/22/2022, the work description noted, Clean all tile in the kitchen . Wipe and disinfect all walls . Wipe down and disinfect counters, sinks, appliances, dishes, carts . Fog/disinfect kitchen . Move of content for cleaning and disinfecting . Power wash walls and appliances . On 3/10/22 at 1:55 PM, during an observation of the cookline, Dietary Manager OO stated that the tilt skillet was not currently working and hasn't been used recently. At this time, the interior of the tilt skillet was observed to have dried encrusted food and grease deposits covering the entire bottom surface. According to the 2013 FDA Food Code Section 6-501.114 Maintaining Premises, Unnecessary Items and Litter. The PREMISES shall be free of: (A) Items that are unnecessary to the operation or maintenance of the establishment such as EQUIPMENT that is nonfunctional or no longer used; and (B) Litter. On 3/10/22 at 1:58 PM, the interior surfaces of the commercial oven were observed to have excessive grease deposits and carbon build-up. Dietary Manager OO stated that the oven is currently used as cooking equipment for food. According to the 2013 FDA Food Code Section 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. Pf (B) The FOOD-CONTACT SURFACES of cooking EQUIPMENT and pans shall be kept free of encrusted grease deposits and other soil accumulations. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	(C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris. On 3/10/22 at 2:06 PM, a wall mounted hose, located near the dish machine room, was observed to not be provided with a backflow protection device to preclude contaminated liquids from entering the potable water supply system. According to the 2013 FDA Food Code Section 5-203.14 Backflow Prevention Device, When Required. A PLUMBING SYSTEM shall be installed to preclude backflow of a solid, liquid, or gas contaminant into the water supply system at each point of use at the FOOD ESTABLISHMENT, including on a hose [NAME] if a hose is attached or on a hose [NAME] if a hose is not attached and backflow prevention is required by LAW, by: (A)Providing an air gap as specified under S 5-202.13 P; or (B) Installing an APPROVED backflow prevention device as specified under S 5-202.14. P On 3/10/22 at 2:09 PM, an accumulation of dust was observed on the stainless-steel table surface, where the coffee machine is stored. At this time, Dietary Manager OO stated that all the surfaces of equipment were wiped down after the [cleaning company] did the fog/disinfect and that the dust was just normal accumulation. On 3/10/22 at 2:11 PM, food debris accumulation was observed on the preparation table by the microwave. On 3/10/22 at 2:12 PM, multiple ants were observed behind the oven on the floor. At this time, soil and food debris were observed on the floor behind the oven. On 3/10/22 at 2:18 PM, the walk-in cooler fan grids were observed to be accumulating dust. Additionally, the floor was observed to have food debris and dried spills. The threshold at the door to the walk-in freezer was observed to have a 1 inch gap on the floor that was accumulating wet food debris that extended to the length of the threshold. On 3/10/22 at 2:20 PM, the floor of the dry storage room was observed to be accumulating food debris, such as noodles, lentils, grains, and food wrappers. On 3/10/22 at 2:22 PM, multiple ants were observed on the floor underneath the two compartment sink. At this time, Dietary Manager OO stated that they were unaware that there were ants in the kitchen. According to the 2013 FDA Food Code Section 6-501.111 Controlling Pests. The PREMISES shall be maintained free of insects, rodents, and other pests. The presence of insects, rodents, and other pests shall be controlled to eliminate their presence on the PREMISES by: (A) Routinely inspecting incoming shipments of FOOD and supplies; (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	(B) Routinely inspecting the PREMISES for evidence of pests; (C) Using methods, if pests are found, such as trapping devices or other means of pest control as specified under SS 7-202.12, 7-206.12, and 7-206.13; Pf and (D) Eliminating harborage conditions. 37771 On 3/10/22 at 12:45 PM, an observation was made of the dry storage area of the kitchen. The floor of the dry storage area was littered with food debris, packaging debris and spills on the floor and walls underneath the shelving units. There was red sauce by the door and on the ceiling tiles. Behind the door was debris of flaking white substance and the trim was coming off the wall near the base of the wall with paint and drywall material. The wall had black substance underneath where the trim was pulled away from the wall. The mop room that was located near the dry storage area had a hole in the wall near the base that was open and the space in the wall was visible. On 3/10/22 at 1:00 PM, an observation was made in the kitchen area with the Administrator and the Dietary Manager OO. The juice machine had brown liquid in the dispenser. The box of juice indicated it was Orange Blend 100% but was brown in color. The juice dispenser was set up to dispense the juice. The Administrator dispensed some of the juice into a cup and the smell was rancid. The Dietary Manager reported that they were using other containers for orange juice. The Dietary Manager retrieved another box of juice of Orange Blend that was orange in color. The Administrator indicated to not use the juice dispenser.

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F 0888 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure staff are vaccinated for COVID-19 22347 Based on observation, interview and record review, the facility 1) Failed to ensure that 3 of 3 reviewed employees (Nurse, RN R, Admission Director J & Housekeeper M) with COVID-19 vaccine exemptions were tested for COVID-19 per policy (daily), 2) Failed to ensure that 1 employee (Housekeeper I) had documentation of COVID-19 vaccination status or of an exemption, and 3) Failed to ensure that 1 employee (Housekeeper M) of 3 reviewed employees with COVID-19 exemptions followed facility policy and staff exemption guidelines regarding wearing a N95 facial mask while in the facility, resulting in the high likelihood for the spread of COVID-19 to residents, visitors and staff members. Findings Include: Review of employee's Admission Director J's and Nurse, RN R's facility corporate COVID-19 exemption forms dated 2/18/22 and 2/24/22, revealed the employees had been granted a non-medical exemption. Review of the exemptions dated 2/18/22 and 2/24/22, stated You informed (facility) your request for a (non-medical exemption) for the COVID-19 vaccine. Part of the exemption process is reviewing the details of your request. Based on the Covid Vaccination Policy, all care team members approved for this accommodation/exemption will be required to follow the policy by: -Daily Covid test prior to the start of shift. -Require wearing full PPE (personal protective equipment) at all times, including face shield and N95 Respirator. An interview was done on 3/8/22 at 2:30 p.m., with Housekeeper M accompanied by the Director of Nursing/DON and Housekeeping Director N. Housekeeper M came in the room to be interviewed with a surgical mask over her mouth only; she had pulled it down off her nose. When this surveyor asked her if she was working (on 3/8/22), she said yes. When this surveyor asked her why she did not have a N95 mask on, she stated, I can't breathe with it on when I 'am mopping and vacuuming. Housekeeper M got very up-set when questioned and said she was being picked on; the DON and this surveyor had to calm her down to continue the interview. Housekeeper M stated I got a medical exemption about one and a half months ago; I work on the floor. Housekeeper M said she worked on the Assisted Living side and on the Long Term Care side of the facility as a housekeeper. Housekeeper M said she was tested on ce a week, we do it once a week, the COVID-19 test; it was every day when there was an outbreak. Housekeeper M was not testing for COVID-19 daily and she was not wearing a N95 mask while on the Long Term Care side of the building. During an interview done on 3/8/22 at 1:40 p.m., the Director of Housekeeping N denied having documentation of Housekeeper I's COVID-19 vaccination status in house, or of an exemption. After several requests made, this surveyor was not given any exemption documentation for Housekeeper I, therefore this employee had no exemption documentation and no COVID-19 vaccine documentation; the facility was not in compliance with the COVID-19 vaccination rate. Review of the facility Point of Care Testing Results for employees Housekeeper M, Nurse, RN R and Admission Director J, revealed the following: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235132	A. Building B. Wing	03/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Majestic Care of Flushing	540 Sunnyside Dr Flushing, MI 48433

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 0888 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Admission Director J had been in the facility on 2/28/22 for all day orientation without being tested for COVID-19. During an interview done on 3/8/22 at 2:00 p.m., Admission Director J said she sat in the facility all day doing orientation on 2/28/22, no COVID-19 test had been done that day by the facility. Admission Director J's non-medical exemption was dated 2/18/22. -Nurse RN R worked on the North Unit for the entire shift on 3/4/22, and she did not have a COVID-19 test done prior to her shift. Nurse R tested positive for COVID-19 two days later. During a phone interview done on 3/8/22 at approximately 3:20 p.m., Nurse R stated I asked someone, I don't remember who what I was supposed to do. It was my first day I was confused; on the morning of the 6th (3/6/22) I tested positive. Nurse R said she did have an exemption and knew she was supposed to be tested daily prior to her shift. Nurse R's facility non-medical exemption was dated 2/24/22. During an interview done on 3/8/22 at 12:00 p.m., the DON said everyone who had an exemption was required to wear a face shield and N95 mask, have exemption documentation and be tested for COVID-19 daily. The DON said there was no in house Infection Control Nurse at the facility, no one person was monitoring and tracking COVID-19 exemption staff and data. During a phone interview done on 3/8/22 at 12:50 p.m., Corporate Nurse O said she was sick and unable to cover at the facility as an Infection Control Nurse. Corporate Nurse RN O stated, Corporate is making exemptions, they are having a corporate person until they can decide (a full time Infection Control Nurse, the prior IC nurse had quit). I am sick, so I couldn't come, I am regional, so I am responsible. Review of the facility Mandatory COVID-19 Vaccination's policy dated 9/21, stated Requirements upon receiving exception (exemption): If an exception is granted the Care Team Member will be required to wear a N-95 respirator and a full-face shield at all times while in the facility and/or within 6 feet of any Care Team Member (i.e: meal breaks). In addition, the Care Team Member will be required to test daily for COVID-19 prior to the start of their scheduled shift.