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	05/04/2023

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22347 Based on observation, interview and record review, the facility failed to ensure residents' dignity by 1) Not ensuring staff assisted 2 residents with the noon meal (Resident's #30 and Resident #45), 2) Not offering drinks and/or food while 6 residents were waiting to be served the noon meal in the main dining room, 3) Not serving the correct monthly menu, 4) Not answering call lights in a timely manner for 4 residents (Resident #14, Resident #25, Resident #29 and Resident #30), and 5) Complaints regarding food preferences not being honored for 4 of 8 residents in the the confidential Resident Council meeting of a total of 20 residents reviewed for dignity, resulting in the likelihood for weight loss, anger, shame, embarrassment, and isolation with decreased socialization. Findings Include: Review of the facility Dignity policy dated 3/23, reported It is the practice of this facility to protect and promote residents rights and teat each resident with respect and dignity as well as care for each resident in a manner and in an environment, that maintains or enhances resident's quality of life by recognizing each resident's individuality. Call Lights and Food Assistance: Resident #14: Review of the face Sheet, MDS dated [DATE] and diagnosis sheet, revealed Resident #14 was [AGE] years-old, admitted to the facility on [DATE], dependent on staff for all activities of daily living. The resident's diagnosis included, respiratory failure, diabetes, Depressive Disorder, Anxiety, Restless Leg Syndrome, high blood pressure and embolism and thrombosis of arteries of the lower extremities. The resident had a artificial breathing tube (trach) and was a full code. Review of the MDS cognitive assessment dated [DATE], revealed the resident was alert and able to make her own healthcare decisions. During an interview done on 4/25/23 at 12:48 a.m., Resident #14 said staff take over an hour to answer her call light and stated, I had wet myself because they don't answer my call light. I get angry, there is nothing much I can do, I can tell the nurse. I cough so, so much and they won't come, it's scary. It has been up to 2 hours to get them to answer my light. I have had accidents and I get angry with them. It depends on who is working, how long it takes to answer my light. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #29: Review of the Face Sheet, MDS dated ,d+[DATE], and care plans dated 2019 revealed, Resident #29 was [AGE] years-old, alert, and able to make her own healthcare decisions, admitted to the facility on [DATE], had a tracheostomy, and dependent on staff for Activities of Daily Living. The resident's diagnosis included, chronic respiratory failure, diabetes, depression, tracheostomy, muscle weakness, stenosis of the larynx and high blood pressure. Review of the MDS dated ,d+[DATE], revealed the resident was alert and able to make her own healthcare decisions. During an interview done on 5/3/23 at 9:40 a.m., Resident #29 stated It takes them a long time to answer my call light, depends on who is working; about an hour sometimes. Resident #30: Review of the Face Sheet, Minimum Data Set (MDS, dated [DATE]), and diagnosis sheet revealed Resident #30 was [AGE] years-old, admitted to the facility on [DATE], alert and dependent on staff for all Activities of Daily Living including food set-up. The resident's diagnosis included, stroke, diabetes, heart disease, chronic kidney, heart failure, spastic hemiplegia of the left side (required assistance with cutting foods up), anxiety and major depression. Review of the resident's cognitive assessment dated [DATE], revealed he was alert and able to make his own healthcare decisions. Observation made on 4/25/23 at approximately 1:00 p.m., revealed Resident #30 was in room in bed. The resident had a chicken breast on his lunch plate, and it was not eaten. When this surveyor asked him why he had not eaten his chicken he stated, I can't use my left arm, and no one cut it up for me. The resident verbalized he wanted to eat the chicken, but was unable to cut it up to eat; no one set-up his meal tray for him when they delivered his tray. Resident #45: Review the Face Sheet, Minimum Data Set (MDS, dated [DATE]), care plans dated 1/24/23 through 4/27/23, revealed Resident #45 was [AGE] years-old, admitted to the facility on [DATE], was alert and making her own healthcare decisions, required staff assistance with all Activities of Daily Living and was blind in right and left eyes. The resident's diagnosis included, Right and Left eye blindness (category 5, only see's close-up shadows), glaucoma secondary to eye disorder, stroke, high blood pressure, chronic heart and lung disease, diabetes, chronic kidney disease, difficulty walking, epilepsy, and muscle weakness. During a second interview done on 5/3/23 at 8:40 a.m., Resident #45 was observed sitting on her bed with her breakfast tray in front of her and it had not been set-up for her. The resident stated They did not set-up my breakfast today. She (staff) took the top off and ran out of the room so fast I couldn't tell her anything. I had to go to the bathroom and now my food is cold because she took the top. It still takes them forever to answer my light, about 45 minutes to an hour. I have had accidents and I get hurt and angry. It takes them over an hour to answer my light, there are no staff. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility Call Lights: Accessibility and Timely Response policy (un-dated), reported The purpose of this policy is to assure the facility is adequately equipped with a call light at each resident's bedside, toilet, and bathing facility to allow residents to call for assistance. Call lights will directly relay to a staff member or centralized location to ensure appropriate response. This policy does not address an appropriate approved time response. During an interview done on 5/2/23 at 3:23 p.m., the Administrator said 30 minutes was appropriate for staff to answer resident's call light's. During the interview done on 5/2/23 at 3:25 p.m., the Director of Nursing stated 3 to 5 minutes is appropriate for staff to answer resident's call lights. Main Dining Observation: On 4/25/23 at 12:00 p.m., 6 residents were observed sitting in the main dining room at tables waiting for their noon meal trays to arrive. 6 of 6 residents did not have any drinks or snacks at all while waiting. No coffee, drinks, or snacks were observed in the main dining room or in the dining room kitchenette. During an interview done on 5/2/23 at 11:55 a.m., Activity Aide P stated I don't know why they don't have drinks or coffee before meals. During an interview done on 5/2/23 at 12:00 p.m., Director of Activities Q stated Last week there was a lot of confusion with the kitchen staff, that's why we didn't have drinks. Inaccurate Facility Food Menu: Observation made on 4/25/23 at the noon meal, Resident's #30 and #45 both had chicken breast on their food tray's. Observation of the menu dated Week 1 revealed on 4/25/23, Marinated chicken, Sugar Snap Peas, Potatoes and Dinner Roll/bread, Chocolate Chip cookie, were to be served. Resident's #30 and #45, did not have snap peas, a dinner roll or chocolate chip cookies on their tray's. Review of the facility daily menu for 4/26/23's noon meal reported Meatloaf, Honey Roasted Carrots, Mashed Potatoes, Poppy Seed Dinner Roll (and) Lemon Bar. During a test tray gotten on 4/26/23, the noon meal the surveyor team was served had meatloaf, potatoes, and lemon bar. The tray was missing a vegetable and the poppy seed roll. 22927 Confidential Resident Council Meeting: (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interviews on 04/26/23 at 09:52 AM had eight residents and a few stragglers that entered once meeting started. Subjects included meals/food items: Most of the residents consensus was that the facility staff take the resident order and when the tray comes it is not what they ordered, and that the 'My Choice Menu' a form a resident choose from alternate menu items do not get taken to the residents rooms for them to choose from. Residents in attendance stated that most meals have bread or pasta, the food just does not taste right, over cooked. It is not what they order, they just give you what they cook, you get what you get, the foods cold, not what is on the menu. We get mostly sandwiches for dinner. When asked about the substitution menu the consensus was of the group was: Yes, we have one, but they do not bring us the choice menu sheets to fill out. Respect & Dignity? The aides talk about their personal lives while doing our care, and they talk about short staffing issue, and some staff use their phones in our rooms. The Confidential Resident Council group were asked about the courtesy and respect shown by staff members to residents and seven out of 8 Residents voiced concerns of not enough staff, and that weekend staff is the worst. Residents in the group revealed the facility have call-ins all the time and then pull staff members from a resident care unit the residents end up with one aide and a nurse during the day and afternoon shifts, because they call in and they do not replace the staff member with someone else. The surveyor asked if this effects the care they receive and call light response time? One resident stated that the staff come into the room and shut the call light off and say they will come back, but they do not, so the resident will have to put the light back on. Another resident revealed that the staff tell me that they do not have enough staff to get him up and that they have had bowel accidents in their briefs. 37668 Resident #250: (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/26/23 at 10:10 AM, Resident #250 was observed in their room sitting in their wheelchair. A significant amount of facial hair was present on the Resident's face including long hairs on their chin. An interview was completed at this time. Resident #250 was alert, pleasant, and oriented to person, place, time and situation. When queried, Resident #250 revealed they came to the facility from the hospital after they fell and fractured their hip. When queried regarding the care they were receiving at the facility, Resident #250 did not respond verbally but shrugged their shoulders. When queried what they meant, Resident #250 conveyed they did not want to cause any trouble. When queried how much assistance they require to get out of bed, Resident #250 indicated they were getting therapy but could not get out of bed without staff assistance. When Resident #250 was queried regarding their bowel and bladder elimination and if they knew when they had to go to the bathroom and stated, Yes. When asked if facility staff assist them to get up to use the toilet. Resident #250 replied, No. When asked why staff did not assist them, Resident #250 replied, They just don't. I have to wear a pad (brief). When asked if they wore pad/briefs prior to coming to the facility, Resident #250 verbalized they were using the bathroom at home. When queried if they put on their call light when they needed to use the restroom, Resident #250 revealed they did when they could find/reach it. Resident #250 was asked approximately how long, on average, it took for staff to respond to their call light and replied, Approximately one hour to never. When asked what never meant, Resident #250 revealed that some staff would come in, shut off the light without providing care, and never come back. Resident #250 proceeded to express they did not like having to go (urinate) in their pad (brief). When asked how that made them feel, Resident #250 stated, It makes me feel horrible. When asked if staff had offered them assistance to use the bathroom, Resident #250 revealed they had not and just put them in a diaper. Resident #250 stated, I just have to go in a diaper like a baby. It's demeaning. Record review revealed Resident #250 was admitted to the facility on [DATE] with diagnoses which included right femur fracture, diabetes mellitus, overactive bladder, and arthritis. Review of the 5-Day MDS assessment dated [DATE] did not include documentation of the Resident's cognitive status and did not specify the level of assistance the Resident required for ADL care completion as the ADL activities had Occurred 2 or Fewer Times. Review of Resident #250's Nursing Admission/Readmission Evaluation dated 4/17/23 detailed, Level of consciousness: Alert . Resident is able to communicate wants and needs. Consider both verbal and non-verbal communication: Yes . Activities of Daily Living . a. Level of assistance needed for Ambulation . Totally Dependent . b. Level of assistance needed for Transfers . Totally Dependent . Level of assistance needed for Toileting . Totally Dependent . Level of assistance needed for Bathing . Totally Dependent . Level of assistance needed for Eating . Independent . F. Gastrointestinal . a. Resident is continent of bowel: 1. Yes . a1. Bowel continence history: 1. Incontinence is new, resident was continent prior to current hospitalization /illness . b4. Is the resident aware of the urge to defecate? 1. Yes . b5. Is the resident aware of when they are soiled? 1. Yes . F. Urinary Incontinence . a. Resident is continent of bladder . 2. No . a1. Bladder continence history . 1. Incontinence is new, resident was continent prior to current hospitalization /illness . Is resident aware of urge to urinate? 1. Yes . b2. Is the resident aware when they are wet? 1 Yes . Does resident have any limitations in range of motion . Yes . RLE (Right Lower Extremity) . Review of Resident #250's EMR revealed the Resident did not have a care plan and/or a care plan with interventions specifically related to showering and oral care. A care plan entitled, Resident needs assistance with activities of daily living (Initiated: 4/18/23) was noted in the EMR. The care plan included the interventions: (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Continence - assist with incontinent care (Initiated: 4/18/23) - Bed Mobility; Staff assistance (Initiated: 4/18/23) - Eating: Set up and staff assistance as needed (Initiated and Revised: 4/24/23) - Personal Hygiene: Staff assistance (Initiated: 4/18/23) - Ambulation: The resident requires staff assistance: (SPECIFY). Assistive Device used: (SPECIFY) (Initiated: 4/18/23) - Toilet Use: Staff assistance (Initiated: 4/18/23) - Transfer: Staff assistance with one person (Initiated: 4/18/23; Revised: 4/21/23) On 5/2/23 at 3:01 PM, Resident #250 was observed in their room. The facial and chin hair remained. An interview was completed at this time. When queried regarding the hair on their face/chin, Resident #250 revealed they removed it when they were at home but did not have anything to remove it with at the facility. When asked if staff had offered assistance to remove the hair, Resident revealed they had not. When asked if they hair bothered them, Resident #250 stated, Yes and reiterated they always remove it when they are home. Review of Hospital documentation, dated 4/12/23 to 4/14/23, revealed the Resident was not incontinent of bowel or bladder. An interview was conducted with Confidential CNA PP on 5/2/23 at 7:21 PM. When queried if facial hair removal for female residents is completed as part of daily care, CNA PP revealed it is supposed to be. When queried regarding Resident #250's facial hair and not being assisted to the bathroom, CNA PP revealed there is not enough staff to care for the Residents in the facility and the staff do the best they can. No further explanation was provided. An interview and review of Resident #250's medical record was completed with MDS RN O on 5/3/23 at 1:20 PM. When queried regarding Resident #250 not having a care plan in place specific to bowel/bladder elimination and facial hair removal, RN O confirmed there was not a specific care plan and/or interventions. On 5/4/23 at 11:50 AM, an interview was conducted with the DON. When queried regarding Resident #250 knowing when they need to use the restroom and not being assisted by staff, the DON indicated the Resident should be assessed and assisted to the bathroom as appropriate. When informed about the Resident's statement, an explanation was not provided. The DON was queried if facial hair removal is considered part of daily care for female residents and indicated it is based upon resident request/wishes. When asked about Resident #250's facial hair, an explanation was not provided. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of facility policy/procedure entitled, Promoting/Maintaining Resident Dignity (Revised: 3/23) revealed, It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment that maintains or enhances the resident's quality of life . 4. The resident's former lifestyle and personal choices will be considered when providing care . 6. Respond to requests for assistance in a timely manner . 9. Groom and dress residents according to resident preference .

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22347 Based on observation, interview and record review, the facility failed to implement supportive interventions for blind residents regarding the environment, safety, Activities of Daily Living (ADL) and food service for 1 resident (Resident #25) of 20 Residents reviewed for accommodation of needs, resulting in the potential for unmet care needs, food safety concerns and weight loss, falls with injury, isolation with feelings of frustration, and anger. Findings include: Resident #45: Review the Face Sheet, Minimum Data Set (MDS, dated [DATE]), care plans dated 1/24/23 through 4/27/23, revealed Resident #45 was [AGE] years-old, admitted to the facility on [DATE], was alert and making her own healthcare decisions, required staff assistance with all Activities of Daily Living and was blind in the right and left eyes. The resident's diagnosis included, Right and Left eye blindness (category 5, only see's close-up shadows), glaucoma secondary to eye disorder, stroke, high blood pressure, chronic heart and lung disease, diabetes, chronic kidney disease, difficulty walking, epilepsy, and muscle weakness. Review of the MDS dated [DATE], revealed the resident was a 15 (alert and able to make own decisions) cogitation. Review of the facility Incident reports dated 3/13/23 and 4/8/23, revealed the resident had 2 falls. On 4/25/23, review of the resident's facility care plans dated 1/18/23 and 1/19/23, revealed no documentation of interventions regarding impaired vision or blindness. Interventions for a blind person to ensure safety, care needs, safe self ambulation and transfer, mental health, and community involvement were met by the facility. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview of Resident #25 was done on 4/25/23 at 12:00 p.m., she was in her room with Family Member J. The resident was just brought back from a shower with Certified Nursing Assistant (CNA) K. When CNA K left the room, the resident was left sitting in her wheelchair in the middle of the room with no call light within reach. On the right sided of her bed, the bottom dresser drawer was partly open; if she walked on that side, she would ran into the drawer. After being left in the wheelchair for approximately 10 minutes, staff member CNA K brought in her lunch tray and sat it down on the resident's bedside table. CNA K bent over to the resident's right ear and yelled to her that her lunch tray was there for her. The resident stated, I am not dumb or deaf, I am blind. The tray top was not taken off, the food was not cut up, nor was the resident taken to the food tray or the tray brought to her. When CNA K left the room, the resident got up from her wheelchair on her own, walked around the back side of her bed with her hands and finial sat on her bed. She sat on her call light and was not able to find it when asked by this surveyor. The resident herself took the top off the food tray after finding the plate with her hands, touched all the food to identify it and used the butter knife to cut up the chicken breast with her hands. The resident did not get any coffee and asked this surveyor for coffee, saying they never give me coffee, they think I will spill it. I don't want a bib; I'll take a towel. I get embarrassed and then I get disappointed in me. When they yell at me it makes me angry. The resident said she stays in her room to eat because she gets embarrassed when she is with other people. The resident said the only blind technique she knows is to use the spider (crawl with your fingers to find food) when she eats. The resident said she has fallen 2 times because her room is not kept the same exact way, and she was informed by therapy to get up on the right side of her bed due to left sided weakness. The resident had not been properly orientated to the right side of her room; therefore she fell 2 times. She said she had never been taught any techniques for blind to use but the spider. The resident said she had fallen 2 times because she was not able to find her way (navigate her environment) in her room. During an interview done on 4/27/23 at 11:15 a.m., Speech Therapist L stated I have never worked with her, I did not get a referral. I did not go to the care conference; I would be able to help her with cognition. During an interview done on 4/27/23 at 11:50 a.m., the Director of Rehabilitation/Occupational Therapist M said the residents care plans are not tailored toward her environmental safety concerns regarding her blindness and had no blind interventions at all on them. She said the resident had fallen 2 times and stated, there is nothing therapy is doing regarding her blindness. During an interview done on 4/27/23 at 12:03 p.m., Physical Therapist N said he was working with the resident walking with her, however no therapy safety interventions regarding environmental safety. During an interview done on 4/27/23 at 12:32 p.m., Social Worker H said she had not addressed the resident's blindness on her care plan, nor had she documented any interventions regarding blindness, safety, meal set-up or addressed the resident's anger. SW H stated, it should be on her care plan. During an interview done on 4/27/23 at 12:50 p.m., MDS Coordinator O stated I own it, when I do the annual and quarterly, I should have put interventions in for blindness. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility Accommodation of Need policy dated 2022, reported The facility will treat each resident with respect and dignity and will evaluate and make reasonable accommodations for the individual needs and preferences of a resident, except when the health and safety of the individual or other residents would be endangered. The facility will make reasonable accommodations to individualize the resident's physical environment including their personal bathroom and bedroom and the common living areas within the facility. The facility will ensure that common areas frequented by residents are accommodating of physical limitations and enhance their abilities to maintain independence. Facility staff shall make efforts to reasonably accommodate the needs and preferences of the resident as they make use of their physical environment.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37668 Based on interview and record review, the facility failed to ensure that guardianship documentation was present in the medical record for one resident (Resident #10) of one resident reviewed, resulting in a lack of review and confirmation of legal guardianship prior to implementing the decision maker, and the potential for inaccurate guardianship and care decisions. Findings include: Resident #10: On [DATE] at 11:30 AM, Resident #10 was observed in their room in bed with their eyes closed. The Resident was positioned on their back with their heels directly on the mattress. The Resident did not provide meaningful responses when asked questions. Record review revealed Resident #10 was admitted to the facility on [DATE] with diagnoses which included hemiplegia and hemiparesis (one sided paralysis) following cerebral infarction (stroke), bipolar disorder, epilepsy, dysphagia (difficulty swallowing), and gastrostomy (tube inserted into the stomach through a surgically created opening in the abdominal wall for the insertion of food). Review of the MDS assessment dated [DATE] revealed the Resident was moderately cognitively impaired and required extensive to total assistance to complete all ADL's with the exception of eating. Review of Resident #10's care plans included a care plan entitled, (Resident #10) or representative if resident unable to) has established advanced directive and wishes to be Full Code (Initiated and Revised: [DATE]). The care plan included the interventions: - Activate resident's advanced directive as indicated (Initiated: [DATE]) - Notify MD and representative of changes in resident condition/status (Initiated: [DATE]) - Refer to Physician Orders for Scope of Treatment (POST) for Designation of Patient's Preferences (Initiated: [DATE]) - Review advance directives with resident and/or representative quarterly and as needed. Provide education and assistance as needed (Initiated: [DATE]) - Support resident and family with ongoing decisions (Initiated: [DATE]) (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	05/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was completed with Social Worker H on [DATE] at 8:46 AM. When queried regarding Resident #10, Social Worker H indicated the Resident had a guardian. When asked where legal guardianship documentation was maintained, Social Worker H indicated guardianship documentation is maintained in the miscellaneous scanned section of each Resident's Electronic Medical Record (EMR). Social Worker H was asked to assist in locating Resident #10's guardianship documentation in the EMR. After Social Worker H reviewed Resident #10's EMR and confirmed there was no guardianship documentation. When asked where the Resident's guardianship documentation was, Social Worker H replied, Not sure. When queried how they knew that Resident #10 had a legal guardian and who their guardian was without documentation, Social Worker H stated, Well, they said. Social Worker H was asked who said the Resident had a legal guardian and indicated the information either came from the hospital when the Resident was discharged or from the facility Admission. When asked if they verified the Resident had a court ordered legal guardian and the name of the guardian, Social Worker H replied, No. When asked how they knew the guardianship was active and not expired, Social Worker H stated, I don't. Social Worker H indicated Admissions Staff YY would be able to provide further information as they were responsible for obtaining guardianship documentation when Residents are admitted to the facility. An interview was completed with Admissions Staff YY on [DATE] at 9:07 AM. When queried regarding their role related to obtaining and verifying guardianship documentation in the EMR, Staff YY stated, In the admissions agreement there is a box to check to see if they have a guardian or not. When asked if they review/verify that the Resident actually has a guardian and that that the legal guardianship is active, Staff YY revealed they don't and stated, I thought that social work followed up. When queried how they initially determined if the Resident had a guardian, Staff YY revealed they review the contact information obtained from the hospital face sheet. Staff YY stated, I don't follow up. An interview was conducted with the Director of Nursing (DON) on [DATE] at 11:50 AM. When queried regarding the facility not having a copy of Resident #10's guardianship documentation and not verifying the guardianship, the DON verified the lack of guardianship documentation and that a copy should be maintained in each residents medical record as applicable. No further explanation was provided. Review of facility policy/procedure entitled, Advance Directives (Revised [DATE]) revealed, Policy . Prior to or upon admission of a resident to our facility, the Social Services Director or designee will provide written information to the resident concerning his/her right to make decisions about medical care, including the right to accept or refuse medical or surgical treatment, and the right to formulate advance directives . Prior to or upon admission of a resident, the Social Services Director or designee will inquire of the resident, and/or his/her family member(s) or representative, about the existence of any written advance directives. Should the resident and/or representative indicate that he or she has issued advance directives about his or her care, documentation must be recorded in the medical record of such directive and a copy of such directive must be included in the resident's medical record .

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22927 Based on observation, interview and record review, the failed to issue a beneficiary notice (ABN/Nomnic) for one resident (Resident #28) and notify eligible residents in writing of the items and services which are or are not covered under Medicaid or by the facility's per diem rate, including the cost of those items and services, resulting in Resident #28 having no documentation of beneficiary notices (ABN of NOMNIC) found with in her electronic record or in a paper format within the facility resulting in the likelihood for financial hardship. Findings include: Record review of facility 'Advanced Beneficiary Notices' policy dated 3/23/2023 revealed it is the policy of the facility to provide timely notices regarding Medicare eligibility and coverage. The business office manager is responsible for issuing notices. To ensure the resident or representative has enough time to make a decision whether or not to receive services in question and assume financial responsibility, the notice shall be provided at least two days before the end of the Medicare covered Part A stay or when all of Part B therapies are ended. Record review of the entrance conference worksheet for beneficiary notices issued for the last six months was reviewed on 4/26/2023 by state surveyor. The State surveyor randomly chose three residents from the list: #28, who on 1/9/2023 chose to remain in the facility and two other residents. In an interview and record review on 04/26/23 at 09:05 AM with the social worker (SW) H revealed she gets the cut letters and get the resident to sign and then she scans/uploads the letter to the corporate office in Indiana to corporate social worker and they hold them. SW H stated that she has not worked in a facility that the business office did not handle them. Observation and record review of electronic medical record for Resident #28 revealed there were no uploaded NOMIC or SNFABN forms found in the medical closed record of the three residents randomly chosen from the list the facility provided. SW H had to call the business office. In an interview and record review on 04/26/23 at 09:16 AM with the Business Office Manager V stated that the Notice of Medicare Non-Coverage forms are not in my book/binder of paper forms. Observation page by page of all forms and pages revealed there was no forms found for Resident #28 for discharge date of [DATE] when the resident chose to remain in the facility. The Business office Manager reviewed the electronic medical record and there was none there. The Business Office Manager stated that she looked in case management and there was none there. In the interview and observation of the Business Office to file pile basket, document by document, revealed Resident #28 notice was not found for the date of 1/9/2023. The Business Office Manager stated that she began the issue of notice's when the facility were in between social workers. Office Manager stated that she was not doing them back in January 2023, and continued to look through the file basket items dated back to December 2022 there were no forms found for Resident #28, and not in the medical record for the date of 1/9/2023 per the beneficiary list provided. (continued on next page)

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	235132	A. Building B. Wing	05/04/2023

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 04/26/23 at 09:29 AM with the Long-Term Care Social Work Designee W revealed that was still in school/classes for social service degree. Designee W stated that she looked in her office and did not find any Notice of Medicare Non-Coverage forms.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities 22347 Based on interview and record review, the facility failed to update Preadmission Screening and Resident Review (PASARR), mental health screening, for 10 residents of a census of 92 residents reviewed for PASARR screenings, resulting in the potential for unmet mental health and psychiatric care needs. Findings Include: Review of the facility list of facility residents who do not have timely PASARR's, dated 4/27/23, and given to this surveyor on 4/28/23 at 11:20 a.m., from the Director of Nursing revealed a total of 10 residents out of a total census of 96 residents whose PASARR was not done at all or late to be done. During an interview done on 4/28/23 at 8:15 a.m., Social Worker H stated About November or December (of 2022) when I got here (started at the facility), I had no access to get into OBRA (Budget Reconciliation Act) to do the PASARR's. I contacted OBRA web site when I got here. The social worker before me who had left was still in the system. Neither of us (2 facility social workers) have access to get in and do the PASARR's, so they (the facility resident's) are behind. I did not get an answer from OBRA, so about 1 month ago I called them, and they said they would work on it (no documentation regarding OBRA contacts, notes or names were available). I did tell the Administrator when I got here and again in the IDT (Interdisciplinary Team) meetings that I still could not get in; she (the Administrator) said she would work on it at that time. I last told the Administrator about 1 month ago again I could not get in. During an interview done on 4/28/23 at 8:45 a.m., the Administrator stated They (Social Workers at facility) said they could not get in (to OBRA system to do PASARR's) so I emailed (cooperate staff). The same person trained the social workers about 5 months ago. I was not aware they still could not get into the system; no one came and told me. I will email cooperate again right now. During an interview done on 4/28/23 at 9:30 a.m., VP (Vice President) of Operations E stated I just talked to (Cooperate) and she is going to get them access. During an interview done on 5/2/23 at approximately 10:00 a.m., Social Worker H said she had still not gotten access to do resident's PASARR's. Review of the 42 CFR Part 483 Subpart C Preadmission Screening and Annual Review of Mentally Ill and Mentally Retarded Individuals Public Health rule dated 11/30/92, reported Preadmission screening of all individuals with mental illness or intellectual disability (Medicaid), initial review of all current residents with intellectual disability or mental illness (and) at least annual review of all residents with mental illness or intellectual disability will have PASARR's done. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility resident Assessment-Coordination with PASARR Program policy dated 2022, reported This facility coordinates assessments with the preadmission screening and resident review (PASARR) program under Medicaid to ensure that individuals with a mental disorder, intellectual disability, or a related condition receives care and services in the most integrated setting appropriate to their needs. The Social Services Director shall be responsible for keeping track of each resident's PASARR screening status and referring to the appropriate authority.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22927 Based on observation, interview and record review, the facility failed to develop or implement comprehensive care plans for four residents (Resident #37, Resident #45, Resident #46, and Resident #79) of 20 residents reviewed for care plan implementation, resulting in care plans not being comprehensive with interventions of Activities of Daily Living, accommodations for the blind, and monitoring of weight loss, Findings include: Record review of the facility 'Comprehensive Care Plans' policy dated 3/2023, revealed it is the policy of the facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. Resident #37: Observation and interview on 04/25/23 at 01:47 PM of Resident #37's room noted Resident #37 sitting with head of bed slightly up and the resident to be bent to the right side with head tipped eating her noon meal by herself. Observed the food items off the plate and Resident #37 to be eating with her fingers. The state surveyor asked about pain and concerns. Resident #37 stated that she has a sore on her left heel. The State surveyor observed green Velcro close soft boots in the chair behind the curtain across the room next to the door. One soft boot was standing upright, and the left boot was laying on its side. Observation and interview on 04/26/23 at 01:25 PM with Resident #37 were lying in bed on her back. made good eye contact, surveyor asked about her feet? I got the sores to my feet here at this place, I do not know why, I got a shower today and it felt good, they already did my bandages to my legs and butt. My lunch was meatloaf, it was ok. Resident #37 stated that she had a sore on my butt also, and to look at those for her. The state surveyor observed Green soft cushion boots (a pair) for bilateral feet in the chair behind the curtain next to the door, the boots were in the same position as the previous day one upright and the other laying on its side. Resident #37 was asked about the boots and the resident stated that they do not put them on me. Record review of Resident #37's care plans pages 1- 25, revealed Activities of Daily Living (ADL) self-care deficit as related to CVA (Cerebral Vascular Accident) with left hemiparesis, reduced balance/coordination, incontinence, decreased endurance. Intervention dated 3/17/2023 of soft bilateral APF boots on while in bed as patient tolerates. Record review of 'Risk of Skin Break down' care plan with revision on 3/28/2023 noted Stage II on both buttocks, posterior left and right calf, and left heel. Intervention dated 4/7/2023 of heel lift boots on feet as tolerated. Record review of care plans 1-25 noted that enhanced barrier precautions care plan in place. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #37's April 2023 Medication Administration Record (MAR) and Treatment Administration Record (TAR) revealed resident to be on enhanced barrier precautions every shift for peg tube printed on 4/27/2023 revealed that nursing staff initials as performed each shift. Record review of Resident #37's May 2023 Medication Administration Record (MAR) and Treatment Administration Record (TAR) revealed resident to be on enhanced barrier precautions every shift for peg tube printed on 5/2/2023 revealed that nursing staff initials as performed each shift. Observation and interview on 04/27/23 at 07:00 AM Observed Licensed Practical Nurse (LPN) S at Nursing station and then at treatment cart got into the cart and retrieved wound dressing supplies, walked to the resident's room. Surveyor observed soft green boots in chair behind the curtain, not on the resident. LPN S pulled the over bed table to the left side of bed, placed barrier cloth, and supplies onto the barrier. Closed the bathroom door and pulled on gloves. LPN S and Certified Nurse Assistant (CNA) VV, observed room [ROOM NUMBER] private room, Resident #37 noted laying on her back in bed. Observation of room revealed there to be Enhanced Barrier Precaution signage. PPE caddy or plastic three drawer isolation bin noted outside the room in hallway. Resident Care planned for precautions. Observed mid-line abdominal peg tube with no dressing in place. LPN S stated that the wounds started at the facility in March 2023 as a buttocks blister and then progressed from one wound to 4: Left Buttocks, left posterior leg (between ankle and knee), left heel, and right posterior leg (between ankle and knee). LPN S stated that Resident #37 had developed thrush in her mouth and it hurt to eat, and she lost weight, went to the hospital and they put in a tube feeding in her abdomen, observed midline tube feeding in place with no dressing noted. LPN S stated that the resident came back all better, and her skin looked great, no open or red areas were noted when she came back. The tube feeding was continuous and is now not used because she can eat normal. LPN S and CNA VV positioned resident onto her right side and lowered the brief. Removed the old dressing dated 4/25/2023. Surveyor observed a Stage II open wound with scant drainage noted. The LPN S removed her gloves, went to the wall, and used hand sanitizer and pulled on large gloves. Surveyor noted long artificial fingernails, estimated over a three-fourths inch in length. LPN S then pulled the curtain, so the door was covered, went to the over bed table, and opened packages of 4x4 gauze used wound cleaner spray to spray the 4x4's, turned to the resident's back side and plotted the left buttocks opened wound bed area and then did a pat dry with dry 4x4 gauze. Applied Hydrogel from container onto the wound itself and covered with a sacral shaped foam boarder pink dressing. With the same gloves the LPN then moved to the lower posterior left leg wound and removed the old dressing dated 4/25/2023. Surveyor observed a Stage II or III with slough in center with red/pink edges, clear to tan drainage was noted to the bottom sheet of the bed and on the old dressing removed. The bed had brown moisture rings noted on the bottom sheet where the leg rests on the sheet. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The surveyor observed LPN S remove her gloves go to the wall and use hand sanitizer, pull on gloves and open packages of 4x4 gauze, spray the 4x4 gauze and blot the wound bed, yellow stringy slough was noted in wound bed loose, not attached to the edges, drainage noted to gauze. Hydro gel applied directly into the wound (clear gel) and covered with a 4x4 foam boarder dressing. LPN S then went to the left heel, unwrapped a roll of gauze from around the left foot/heel, noted to have edema to foot +2, CNA VV pressed on the left foot edema area. Pink foam boarder dressing was peeled back, and the surveyor observed a dark to black area covering the left-out aspect of the heel. LPN S stated that the blister had popped since she saw it last, drainage was noted. Dressing placed back into place and gauze was not replaced. LPN S then removed her gloves and helped to reposition the resident across the bed and rolled up onto her left side. LPN S then pulled the bedside table over to the right side of the bed and put on gloves and removed the dressing from the right lower leg (Between the ankle and knee) posterior, dressing dated 4/25/2023. Surveyor observed an opened area with pink/red wound bed with a small open area noted with bleeding. LPN S removed gloves and put on new gloves and opened 4x4 gauze and sprayed the gauze with wound cleaner, blotted the wound bed, and did a pat dry with 4x4 gauze. Surveyor asked the LPN S and CNA VV about the soft boots in the chair. LPN S and CNA VV stated that they are to be on when the resident is in bed. CNA VV stated that she would put the green boots on now. In an interview on 04/27/23 at 12:02 PM Licensed Practical Nurse/Unit manager U stated that in March Resident #37 had Thrush in mouth and went to hospital for unresponsiveness. Resident #37 received a peg tube to her abdomen, and she came back March 16th on tube feed. LPN U did not see her skin when she came back. There was a different staff member working as the unit manager at the time of the residents return from hospital. LPN U was notified of her wound she spoke to East staff nurses/CNA's told it is a rash that turned into a blister on her butt. The blisters popped and became stage II open wounds. LPN U did go down and assess the wound on 3/29/2023: left buttocks it was a blister, left lower posterior leg that was also a blister that developed into a stage II until the slough falls off. Then on 4/5/2023 the left heel started as a blister; blisters are caused from rubbing on a surface. LPN U stated that physician ordered protective boots. LPN U the Right posterior calf wound occurred on 4/12/2023, from blister that opened on 4/14/2023. Review of IDT meeting notes on 4/6/2023, then on 4/12/2023 develops a stage II opened wound to right calf. The Boots are soft cushion off-loading boot's purpose to keep the heels from sitting on the mattress. The boots were ordered on 4/5/2023, they are to be on when resident is in bed. Surveyor relayed the observations of the boots not on. LPN U stated that the Right posterior leg started as a blister also, it is from friction. Staffing we have enough staff they are just having calling ins on short notice. Interventions on care plan of soft boots were reviewed with LPN U. Soft boots for off-loading heels were started on 4/5/2023. Surveyor asked how do you ensure that they are on? LPN U stated there should be a task tab. Record review of the task tab revealed that the task to place soft boots on when in bed was not being documented. Record review of the MAR TAR revealed that the boots were not being documented there either. The CNA's are to place the boots on, and the nurses are to monitor the boot placement. There were no refusals to wear the boots documented. Observation and interview on 05/02/23 at 10:00 AM with Certified Nurse Assistant (CNA) R in Resident #37's room dressed in scrubs, there is no enhanced protective barrier gown on, and the white trash can at the door with lid open with no trash bags noted in the can. CNA R stated that he is giving the resident a bed bath and was observed filling container with water and wash clothes. Surveyor observed and picked up a cell phone from the bed and the CNA R stated that it was his phone not the residents and put the phone in his pocket. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview on 05/02/23 at 10:10 AM the surveyor went and got the Registered Nurse/Infection control preventionist (RN/ICP) A and walked with the ICP to the resident #37's room. Both surveyor and RN/ICP A observed resident naked upon the bed with G-tube with no dressing in place to new peg tube. Observed CNA R giving bath with gloves and wash cloth in hand, but no gown for barrier. Brief was undone and folded under resident on left side. RN/ICP A stated that there should be a gown on the CNA when giving a bath it is right on the sign on the door. IN an interview on 05/02/23 at 10:23 AM with RN/ICP A the peg tube usually does have a dressing on the peg tube site. RN/ICP A stated that he spoke with the unit manager, and there should be dressings on the peg tube sites of residents that have peg tubes. Resident #46: Record review on 05/03/23 at 09:43 AM of Resident #46 who was admitted on [DATE], electronic medical record of the shower tasks and bathing task revealed very little to no documentation of bathing. Record review of Resident #46's Care plans revealed that there were no interventions of showers noted. In interview and record review on 05/03/23 at 11:55 AM with Licensed Practical Nurse (LPN/MDS) O, of Resident #46's showers for 30 days look back revealed no showers in a month, and bathing task revealed four assisted with bathing in a month. There were no refusals and reasons documented in the progress notes as to why the showers were not given. Licensed Practical Nurse (LPN/MDS) O, stated that she knows that there is a bathing bed on wheels located on the East unit that can be used for showers. Record review of Resident #46's physician orders revealed Lexapro antidepressant 10 mg oral every day, Lamictal antipsychotic 50mg oral twice daily for schizoaffective disorder, Seroquel ant psychotropic oral 100mg and 25mg for a total of 125mg at bedtime for schizoaffective disorder, and Seroquel 50mg oral every day for schizoaffective disorder. Record review of Resident #46's care plans pages 1-16, revealed 'Behavioral' care plan dated 1/30/2023 with interventions of: Administer medications as ordered, and document behaviors. There were no interventions of antipsychotic medications or non-pharmaceutical interventions. Record review of the 'New Admission' care plan dated 1/30/2023 noted no interventions. Record review of 'Risk of Complications' care plan dated 1/30/2023 revealed interventions of labs as ordered and medications and treatments per physician orders. There were no interventions noted in the care plans to assess and monitor for side effects of psychotropic medications. Resident #79: In an interview and observation 04/25/23 1 at 2:56 PM with Resident #79's family member revealed that the resident had lost weight since admission to the facility. The family member revealed that Resident #79 use to be around two hundred pounds and now is below 150 pounds. Resident #79 does have a tube feed tube in his abdomen. Resident #79 walked over to show the surveyor his peg tube with no dressing in place and crusty material around the opening. The family member stated that Resident #79 is takes food by mouth and that the tube has not been used for a while. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review on 5/4/2023 of Resident #79's electronic weight log from admission in October 2022 revealed a weight of 176.4 pounds. The Resident #79 was stable through March 3, 2023, weight of 170 pounds. April 5, 2023, weight was documented as 139. That was a 31-pound weight loss within a 34-day time period. The electronic medical record documented a 19.4% weight loss in 30 days. 22347 Resident #45: Review the Face Sheet, Minimum Data Set (MDS, dated [DATE]), care plans dated 1/24/23 through 4/27/23, revealed Resident #45 was [AGE] years-old, admitted to the facility on [DATE], was alert and making her own healthcare decisions, required staff assistance with all Activities of Daily Living and was blind in right and left eyes. The resident's diagnosis included, Right and Left eye blindness (category 5, only see's close-up shadows), glaucoma secondary to eye disorder, stroke, high blood pressure, chronic heart and lung disease, diabetes, chronic kidney disease, difficulty walking, epilepsy, and muscle weakness. Review of the facility Incident reports dated 3/13/23 and 4/8/23, revealed the resident had 2 falls. On 4/25/23, review of the resident's facility care plans dated 1/18/23 and 1/19/23, revealed no documentation of interventions regarding impaired vision or blindness. Interventions for a blind person to ensure safety, care needs, safe self ambulation and transfer, mental health, and community involvement were met by the facility. (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	05/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview of Resident #45 was done on 4/25/23 at 12:00 p.m., she was in her room with Family Member J. The resident was just brought back from a shower with Nursing Assistant/CNA K. When CNA K left the room, the resident was left sitting in her wheelchair in the middle of the room with no call light within reach. On the right sided of her bed, the bottom dresser drawer was partly open; if she walked on that side, she would ran into the drawer. After being left in the wheelchair for approximately 10 minutes, staff member CNA K brought in her lunch tray and sat it down on the resident's bedside table. CNA K bent over to the resident's right ear and yelled to her that her lunch tray was there for her. The resident stated, I am not dumb or deaf, I am blind. The tray top was not taken off, the food was not cut up, nor was the resident taken to the food tray or the tray brought to her. When CNA K left the room, the resident got up from her wheelchair on her own, walked around the back side of her bed with her hands and finial sat on her bed. She sat on her call light and was not able to find it when asked by this surveyor. The resident herself took the top off the food tray after finding the plate with her hands, touched all the food to identify it and used the butter knife to cut up the chicken breast with her hands. The resident did not get any coffee and asked this surveyor for coffee, saying they never give me coffee, they think I will spill it. I don't want a bib; I'll take a towel. I get embarrassed and then I get disappointed in me. When they yell at me it makes me angry. The resident said she stays in her room to eat because she gets embarrassed when she is with other people. The resident said the only blind technique she knows is to use the spider (crawl with your fingers to find food) when she eats. The resident said she has fallen 2 times because her room is not kept the same exact way, and she was informed by therapy to get up on the right side of her bed due to left sided weakness. The resident had not been properly orientated to the right side of her room; therefore she fell 2 times. She said she had never been taught any techniques for blind to use but the spider. The resident said she had fallen 2 times because she was not able to find her way (navigate her environment) in her room. Review of the resident's facility care plans dated 1/18/23 and 1/19/23, revealed no documentation of interventions regarding impaired vision. Interventions for a blind person to ensure safety, mental health, and community involvement. During an interview done on 4/27/23 at 11:50 a.m., the Director of Rehabilitation/Occupational Therapist M said the residents care plans are not tailored toward her environmental safety concerns regarding her blindness. She said the resident had fallen 2 times and stated, there is nothing therapy is doing regarding her blindness. During an interview done on 4/27/23 at 12:03 p.m., Physical Therapist N said he was working with the resident walking with her, however no interventions regarding environmental safety. During an interview done on 4/27/23 at 12:32 p.m., Social Worker H said she had not addressed the resident's blindness on her care plan, nor had she done any interventions regarding blindness, safety, meal set-up or addressed the resident's anger regarding treatment from staff. SW H stated, it should be on her care plan. During an interview done on 4/27/23 at 12:50 p.m., MDS Coordinator O stated I own it, when I do the annual and quarterly, I should have put interventions in for blindness. (continued on next page)

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	235132	A. Building B. Wing	05/04/2023

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility Documentation in Medical Records policy dated 3/23, reported Each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the residents progress through complete, accurate, and timely documentation. Documentation shall be completed at the time of service, but no later than the shift in which the assessment, observation, or care service occurred. Review of the facility Comprehensive Care Plan policy dated 3/23, reported It is the policy of this facility to develop and implement a comprehensive person-centered care for each resident, consistent with resident rights, that includes measurable objectives and timeframe's to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. The comprehensive care plan will be developed within 7 days after the completion of the comprehensive MDS assessment. Resident specific interventions that reflect the resident's needs and preferences and align with the resident's cultural identity as indicated. This would include interventions for blindness.

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	235132	A. Building B. Wing	05/04/2023

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 22927 Based on observation, interview and record review, the facility 1) Failed to ensure that Resident #1's advanced directive care plan was updated when the resident received hospice services, 2) Failed to ensure that Resident #46's antipsychotic medication care plan was updated with a new order on 05/03/2023, and 3) Failed to ensure that Resident #79 weight loss/re-weights were care planned, resulting in a failure to review and update care plans timely for three residents (Resident #1, Resident #46, and Resident #79), resulting in a failure to that ensure interventions were in place necessary for care and services to maintain the highest level of well-being. Findings include: Record review of the facility 'Care Plan Revisions Upon Status Change' policy dated 3/2023, revealed the purpose of the procedure is to provide a consistent process for reviewing and revising the care plan for those residents experiencing a status change. The comprehensive care plan will be reviewed, and revised as necessary, when a resident experiences a status change. 2.) (d.) The care plan will be updated with new or modified interventions. Resident #1: In an interview and record review on 05/03/23 at 12:29 PM with Licensed Practical Nurse (LPN) O the MDS nurse, revealed that the Registered Nurse for MDS left 2 weeks ago. LPN O performed record review of care plans with state surveyor revealed that the resident #1 was admitted to hospice on March 13th, 2023. The medical record of facility for Resident #1 revealed there was no Hospice care found in the record. Record review of Resident #1's Advance directive care plan dated 5/22/2022 revealed full code and was not updated when resident began hospice services. Resident #46: Record review of Resident #46's physician orders revealed Lexapro antidepressant 10 mg oral every day, Lamictal antipsychotic 50mg oral twice daily for schizoaffective disorder, Seroquel antipsychotic oral 100mg and 25mg for a total of 125mg at bedtime for schizoaffective disorder, and Seroquel 50mg oral every day for schizoaffective disorder. Record review of Resident #46's care plans pages 1-16, revealed 'Behavioral' care plan dated 1/30/2023 with interventions of: Administer medications as ordered, and document behaviors. There were no interventions of antipsychotic medications or non-pharmaceutical interventions. Record review of the 'New Admission' care plan dated 1/30/2023 noted no interventions. Record review of 'Risk of Complications' care plan dated 1/30/2023 revealed interventions of labs as ordered and medications and treatments per physician orders. There were no interventions noted in the care plans to assess and monitor for side effects of psychotropic medications. (continued on next page)

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	235132	A. Building B. Wing	05/04/2023

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 05/03/23 at 09:00 AM with social worker G revealed that she did not know if there are consents for any of the new residents with antipsychotic medications, because the old Social Worker did those and maybe there is a book in her office or something. Record review of Resident #46's physician orders revealed that there are quetiapine (Seroquel) 50mg every day and 125mg at HS. Lamictal 50mg daily for schizoaffective disorders daily. Record review of Resident #46's electronic medical record with social worker G revealed that there was no consent found for antipsychotic medications noted. Resident #46's new order for Seroquel antipsychotic added on 5/2/2023, revealed there was no updated care plan noted. Record review on 05/03/23 at 09:38 AM with social worker G reviewed of the care plan revealed that there was no antipsychotic medication care plan or interventions for signs and symptoms of monitoring effects. Resident #79: In an interview and observation 04/25/23 1 at 2:56 PM with Resident #79's family member revealed that the resident had lost weight since admission to the facility. The family member revealed that Resident #79 use to be around two hundred pounds and now is below 150 pounds. Resident #79 does have a tube feed tube in his abdomen. Resident #79 walked over to show the surveyor his peg tube with no dressing in place and crusty material around the opening. The family member stated that Resident #79 is takes food by mouth and that the tube has not been used for a while. Record review on 5/4/2023 of Resident #79's electronic weight log from admission in October 2022 revealed a weight of 176.4 pounds. The Resident #79 was stable through March 3, 2023, weight of 170 pounds. April 5, 2023, weight was documented as 139. That was a 31-pound weight loss within a 34-day time period. The electronic medical record documented a 19.4% weight loss in 30 days. Record review of the facility 'Weight Monitoring' policy dated 3/2023, revealed (#5.) A weight monitoring schedule will be developed upon admission for all residents: (a.) Weights should be recorded at the time obtained. Mathematical rounding should be utilized (i.e., if weight is X. 5 pounds [lbs] or more, round weight upward to the nearest whole pound. If weight is X. 1 to X. 4 [lbs] round down to the nearest whole pound). (b.) Newly admitted residents - monitor weight weekly for 4 weeks (c.) Residents with weight loss - monitor weight weekly (d.) If clinically indicated - monitor weight daily (e.) All others - monitor weight monthly (#6.) Weight Analysis: The newly recorded resident weight should be compared to the previous recorded weight. A significant change in weight is defined as: (a.) 5% change in weight in 1 month (30 days) (b.) 7.5% change in weight in 3 months (90 days) (c.) 10% change in weight in 6 months (180 days). In an interview and record review on 05/04/23 at 08:27 AM with Registered Dietician (RD) BB of Resident #79's electronic medical record review of the resident's weight log of 3/3/2023 weight of 170.0 pounds was noted. On record weight of 139.0 that was a 31-pound weight loss in 30 days, and a 35-pound weight loss since admission. RD BB stated that Resident #79 was NPO (nothing by mouth) at the time due to the tube feedings resident was getting. The tube feedings were increased, and he was stable in his weight. On 2/27/2023 he had a video laryngeal test that noted reduced swallow with aspiration risk. The RD BB was getting agitated and seeking out food. He was restless, getting up and down, seeking out food, hanging out at nurse station near food carts. Resident #79 was wanting to eat food items. Weights are once a month when stable. We met in April with the guardian (Father or brother), and he wanted the resident to have regular diet with food items and to hold the tube feedings. The Resident #79's care plan was updated. (continued on next page)

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	235132	A. Building B. Wing	05/04/2023

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #79's care plans pages 1-21, revealed that tube feeding care plan intervention dated initiated 3/3/2023 weigh as ordered and as needed. Record review of nutrition care planned initial date of 10/5/2022 and revision date of 3/3/2023 revealed only one intervention: Diet as ordered; resident is NPO (nothing by mouth) receives nutrition via his G-tube. There were no interventions for how often to re-weight the resident with a 30 pound weight loss in 30 days found.

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	235132	A. Building B. Wing	05/04/2023

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37668 Based on interview and record review, the facility failed to ensure an appropriate documentation, assessment, and diagnosis for psychotropic medication use for one resident (Resident #84) of one resident reviewed, resulting in Seroquel (antipsychotic medication frequently used to treat Bipolar, caution use in individuals with dementia) being administered without a consent, a comprehensive assessment, and a documented diagnosis for use. Findings include: Resident #84: On 4/25/23 at 12:29 PM, Resident #84's room door was closed. Upon knocking and entering the room, an overwhelming foul body odor was instantly noted. Resident #84 was observed in their bed with their eyes open. The Resident had an unkept and ungroomed appearance. An interview was completed at this time. When queried regarding the medications they receive in the facility, Resident #84 revealed they did not know and just take what the nursing staff give them. Record review revealed Resident #84 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included repeated falls, diabetes mellitus, mood disturbance, anxiety, and dementia without behavioral disturbance. Review of the MDS assessment dated [DATE] revealed the Resident was cognitively intact and required total assistance for bathing and limited assistance with transferring, dressing, and toilet use. Review of Resident #84's Health Care Provider (HCP) orders and Medication Administration Record (MAR) documentation revealed the Resident had received the following psychotropic drugs: - Seroquel Oral Tablet 50 mg (Quetiapine Fumarate; Antipsychotic medication frequently used to treat Bipolar, black box warning for use in individuals with dementia), Give 1 tablet by mouth two times a day for Dementia (Start: 2/9/23; Discontinued: 2/24/23) - Quetiapine Fumarate (Seroquel) Tablet 50 mg; Give 1 tablet by mouth two times a day for bipolar (Start Date: 3/17/23; Discontinued: 4/19/23) Review of Resident #84's active and discontinued care plans revealed the Resident did not have a care plan related to psychotropic medication use, mental health, and/or dementia. Review of Resident #84's Electronic Medical Record (EMR), including all scanned documentation, revealed no consent for Seroquel. There was also not documentation demonstrating the Resident had been seen and/or evaluated by a Mental Health Provider. The following progress note documentation was noted in Resident #84's EMR: (continued on next page)

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	235132	A. Building B. Wing	05/04/2023

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 2/9/23: Progress Notes . seen today to establish care . past medical history of dementia, diabetes hyperlipidemia, hypertension, and hard of hearing. Patient presented to the emergency room with complaints of feeling weak and dizzy with falls at home . found to have elevated blood sugars and be clinically dehydrated . stabilized and sent to this facility for further medical care and rehab . Unspecified dementia without behavioral disturbance: Mood stable. Continue Seroquel . Authored by Nurse Practitioner (NP) DDD. - 4/19/23: Progress Notes .seen today to assess for a GDR (Gradual Dose Reduction). Patient has a past medical history of bipolar disease and dementia . Dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety . Patient's Seroquel has been dose reduced . Authored by Nurse Practitioner (NP) DDD. Psychoactive medication consent documentation for Resident #84 was requested via email from the facility Administrator on 5/3/23 at 8:35 AM. Review of Resident #84's Hospital documentation dated 3/7/23 to 3/13/23 revealed no documentation of the Resident having a diagnosis of bipolar disorder. An interview and review of Resident #84's EMR was completed with Social Worker H on 5/3/23 at 8:51 AM. When queried regarding Resident #84's psychotropic medications including consent for Seroquel, Social Worker H stated, No consent. When asked if the Resident had been seen and evaluated by psychiatric services/mental health provider in the facility, Social Worker H stated, No. When asked why the Resident was not seen and evaluated for medication management, Social Worker H indicated the Nurse Practitioner in the facility will manage medications. When asked why the indication for Seroquel use in February 2023 was listed as Dementia when Seroquel is not an appropriate treatment for dementia, Social Worker H did not provide an explanation. When asked why the indication for use of Seroquel was listed as Bipolar in March and April 2023 when the Resident did not have a diagnosis of bipolar, Social Worker H was unable to provide an explanation. An interview was conducted with Social Worker H and Unit Manager Licensed Practical Nurse (LPN) TT on 5/4/23 at 10:50 AM. When queried regarding facility policy/procedure related to psychotropic medications including consents and who obtains the consents for the medications, Social Worker H stated, I'm not following up with Residents on psych meds. When asked who is following up and obtaining consents, Social Worker H replied, I was told by the Administrator that it was nursing. LPN TT was then asked if nursing staff obtain consents and follow up with Residents receiving psychoactive medication and stated, No, I was told it was Social Work. An interview was completed with the Director of Nursing (DON) on 5/4/23 at 11:58 AM. When asked who is responsible to obtain consents and follow up for Residents receiving psychotropic medications, the DON stated, Definitely Social Work. When queried why the indication for use for Seroquel was listed as dementia in February and bipolar in March and April 2023, the DON revealed they were unsure. When queried if dementia was an appropriate reason for Seroquel use, the DON verbalized it was not. The DON was then asked where the Resident's diagnosis of bipolar was listed in the EMR. After reviewing Resident #84's EMR, the DON revealed they unable to locate a bipolar diagnosis. When asked who is responsible to ensure there are appropriate indications for use, assessment, and diagnoses for psychotropic medication use, the DON revealed the HCP and facility Social Worker were primarily responsible and nursing staff monitor for medication side effects. (continued on next page)

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	235132	A. Building B. Wing	05/04/2023

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/4/23 at 12:05 PM, an interview was conducted with Nurse Practitioner (NP) DDD and the DON. When queried regarding Resident #84's Seroquel, NP DDD stated, I believe (Resident #84) came to us on it from the hospital and indicated the medication was discontinued in April 2023. When queried regarding the procedure in the facility related to psychotropic medication consent, NP DDD revealed consents are obtained by facility staff. When queried regarding consultation with a psychiatric/mental heath provider for assessment as well as evaluation of medications and medication management, NP DDD stated, I only refer to psych if they (residents) are having behaviors and it is necessary. NP DDD was then queried regarding the reason and diagnosis for Resident 84 receiving Seroquel was listed as dementia in February 2023 and then changed to bipolar in March and April 2023. NP DDD revealed they must have changed the diagnosis. When asked where it was identified that the Resident had a diagnosis of bipolar in the EMR, NP DDD reviewed the Resident's EMR and the Resident's hospital medical record documentation. After review, NP DDD stated, I can't find where the bipolar (diagnosis) is from. NP DDD was asked to clarify if they were saying they had prescribed and Resident #84 had received a psychotropic medication without appropriate assessment for and a diagnosis of bipolar disorder, NP DDD restated that they were unable to locate a diagnosis of bipolar disorder in the EMR. Review of facility policy/procedure entitled, Use of Psychotropic Medication (No Date) revealed, Policy: Residents are not given psychotropic drugs unless the medication is necessary to treat a specific condition, as diagnosed and documented in the clinical record, and the medication is beneficial to the resident, as demonstrated by monitoring and documentation of the resident's response to the medication(s) . 3. The attending physician will assume leadership in medication management . 4. The indications for use of any psychotropic drug will be documented in the medical record. a. Pre-admission screening and other pre-admission data shall be utilized for determining indications for use of medications ordered upon admission to the facility. b. For psychotropic drugs that are initiated after admission to the facility, documentation shall include the specific condition as diagnosed by the physician. i. Psychotropic medications shall be initiated only after medical, physical, functional, psychosocial, and environmental causes have been identified and addressed. ii. Non-pharmacological interventions that have been attempted, and the target symptoms for monitoring shall be included in the documentation . 7. Residents who use psychotropic drugs shall also receive non-pharmacological interventions to facilitate reduction or discontinuation of the psychotropic drugs . 14. Use of psychotropic medications in specific circumstances . b. Enduring conditions (i.e., non-acute, chronic, or prolonged): i. The resident's symptoms and therapeutic goals shall be clearly and specifically identified and documented. ii. An evaluation shall be documented to determine that the resident's expressions or indications of distress are: 1. Not due to a medical condition or problems that can be expected to improve or resolve as the underlying condition is treated or the offending medications(s) are discontinued; 2. Not due to environmental stressors alone, that can be addressed to improve the symptoms or maintain safety; 3. Not due to psychological stressors, anxiety, or fear stemming from misunderstanding related to his or her cognitive impairment that can be expected to improve or resolve as the situation is addressed; and 4. Persistent, and negatively affect his or her quality of life. c. New admissions: i. The facility shall identify the indication for use, as possible, using pre-admission screening and other pre-admission data. ii. The physician in collaboration with the consultant pharmacist shall re-evaluate the use of the medication and consider whether or not the medication can be reduced or discontinued upon admission or soon after admission .

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	235132	A. Building B. Wing	05/04/2023

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22347 Based on observation, interview and record review, the facility failed to ensure that bathing/shower activities were provided and assistance with dressing and shaving for 12 residents (#10, #14, #18, #21, #29, #33, #37, #45, #46, #84, #245 and #250), and 4 of 8 confidential residents from the Resident Council meeting of 20 residents reviewed for Activities of Daily Living (ADL) care, resulting in poor hygiene and the potential for infection, skin irritation, body odor and feelings of embarrassment, diminished self-worth, and lack of dignity. Findings Include: Resident #14: Review of the face Sheet, MDS dated [DATE] and diagnosis sheet, revealed Resident #14 was [AGE] years-old, admitted to the facility on [DATE], dependent on staff for all activities of daily living. The resident's diagnosis included, respiratory failure, diabetes, Depressive Disorder, Anxiety, Restless Leg Syndrome, high blood pressure and embolism and thrombosis of arteries of the lower extremities. The resident had a artificial breathing tube (trach) and was a full code. The resident was a total assistance for showers and bed baths. Review of the MDS cognitive assessment dated [DATE], revealed the resident was alert and able to make her own healthcare decisions. During an interview done on 4/25/23 at 12:48 a.m., Resident #14 said staff do not give her bed baths (she does not like showers) regularly. She said she only gets showers when (Shower Aide X) works. I do not get my showers or bed baths weekly. I get one bed bath every other week. Review of the facility Central Hall Shower schedule revealed the resident should have been getting a bath or shower on Tuesdays and Fridays. Review of the resident's electronic record shower/bath record dated 4-4-23 through 5-2-23 revealed, only 4 bed baths were given, and no refusals were documented. The resident went from 4/8/23 through 4/17/23 without a bed bath or shower given. During an interview done on 5/3/23 at 11:50 a.m., MDS Coordinator O stated I didn't find any notes in the record why she did not get her showers or baths. The bathing preference sheet should be documented the same as the shower/bath sheet. It's the responsibility of the Aides (CNA's) on the floor if the showers don't get done on days to do them. (Shower Aide X) only works on day's; they (CNA's) should be doing the showers and bath's if she can't get them on their scheduled days. If they (Resident's) refuse, there should be a note put in. The shower Aide gets pulled to the floor about once or twice a week. (continued on next page)

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	235132	A. Building B. Wing	05/04/2023

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility Documentation in Medical Records policy dated 3/23, reported Each residents medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the residents progress through complete, accurate, and timely documentation. Documentation shall be completed at the time of service, but no later than the shift in which the assessment, observation, or care service occurred. Resident #29: Review of the Face Sheet, MDS dated [DATE] and care plans dated 2/19, revealed Resident #29 was 47, alert, admitted to the facility on [DATE], and dependent for all Activities of Daily Living (ADL). The resident's diagnosis included, chronic heart and lung disease, diabetes, anxiety disorder, restless leg syndrome, muscle weakness, stenosis of larynx, and high blood pressure. Review of the MDS dated [DATE], revealed the resident was a alert and able to make own decisions. Review of the Central Hall Shower schedule revealed the resident should have been getting a bath or shower on Tuesdays and Fridays. Review of the resident's electronic record shower/bath record dated 4-4-23 through 5-2-23 revealed, the resident had a total of 10 days without shower or bed bath. The resident had a refusal on 4/26/23, no documentation was found in the electronic record of why he refused or if staff attempted to give a shower later in the day. During an interview done on 5/3/23 at 11:30 a.m., MDS Coordinator O stated There was no notes about (Resident #29) refusal in the electronic record. Resident #33: Review of the Face Sheet, MDS dated [DATE], and care plans dated 9/22, revealed Resident #33 was [AGE] years-old, alert, admitted to the facility on [DATE] and required assistance with ADL's. The resident's diagnosis included, heart disease, diabetes, major depression, adjustment disorder, gasto-reflux, muscle weakness, and muscle weakness. Review of the MDS dated [DATE], revealed the resident was fully alert and able to make his own healthcare decisions. During an interview done on 4/27/23 at 9:10 a.m., Resident #33 stated If I do not get my shower, and sometimes they try, I pitch a bitch. Resident #45: Review the Face Sheet, Minimum Data Set (MDS, dated [DATE]), care plans dated 1/24/23 through 4/27/23, revealed Resident #45 was [AGE] years-old, admitted to the facility on [DATE], was alert and making her own healthcare decisions, required staff assistance with all Activities of Daily Living and was blind in right and left eyes. The resident's diagnosis included, Right and Left eye blindness (category 5, only see's close-up shadows), glaucoma secondary to eye disorder, stroke, high blood pressure, chronic heart and lung disease, diabetes, chronic kidney disease, difficulty walking, epilepsy, and muscle weakness. The resident was a total assist for showers and bed baths. (continued on next page)

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	235132	A. Building B. Wing	05/04/2023

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the MDS dated [DATE], revealed the resident was a 15 (alert and able to make own decisions) cogitation. Review of the Central Hall Shower schedule revealed the resident should have been getting a bath or shower on Tuesdays and Fridays. Review of the resident's electronic record shower/bath record dated 4-4-23 through 5-2-23 revealed, the resident went from 4/7/23 to 4/13/23 with no documented showers or bed baths from 4/4/23 through 5/2/23 (a total of 10 days without shower or bed bath). During an interview done on 5/3/23 at 11:50 a.m., MDS Coordinator O stated All the documentation should be in the electronic record. During an interview done on 4/27/23 at 9:00 a.m., Shower Aide/ CNA X stated I am just the one (shower aide) for the whole facility. I am responsible to do 14 to 15 showers a day. I don't get them all done. I do 8 hours a day. If they (resident showers) don't get done, we don't have the staff, so that means they won't get done. The next shift CNA's are supposed to do them. During an interview done on 4/27/23 at 8:55 a.m., CNA Z stated She (Shower Aide X) has to do the whole building, all the showers. During an interview done on 4/27/23 at 8:50 a.m., Nurse, RN U stated We have a lot of call-In's, seconds is our problem. We usually only have 2 CNA's, it's a problem. Honestly, they (resident showers) don't get done. During an interview done on 4/27/23 at 8:45 a.m., Nurse, RN AA stated Management expects us to get them (resident showers) all done. There is one day shift shower aide and seconds doesn't have one. I do get complaints from resident's lately complaining to me they don't get their showers. During an interview done on 4/27/23 at 9:05 a.m. the DON stated, We have one shower Aide now, it just got changed when the census went down (cut staff). Review oaf the facility Activities of Daily Living (ADL) policy dated 3/23, reported The facility will, based on the resident's comprehensive assessment and consistent with the resident's needs and choices, ensure a resident's abilities in ADL's do not deteriorate unless deterioration is unavoidable. Care and services will be provided for the following activities of daily living: Bathing, dressing, grooming and oral care. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Review of the facility Resident Showers policy dated 3/23, reported It is the practice of this facility to assist residents with bathing to maintain proper hygiene, stimulate circulation and help prevent skin issues as per current standards of practice. Residents will be provided showers as per request or as per facility schedule protocols and based upon resident safety. Review of the facility Bed Baths policy dated 3/23, revealed the procedure for a bed bath; no documentation of how often they are to be done is documented. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the Central Shower Schedule (un-dated) revealed, all resident rooms assigned to 2 days per week for showers or bed baths. All residents are assigned to 2 showers per week. 37668 Resident #10: On 4/26/23 at 11:30 AM, Resident #10 was observed in their room in bed with their eyes closed. The Resident was positioned on their back with their heels directly on the mattress. The Resident did not provide meaningful responses when asked questions. The Resident had an unkept appearance and their hair was uncombed and oily in appearance. A urinary catheter drainage bag was present on the right side of the Resident's bed (away from the doorway) with the drainage bag positioned directly on the floor. Record review revealed Resident #10 was admitted to the facility on [DATE] with diagnoses which included hemiplegia and hemiparesis (one sided paralysis) following cerebral infarction (stroke), bipolar disorder, epilepsy, dysphagia (difficulty swallowing), and gastrostomy (tube inserted into the stomach through a surgically created opening in the abdominal wall for the insertion of food). Review of the MDS assessment dated [DATE] revealed the Resident was moderately cognitively impaired and required extensive to total assistance to complete all ADL's with the exception of eating. Review of Resident #10's Electronic Medical Record (EMR) revealed a care plan entitled, Resident needs assistance with activities of daily living r/t (related to) developmental disability . (Initiated: 3/22/23; Revised: 3/23/23). The care plan included the interventions: - Continence - assist with incontinent care (Initiated: 3/22/23) - Resident has indwelling catheter, make certain catheter is secured to leg, and kept at a level below the bladder, use privacy bag over urine collection bag (Initiated: 3/23/23) - Bathing/Showering: Nail care on bath day and as necessary. Report any changes to the nurse (Initiated: 3/23/23) - Bed Mobility: Staff assistance 1 pa (person assist) (Initiated: 3/23/23; Revised: 4/6/23) - Dressing: The resident is on (1) staff for dressing (Initiated and Revised: 3/23/23) - Eating: Staff assistance for supervision and cueing to slow down for safety. Resident is on a Pureed with nectar thick liquid diet (Initiated and Revised: 3/23/23) - Eating: The resident is dependent on (1) staff for eating (Initiated and Revised: 3/23/23) - Personal Hygiene: Staff assistance 1 pa (Initiated and Revised: 3/23/23) - Toilet Use: Staff assistance 1 pa (Initiated: 3/23/23; Revised: 4/6/23) - Transfer: Staff assistance one person (Initiated: 3/23/23; Revised: 4/6/23) (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Resident #10 did not have a care plan in place related to refusal of care. Review of Resident #10's progress note documentation in the EMR revealed no documentation of bathing, including showers/bed baths, and/or any refusals of care. Review of Resident #10's Health Care Provider (HCP) orders revealed the order, Shower Days Tuesday/Friday Evening Shift . (Ordered: 3/23/23) Review of Resident #10's EMR Point of Care (POC) task documentation for the prior 30 days was completed on 4/26/23. The tasks, Showers which included the questions, Did the resident receive a shower? and Did the resident receive a bed bath? were blank indicating the Resident had not received a shower and/or bed back in the 30-day period. Review of Documentation Survey Report dated April 2023, for Resident #10 included a section titled, ADL-Personal Hygiene . How resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face and hands (excludes baths and showers) . Documentation of the assistance Resident #10 required to complete personal hygiene care was inconsistent and ranged from the Resident independent (4/21/23 Night) to totally dependent upon staff members for care. Documentation was not completed and blank, indicating no care had been completed on: - 4/9/23 (Night) - 4/11/23 (Night) - 4/12/23 (Evening) - 4/14/23 (Night) - 4/20/23 (Evening) - 4/21/23 (Evening) - 4/22/23 (Night) - 4/25/23 (Night) - 4/26/23 (Evening) Additionally, 8- Activity did not occur . was documented on the following dates: - 4/2/23 Night - 4/3/23 Night - 4/4/23 Evening and Night - 4/6/23 Evening and Night (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- 4/10/23 Night - 4/12/23 Night - 4/13/23 Evening and Night - 4/14/23 Evening - 4/16/23 Evening and Night - 4/17/23 Night - 4/18/23 Night - 4/24/23 Evening - 4/25/23 Evening - 4/26/23 Night An interview was completed with MDS Coordinator Registered Nurse (RN) O on 5/3/23 at 1:38 PM. When queried regarding the frequency Residents should receive showers and/or bed baths, RN O revealed showers were given twice a week but that individual Resident preferences were taken into account. When queried if showering and bathing are included on each Resident's care plan, RN O revealed it is part of the ADL care plan. When queried if there was any reason Resident #10 was unable to receive a shower, RN O disclosed they were not aware of a reason the Resident could not receive a shower. RN O was then asked to review bathing documentation in Resident #10's EMR. RN O stated, It shows no showers given and no bed baths. RN O proceeded to review the Resident's HCP orders and stated, It (shower task) is assigned for staff to complete. When asked why there was no documentation of the Resident having received a shower and/or bed bath, RN O was unable to provide an explanation. When asked to review the ADL-Personal Hygiene task documentation, RN O reviewed the Resident's EMR and stated, Everything contradicts itself in relation to the amount of assistance the Resident required to complete care. When asked about the blank areas on the documentation report, RN O verified the task was not completed. RN O was unable to provide further explanation. Resident #21: On 4/25/23 at 3:14 PM, Resident #21 was observed in their room. The Resident was sitting in a wheelchair visiting with a family member in the room. An interview was conducted with Resident #21 and their family member at this time. When queried regarding the level of assistance they require from staff for transferring and ADL care, Resident #21 revealed they required assistance from staff for transferring and bathing. When queried regarding the frequency in which the Resident received showers, Resident #21 indicated they had not received a shower, but staff had washed them up. Record review revealed Resident #21 was admitted to the facility on [DATE] with diagnoses which included diabetes mellitus, sleep apnea, arthritis, depression, anxiety, and open wound on their left foot. Review of the MDS assessment dated [DATE] revealed the Resident was cognitively intact and required extensive to total assistance to complete all ADL's with the exception of eating. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of Resident #21's POC Shower and Bed Bath documentation for the past 30 days revealed the Resident had not received a shower or bed bath at the facility. Resident #84: On 4/25/23 at 12:29 PM, Resident #84's room door was closed. Upon knocking and entering the room, an overwhelming foul body odor was instantly noted. The odor permeated throughout the room. Resident #84 was observed in their bed with their eyes open. The Resident's hair was long and uncombed with a very greasy appearance. An interview was completed at this time. Resident #84 was asked if they require assistance to complete ADL's, the Resident indicated they do as much as they can by themselves because they want to go home. When queried how frequently they receive showers, Resident #84 indicated they were supposed to get a shower once a week but did not elaborate further. While speaking, Resident #84's teeth were noted to be discolored and visibly dirty with plaque and an unknown dark substance in-between their teeth. Resident #84 was queried regarding oral care and brushing their teeth and revealed they had not brushed their teeth since they came to the facility. A toothbrush was not observed in the bathroom. When asked if they had a toothbrush and toothpaste, Resident revealed they did not know. When asked, Resident #84 provided permission to look for a toothbrush. In the second drawer of the bedside dresser, an unopened toothbrush (contained in plastic) and toothpaste was observed. Record review revealed Resident #84 was admitted to the facility on [DATE] with diagnoses which included repeated falls, diabetes mellitus, and dementia. Review of the MDS assessment dated [DATE] revealed the Resident was cognitively intact and required total assistance for bathing and limited assistance with transferring, dressing, and toilet use. Review of Resident #84's care plans revealed a care plan entitled, Resident needs assistance with activities of daily living. Activity Intolerance (Initiated: 3/17/23). The care plan included the interventions: - Continence - assist with incontinent care (Initiated: 3/23/23) - Bed Mobility: Staff assistance 1 PA (Person Assist) (Initiated: 3/23/23; Revised: 3/29/23) - Dressing: The resident is on (1) staff for dressing (Initiated and Revised: 3/23/23) - Eating: Staff assistance set up (Initiated and Revised: 3/23/23) - Oral Care: Staff to assist/encourage oral care twice daily and as needed. Notify nurse of any redness, irritation or complaints of oral pain (Initiated: 3/23/23) - Personal Hygiene: Staff assistance 1 PA (Initiated and Revised: 3/23/23) - Toilet Use: Staff assistance 1 PA (Initiated and Revised: 3/23/23) - Transfer: The resident is dependent on (1) staff for transferring (Initiated and Revised: 3/23/23) (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of Resident #84's POC Shower documentation for the past 30 days revealed the Resident had not received a shower. On 4/25/23 at 2:24 PM, an interview was conducted with Certified Nursing Assistant (CNA) KK. When asked what time their shift was over, CNA KK replied, I'm staying over until 6:00 (PM) because of low staffing. CNA KK was asked how many staff were scheduled to work on the Medbridge and North units and replied, One aide (CNA). CNA KK was asked about the odor in Resident #84's room and stated, I think it is (Resident #84), it always smell (in their room). CNA KK was asked when Resident #84 had received a shower and revealed they were unsure as the shower aide (CNA) is frequently pulled to work on a unit due to low staffing. On 4/27/23 at 11:11 AM, Resident #84 was not present in their room and the foul odor remained but was less pungent. The water in the bathroom sink was turned on and running with no one in the room. Resident #245: An observation of Resident #245 occurred on 4/25/23 at 12:45 PM in their room. The Resident was in bed, positioned on their back with their heels directly on the mattress. An interview was completed at this time. When queried regarding the care they receive in the facility, Resident #245 expressed how busy the staff are but did not provide a direct response. Resident # 245 was then asked how much assistance they require to get out of bed and disclosed they are dependent on staff for all care as they have limited mobility. Resident #245 was then asked how they brush their teeth and responded that they have dentures. When asked if staff assist them to clean their dentures and/or ensure they have the supplies they need to clean them, Resident #245 stated, They don't. When asked if they had supplies to clean their dentures, Resident #245 indicated they did not this so. With permission, an inspection of their room was completed. No oral care/denture cleaning supplies were present in the room. When asked if they had received a shower since being admitted to the facility, Resident #245 replied, No and indicated the staff clean them when they change their brief. Resident #245 was asked if the staff complete an entire bed bath or if they just clean their peri-area when they change their brief, the Resident revealed the staff primarily wash their peri-area. When queried if they had been offered a shower, Resident #245 revealed they had not. Resident #245 was asked if they would like to take a shower and revealed they would if it could be done safely. Record review revealed Resident #245 was admitted to the facility on [DATE] with diagnoses which included Congestive Heart Failure (CHF), Chronic Obstructive Pulmonary Disease (COPD), Parkinson's disease, and diabetes mellitus. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was cognitively intact and was totally dependent upon staff for all ADL's with the exception of eating. Review of Resident #245's Electronic Medical Record (EMR) revealed the Resident did not have a resident centered care plan with interventions specific to bathing and oral care. A care plan entitled, Resident needs assistance with activities of daily living (Initiated: 4/7/23) was noted in the Resident's EMR. The care plan included the interventions: - Bilateral soft AFO boots on while in bed as the patient tolerates (Initiated: 4/13/23) - Bed Mobility: Staff assistance (Initiated: 4/7/23) (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- Personal Hygiene: Staff assistance (Initiated: 4/7/23) - Toilet Use: Staff assistance (Initiated: 4/7/23) - Transfer: Staff assistance with mechanical lift and 2 people (Initiated and Revised: 4/7/23) Review of Resident #245's Visual/Bedside Kardex Report included the tasks: - Bathing . Showers . - Personal Hygiene/Oral Care . Oral Care (Specify dentures, natural teeth, partials or no teeth) . Note: Dentures were not specified. Review of Resident #245's Documentation Survey Report for April 2023 did not include a shower task. The task, ADL- Bathing (Prefers: SPECIFY) task did not identify what care was provided and indicated inconsistent levels of staff assistance ranging from the Resident completing care independently to being totally dependent upon staff. The task, Oral Care (Specify dentures, natural teeth, partials or no teeth) was not documented as twice daily and did not indicate what care was provided. Review of Resident #245's progress note documentation in the EMR revealed no documentation of bathing, including showers and/or bed baths, oral care/dentures, and/or any care refusals. On 4/25/23 at 2:24 PM, an interview was conducted with Certified Nursing Assistant (CNA) KK. When queried if Resident #245 required assistance to complete oral care, CNA KK revealed they did. When asked if they had assisted the Resident to complete oral care, CNA KK stated, Didn't do their dentures. When asked why they had not assisted the Resident with denture/oral care completion, an explanation was not provided. Resident #250: (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 4/26/23 at 10:10 AM, Resident #250 was observed in their room sitting in their wheelchair. An interview was completed at this time. Resident #250 was alert, pleasant, and oriented to person, place, time and situation. When queried, Resident #250 revealed they came to the facility from the hospital after they fell and fractured their hip. When queried regarding the care they were receiving at the facility, Resident #250 did not respond verbally but shrugged their shoulders. When queried what they meant, Resident #250 conveyed they did not want to cause any trouble. Resident #250 was then asked how much assistance they require to get out of bed and revealed they could not get out of bed without staff assistance. When queried if staff assisted them to brush their teeth, Resident #250 revealed they have dentures. When asked if staff assist them to clean their dentures and/or ensure they have the supplies needed, Resident #250 stated, Not been cleaned. They haven't helped me. Resident #250 revealed their dentures no longer fit very well and stated, I have a sore in my mouth. When asked if they had told nursing staff about the sore, Resident #250 revealed they had but were unable to recall the staff member's name whom they told. Resident #250 was then asked if staff assisted them to take a shower and stated, No. With further inquiry Resident #250 revealed they had not received a shower since being admitted to the facility. When asked if they received any bathing care while at the facility, Resident #250 revealed the indicated the staff had washed them up in bed. When asked how often that occurred, Resident #250 revealed the staff would wash them up when they provided incontinence care. Resident #250 was then asked if they wanted to take a shower and stated, Yeah. The Resident continued to explain how staff do not take them to the bathroom so they have to urinate in their brief and how they would feel better if they were able to take a shower and get clean. Record review revealed Resident #250 was admitted to the facility on [DATE] with diagnoses which included right femur fracture, diabetes mellitus, overactive bladder, and arthritis. Review of the 5-Day MDS assessment dated [DATE] did not include documentation of the Resident's cognitive status and did not specify the level of assistance the Resident required for ADL care completion as the ADL activities had Occurred 2 or Fewer Times. Review of Resident #250's Nursing Admission/Readmission Evaluation dated 4/17/23 detailed, Level of consciousness: Alert . Resident is able to communicate wants and needs. Consider both verbal and non-verbal communication: Yes . Activities of Daily Living . a. Level of assistance needed for Ambulation . Totally Dependent . b. Level of assistance needed for Transfers . Totally Dependent . Level of assistance needed for Toileting . Totally Dependent . Level of assistance needed for Bathing . Totally Dependent . Level of assistance needed for Eating . Independent . Does resident have any limitations in range of motion . Yes . RLE (Right Lower Extremity) . Oral Status . Does the resident have their natural teeth? Yes . Review of Resident #250's EMR revealed the Resident did not have a care plan and/or a care plan with interventions specifically related to showering and oral care. A care plan entitled, Resident needs assistance with activities of daily living (Initiated: 4/18/23) was noted in the EMR. The care plan included the interventions: - Continence - assist with incontinent care (Initiated: 4/18/23) - Bed Mobility; Staff assistance (Initiated: 4/18/23) - Eating: Set up and staff assistance as needed (Initiated and Revised: 4/24/23) - Personal Hygiene: Staff assistance (Initiated: 4/18/23) (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- Ambulation: The resident requires staff assistance: (SPECIFY). Assistive Device used: (SPECIFY) (Initiated: 4/18/23) - Toilet Use: Staff assistance (Initiated: 4/18/23) - Transfer: Staff assistance with one person (Initiated: 4/18/23; Revised: 4/21/23) Review of Resident #250's HCP orders revealed the order, Shower Days Wednesday/Saturday Evening (Start Date: 4/18/23). Review of Resident #250's April 2023 POC Response History . Showers . revealed no documentation of completion. POC documentation titled, Oral Care revealed documentation of daily care completion. Review of Resident #250's April 2023 Documentation Survey Report revealed a section of documentation titled, ADL- Personal Hygiene. Review of the documentation revealed no documentation of care completion and inconsistent documentation of assistance provided. Documentation ranged from independent to total assistance for completion. An interview was conducted with Confidential CNA PP on 5/2/23 at 7:21 PM. When queried regarding the frequency in which Residents receive showers, CNA PP disclosed showers are supposed to be given twice a week. When asked where showers are documented, CNA PP revealed showers should be documented under showers in the EMR. CNA PP then stated, Them residents haven't had no shower in over a month because we don't have no staffing. When queried regarding frequency in which dependent residents including Resident #'s 10, 21, 245, and 250 are turned and repositioned in bed, CNA PP revealed staff do the best they can. When asked if the Residents are turned and repositioned every two hours, CNA PP stated, No, we don't have the staff. An interview and review of Resident #250's EMR was completed with MDS RN O on 5/3/23 at 1:20 PM. When queried regarding the Resident's care plans having (Specify) following staff assistance and assistive device used. RN O replied, I told them (nursing staff) they have to include it when it says specify. When asked to explain further, RN O revealed staff had been educated and instructed to put resident specific information in the care plan area which states specify. Resident #250's shower documentation was reviewed with RN O at this time. When asked if the documentation indicated the Resident had not received a shower, RN O confirmed. When asked the reason Resident #250 had not received a shower, RN O reviewed the EMR, indicated there was no medical reason for the Resident to not shower, and was unable to provide an explanation. RN O then stated, I don't know why, it's on there for them to document (showering). Resident #250's ADL-Care documentation was reviewed with RN O at this time. RN O was asked what specific care task was provided when staff documented the task as completed and revealed they were unsure. When queried regarding the differences in the documented level of assistance provided for care completion, RN O stated, Does not make sense. RN O continued, I've been seeing that. RN O stated, I don't know. They (staff) definitely need some more training. (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	05/04/2023

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	An interview was conducted with the [NAME] President (VP) of Operations, Registered Nurse (RN) E on 5/3/23 at 3:26 PM. The Director of Nursing (DON) was off work due to illness and unavailable for interview. RN E was asked if showers should be documented under Showers in the EMR and stated, Should be. Resident #84's blank shower documentation was reviewed with RN E at this time. When queried if the blank documentation indicated the Resident had not received a shower during the prior 30 days, RN E reiterated there was no documentation. RN E did not provide further explanation but stated, One more thing to add to audits. 22927 Confidential Resident Council Meeting: Interviews on 04/26/23 at 09:52 AM had eight residents and a few stragglers that entered once meeting started revealed that 4 out of 8 Resident of the group voiced concerns of not receiving showers consistently and are told that showers should be twice a week, but they tell residents they do not have the staff to give showers. Another resident revealed that he hardly get a shower at all, staff want residents to wash up in the bathrooms. The 4 other residents of the group voiced that if they get showers or they complain about to staff. Resident #18: Record review of Resident #18's electronic medical record revealed the resident was receiving hospice services. In an interview on 04/25/23 at 11:07 AM with Resident #18 revealed that he did not get showers that the staff give him bed baths. Resident #18 stated that he would like to get in the shower. Why can't I. Hospice only wash me up, but not every time they come. Why can't i get into the shower? Look into that for me. interview and record review on 05/03/23 at 11:55 AM with Licensed Practical Nurse (LPN/MDS) O, reviewed the shower task and

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37668 Based on interview and record review, the facility failed to implement and operationalize guidelines and procedures for the enactment of a Durable Power of Attorney (DPOA) for one resident (Resident #90) of one resident reviewed, resulting in the enactment of a DPOA without determination of legal incompetency and the potential for inappropriate enactment of a DPOA and unwanted care decisions. Findings include: Resident #90: Record review revealed Resident #90 was admitted to the facility on [DATE] with diagnoses which included chronic respiratory failure, heart failure, and lung cancer. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was moderately cognitively impaired and required extensive to total assistance to complete all Activities of Daily Living (ADL's) with the exception of eating. Resident #90 passed away in the facility on [DATE]. Review of Resident #90's Electronic Medical Record (EMR) revealed the following active and discontinued Health Care Provider (HCP) orders: - Full Code (Ordered: [DATE]; Discontinued: [DATE]) - DNR (Do Not Resuscitate) (Ordered: [DATE]) Review of Resident #90's care plans revealed a care plan entitled, (Resident) or representative if resident unable to) has established advanced directive and wishes to be Full Code (Initiated: [DATE]) Review of Resident #90's EMR revealed the following scanned documents: - Durable Power of Attorney (For Care, Custody, and Medical Treatment Decision) and Instructions to Health Care Providers . (Resident #90) . appoint the following as my Patient Advocate: (Witness EEE) and/or (Witness FFF) . signed by the Resident on [DATE]. - Do Not Resuscitate Order . Signed by Witness FFF on [DATE] and Physician GGG on [DATE]. The Attestation of Witnesses section was signed by Licensed Practical Nurse (LPN) TT and the Director of Nursing (DON) on [DATE]. An incompetency determination was not present in Resident #90's EMR. Review of documentation in Resident #90's EMR 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	05/04/2023

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- [DATE]: History and Physical . recently admitted to this facility from the hospital where was treated for a recurrent right pleural effusion (patient was found to have mediastinal lymphadenopathy [enlarged lymph nodes] . biopsy was recommended . but patient's family refused intervention), respiratory insufficiency, and chronic atrial fibrillation (irregular heart rhythm) . no acute complaints at this time . ACP (Advanced Care Planning) done with this patient. Patient has POA (Power of Attorney) documents in the record. These were reviewed . - [DATE]: Progress Notes . Follow up . sent to this facility for further medical care and rehab . has a DNR . Review of the Medical Certificate of Death dated [DATE] specified the Resident died at 9:33 AM died due to an Acute Myocardial Infarction (heart attack) . An interview was conducted with MDS Registered Nurse (RN) O on [DATE] at 1:09 PM. When queried what Resident #90's code status was when they passed, RN O reviewed the Resident's EMR and stated, DNR. RN O was asked if the Resident's care plan should reflect their code status and indicated it should. When queried what Resident #90's code status was, per their care plan, RN O reviewed the Resident's EMR and replied, Care plan says full code. When asked why the information did not match, RN O stated, My best guess is (Resident #90) came in, they (nursing staff) put them as a full code and then changed it. When asked if the care plan should have been changed if the order was changed, RN O stated, Yes. When asked, RN O was unable to explain why the care plan was not changed/updated. RN O was asked if Resident #90 was their own person and capable of making their own medical decisions. RN O reviewed the Resident's EMR and stated, I would say pleasantly confused. Has a DPOA. With further inquiry, RN O revealed Witness FFF signed the Resident's DNR form, and they were the Resident's DPOA. When asked if the DPOA had been activated, RN O replied, I say it is active because of the date on the DPOA. When asked what they were referring to, RN O indicated they were referring to the date the DPOA was created on [DATE]. When asked if the Resident had been deemed incompetent, RN O revealed they did not see incompetency determination in the EMR. When asked how the DPOA was in effect when the Resident had not been deemed incompetent, RN O revealed they were not familiar with DPOA processes. An interview was conducted with Social Worker H on [DATE] at 1:56 PM. When queried regarding Resident #90's code status, Social Worker H stated, (Witness FFF) signed the DNR. When queried why Resident #90 did not sign the DNR form themselves, Social Worker H replied, (Witness FFF) was the POA. Social Worker H was queried regarding documentation of Witness FFF being the Resident's DPOA, Social Worker H reviewed Resident #90's EMR and referred to the DPOA documentation in Resident #90's EMR. When queried if the Resident had been deemed incompetent and unable to make their own medical decisions, Social Worker H replied, I don't know. When asked if an individual had to be deemed incompetent for a DPOA to become activated, Social Worker H replied, (Witness FFF) said it was active. Social Worker H was asked if they had documentation that the Resident was deemed incompetent, Social Worker H did not respond. Social Worker H was then asked if a Resident has to been deemed incompetent for a DPOA to become active and revealed they did. When queried if Resident #90 had been deemed incompetent, Social Worker H replied, (Resident #90) was not deemed incompetent. Social Worker H was then asked why Witness FFF signed the DNR form when the Resident was not incompetent but did not provide an explanation. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was completed with Unit Manager LPN TT on [DATE] at 2:34 PM. LPN TT was queried regarding the facility policy/procedure pertaining to Attestation of Witness signatures on a DNR order. LPN TT revealed two nurses sign the form after the physician signs the order. When queried what the attestation means when they are signing the form, LPN TT revealed they believed they thought it meant that they were verifying the order. When queried if a Resident has to be deemed incompetent for a DPOA to become active, LPN TT indicated they did. LPN TT was then asked if Resident #90 had been deemed incompetent when Witness FFF signed the DNR order, and they signed as a witness. LPN TT revealed facility social services ensures that part of the process is completed prior to the form being signed and presented to the physician and nursing staff. When queried regarding lack of documentation of Resident #90 having been deemed incompetent in the EMR, LPN TT did not provide further explanation. An interview was completed with the Director of Nursing (DON) on [DATE] at 11:58 AM. When queried regarding the facility process/procedure related to enactment of a DPOA and incompetency, the DON revealed a Resident has to be deemed incompetent prior to a DPOA taking effect. When asked whose role that is in the facility, the DON replied, Social work. Resident #90's signed DNR order was reviewed with the DON at this time. When asked why their signature, under Attestation of Witness was dated [DATE] when Witness FFF signed the form on [DATE], the DON revealed they are signing as an attestation of the physician and do not sign the form until they sign it. When queried why Witness FFF signed Resident #90's DNR order and the Resident was made a DNR when they were not deemed incompetent, the DON revealed they were unaware the Resident had not been deemed incompetent. The DON disclosed that the facility Social Worker is supposed to ensure the documentation is in place and correct prior to presenting to nursing staff. Review of facility policy/procedure entitled, Advance Directives (Dated: ,d+[DATE]) revealed, It is the policy of [NAME] Care to provide information to resident/responsible party regarding his/her rights to formulate advanced directives including the right to refuse or accept medical care. The facility will not discriminate against any individual based on whether or not they have implemented an advanced directive. If a resident has a valid Advanced Directive, the facility's care will reflect the resident's wishes as expressed in the Directive, in accordance with state law . 2. Executed Advanced Directives will be documented in the medical record. Code status directives (both full and no code will be documented via a physician's order, on the face sheet and care plan. 3. Advanced Directives will be reviewed quarterly in the care plan conference with the IDT and resident/responsible party as applicable .

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	235132	A. Building B. Wing	05/04/2023

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F 0686 Level of Harm - 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** 37668 Based on observation, interview and record review, the facility failed to implement and operationalize policies and procedures for pressure ulcer (wounds caused by pressure) care for five residents (Resident #10, Resident #21, Resident 37, Resident #245, and Resident #250) of seven residents, resulting in a lack of implementation of resident-centered and/or planned interventions, timely assessment, inaccurate documentation/staging of wounds/pressure ulcers, care per professional standards of practice, Resident #245 developing a Deep Tissue Injury (DTI-unstageable pressure injury with unknown depth due to damage to underlying tissues) and Stage II (partial thickness loss of tissue presenting as a shallow open ulcer with a red pink wound bed, without slough) pressure ulcers, unnecessary pain, and the likelihood for decline in overall health status. Resident #245: An observation of Resident #245 occurred on 4/25/23 at 12:45 PM in their room. The Resident was laying in bed, positioned on their back with their heels directly on the mattress. An interview was completed at this time. Resident #245 appeared uncomfortable during the interview with noted facial grimacing. When asked if they were in pain, Resident #245 revealed they were and stated, I have a sore on my butt. Resident #245 was asked if they had any other pain, Resident #245 indicated they did but the wound on their buttocks was bothering them the most. When queried if they received interventions for pain relief, including medications, Resident #245 indicated they did not receive scheduled medication but were able to receive a pain pill when they ask nursing staff. Resident #245 was then asked how frequently staff reposition them in bed and revealed they are only repositioned when staff check their brief and/or provide incontinence care. When queried how frequently that occurs, Resident #245 revealed it is usually once or twice during a shift. Resident #245 was then asked how often they get out of bed and/or leave their room and replied, Don't leave (their room) to do anything. When asked if they are able to move their legs and feet, Resident #245 revealed they had limited mobility on their own and depended on staff to assist them. When queried regarding their heels being positioned directly against the mattress and if staff elevate their feet and heels off of the bed, Resident #245 revealed they do not and stated they used to have boots that they would wear in bed but did not know what happened to them. With permission from the Resident, an observation of their room was completed, and no heel/positioning boots were present in the room. At 2:20 PM on 4/24/23, Resident #245 was observed laying on their back in bed with their heels positioned directly on the mattress. An interview was completed with Certified Nursing Assistant (CNA) KK on 4/25/23 at 2:24 PM. When queried regarding Resident #245, CNA KK revealed the Resident required staff assistance to turn and reposition in bed and for Activity of Daily Living (ADL) care. When asked if staff work eight or 12-hour shifts, CNA KK specified shifts are scheduled for eight hours. CNA KK then stated, I'm staying over until 6:00 PM because of low staffing. With further inquiry, CNA KK revealed there would only be one aide working on the North and Medbridge units if they did not stay over (24 Residents reside on the units). When asked, CNA KK revealed the facility was frequently short staffed. On 4/26/23 at 10:04 AM, Resident #245 was observed in their room. The Resident was in bed, positioned on their back with their heels directly against the mattress. (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	05/04/2023

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F 0686 Level of Harm - Actual harm Residents Affected - Few	An interview was completed with LPN MM on 4/26/23 at 8:24 AM. When asked if any Residents they were assigned to care for had wounds and/or wound treatments, LPN MM stated, Resident #245 has an open wound on their coccyx. Record review revealed Resident #245 was admitted to the facility on [DATE] with diagnoses which included Congestive Heart Failure (CHF), Chronic Obstructive Pulmonary Disease (COPD), Parkinson's disease, and diabetes mellitus. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was cognitively intact and was totally dependent upon staff for all ADL's with the exception of eating. The MDS further revealed the Resident was at risk for pressure ulcer development, did not have any pressure ulcers, but did have Moisture Associated Skin Damage (MASD- skin damage caused by prolonged exposure to excessive moisture). Review of Resident #245's Electronic Medical Record (EMR) revealed the Resident did not have a resident centered care plan pertaining to their wounds with personalized interventions. A care plan entitled, Resident is at Risk for skin breakdown (Initiated: 4/7/23) was present in the EMR. The care plan included the interventions: - Assist with bed mobility to turn and reposition routinely (Initiated: 4/7/23) - Assist with routine toileting (Initiated: 4/7/23) - Preventative skin care as ordered/indicated (Initiated: 4/7/23) - Skin inspection weekly and as needed, document and notify MD of abnormal findings (Initiated: 4/7/23) Additional review of Resident #245's Electronic Medical Record (EMR) revealed the following documentation: - 4/6/23: Nursing Admission/Readmission Evaluation . Skin Conditions . Groin MASD . Right buttock MASD . Right thigh (front) inner MASD . Right toe(s) lateral great toe red blanchable area tx (treatment) in place . Left toe(s) tip of great toe old, discolored area . - 4/7/23: History and Physical (Physician) . came to this facility after a recent hospitalization . here for rehab and medical care . Positive: Fatigue, Low energy . Skin . Negative . Changes in skin color . Bruises, Rash . Open lesions . Skin: No rash or bruises noted . Negative: Changes in hair or nails, Changes in skin color, Swelling, Itching, Bruises, Rash, Mass, Open lesions . - 4/10/23: Progress Notes (Nurse Practitioner) . Skin: No acute changes . - 4/12/23 at 7:56 AM: Non-Pressure Ulcer - Weekly Observation . (Lock Date: 4/21/23) . Coccyx . MASD . Unchanged . Dry . Drainage: None . Length: 8.5 (centimeters [cm]) . Width: 5.5 (cm) . Current treatment plan: Apply barrier cream Q (every) shift . Wound Progress: Unchanged . - 4/12/23: Progress Notes (Nurse Practitioner) . Skin: No acute changes . (continued on next page)

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	235132	A. Building B. Wing	05/04/2023

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F 0686 Level of Harm - Actual harm Residents Affected - Few	- 4/14/23 at 3:26 PM: Weekly Nursing Summary . Weekly Skin Assessment . 1. Resident skin condition: Warm and dry . 2. Skin turgor . a. Normal turgor . 4. Indicate any current tissue injury . No Current Issues . - 4/17/23: Progress Notes (Nurse Practitioner) . Skin: No acute changes . - 4/19/23 at 7:51 AM: Non Pressure Ulcer - Weekly Observation . (Lock Date: 4/21/23) . Coccyx . MASD . Unchanged . Dry . Drainage: None . Length: 5.5 (cm) . Width: 5.5 (cm) . Describe any changes to treatment plan in the last week: Treatment changed to Hydrogel (wound dressing used for partial and full thickness loss wounds and wounds with slough [moist white/yellow colored wound exudate wound exudate] or eschar [necrotic tissue]) . 2. Current treatment plan: Cleanse coccyx with wound cleanser apply hydrogel cover with border gauze daily and PRN (as needed) . Wound Progress: Unchanged . - 4/20/23 at 1:49 PM: IDT . Risk Review . Reason for review: Weekly Follow-up . IDT Recommendation: IDT team met to discuss resident's plan of care for wound care treatments. Resident presents with 2 wounds: one on buttocks and one on right inner thigh. Coccyx wound unchanged new treatment started, inner right thigh resolved. There are no changes to diet order at this time, new treatment order . for buttocks. Resident is currently not on any additional supplements. Will continue to monitor. - 4/20/23: Progress Notes (Nurse Practitioner) . Skin: No acute changes . - 4/21/23 at 7:28 PM: Weekly Nursing Summary . Weekly Skin Assessment . 1. Resident skin condition: Warm and dry . 2. Skin turgor . a. Normal turgor . 4. Indicate any current tissue injury . No Current Issues . - 4/24/23: Progress Notes (Nurse Practitioner) . Skin: No acute changes . Review of Resident #245's Health Care Provider orders, Medication Administration Record (MAR), and Treatment Administration Record (TAR) revealed the following wound care treatments: - Apply house barrier cream to (B [bilateral]) buttocks, coccyx, right inner thigh, and peri-area every shift with incontinent episodes. May keep at bedside to be reapplied as needed every shift (Ordered: 4/6/23; Start Date: 4/7/23) - Cleanse coccyx with wound cleanser pat dry apply hydrogel cover with border gauze daily and PRN (as needed) for wound care (Ordered: 4/21/23; Start Date: 4/21/23). The treatment was not completed on 4/21/23. - Cleanse coccyx with wound cleanser pat dry apply hydrogel cover with border gauze daily and PRN every day shift for wound care (Ordered: 4/21/23; Start Date: 4/22/23) - Cleanse right lateral great toe with wound cleanser pat dry apply skin prep to right great toe daily every day shift for wound care (Ordered: 4/7/23; Start Date: 4/8/23) (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	05/04/2023

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 4/27/23 at 11:16 AM, Resident #245 could be heard from the hallway of the facility yelling Help me, help me repeatedly. Upon entering the Resident's room, Resident #245 was observed laying in bed, positioned on their back with their heels directly against the mattress. The Resident's call light was hung over the dresser next to their bed and not within their reach. When queried what was wrong, Resident #245 replied, The pain in my buttocks. Resident #245 was visibly uncomfortable, unsuccessfully attempting to move in the bed and non-verbal signs/symptoms of pain including facial grimacing. When asked if they had informed staff of their pain, Resident #245 revealed they had. Resident #245 stated, It been hurting since they changed me around 8:00 (AM). Resident #245 continued, I be hollering, and they get on me about that. When asked what that meant, Resident #245 revealed that facility staff told them to stop that hollering. When queried how that made them feel, Resident #245 revealed they did not like it and asserted, I can't (stop) because of the pain. Resident #245 was asked when they were last repositioned in bed and revealed it was when they were last changed around 8:00 AM. When asked to rate their pain on a scale from zero to 10, with 10 being the worst pain imaginable, Resident #245 stated their pain was a 10. While speaking to Resident #245, Unit Manager Licensed Practical Nurse (LPN) TT entered the Resident's room at 11:18 AM and administered Tylenol to the Resident. LPN TT did not assess the Resident's pain level/location nor provide any non-pharmacologic interventions including repositioning prior to exiting the room. Resident #245 revealed they were going to be discharged home today. When queried if their wound care treatments had been completed, Resident #245 answered they did not recall their wound care dressing being changed. Review of Resident #245's MAR and TAR revealed the Resident's wound care treatments had not been documented as completed on 4/27/23. An interview was completed with LPN TT on 4/27/23 at 11:26 AM. LPN TT was queried regarding Resident #245's pain level and stated, Five (out of 10). When asked what time they had assessed the Resident's pain level at five out of ten, LPN TT did not provide a response. When LPN TT was informed the Resident had stated their pain was at a 10/10, they did not provide further explanation. LPN TT was then queried if Tylenol was the only medication Resident #245 had ordered for pain and indicated they were only able to receive Tylenol at this time. A request to observe Resident #245's skin and wound care treatment prior to their discharge was requested with LPN TT at this time. LPN TT indicated the Resident's nurse had informed them they had already completed the treatment. When asked why Resident #245 did not recall the treatment being completed and the treatment was not documented as completed on the Resident's MAR/TAR, LPN TT revealed that was the first time they had seen the Resident that day and would let the Resident's nurse know. Further review of Resident #245's MAR and TAR revealed the following medication orders for pain management: - Hydrocodone-Acetaminophen (Norco- narcotic medication to treat moderate to severe pain) Oral Tablet 5-325 mg (milligram) . Give 1 tablet by mouth every 6 hours as needed for pain (Start Date: 4/6/23). Per the MAR, Resident #245 reviewed the medication multiple times during the month of April 2023 for pain levels ranging from zero to seven. The Resident had last received the medication on 4/6/23 at 7:31 AM. - Acetaminophen (Tylenol) Oral Tablet . Give 500 mg by mouth every 6 hours as needed for pain (Start Date: 4/7/23). Per the MAR, Resident #245 had received Tylenol once during their admission on 4/27/23 at 11:18 AM when administered by LPN TT. (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	05/04/2023

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Majestic Care of Flushing	540 Sunnyside Dr Flushing, MI 48433

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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 0686 Level of Harm - Actual harm Residents Affected - Few	At 11:40 AM on 4/27/23, Resident #245 was observed laying in bed, positioned on their back with their heels directly on the mattress. On 4/27/23 at 11:42 AM, an observation of Resident #245's wound care treatment was completed with LPN MM and CNA CC. Upon entering the room, Resident #245 was observed in the same position in bed with their heels positioned directly against the mattress. When the facility staff were preparing the turn the Resident to complete the wound care treatment, discolored skin was observed on the medial aspect of the Resident's left heel. Upon request, an observation of the Resident's skin on their bilateral feet was completed. The area of Resident #245's left heel which had been positioned directly against the mattress was noted to be deep/dark red and black in color. When queried if the tissue was blanchable, LPN MM pressed the deep/dark red colored area of the skin, and the tissue was observed to be non-blanchable (lack of blood perfusion). When LPN MM pressed the skin on the Resident's heel, Resident #245 yelled, Ouch! and their facial grimacing was observed. When asked, Resident #245 revealed their heel hurt when touched. LPN MM was asked if the tissue was blanchable and replied, No. With further inquiry regarding the wound, LPN MM indicated they do not stage wounds. When asked if the area was caused by pressure and if it was a pressure ulcer, LPN MM confirmed it was and reiterated they did not stage pressure ulcers. On Resident #245's right foot an open area, approximately the size of a dime, was present on the Resident's right great toe. The wound bed was shallow with visible tissue loss and was shiny and pink in color. There was no dressing in place over the wound and noting in place to prevent the blankets from rubbing on the wound. When asked, Resident #245 revealed their pain level was a nine or 10 out of 10. LPN MM indicated they were going to wait to complete the wound care treatment. Following the observation, Resident #245 remained positioned on their back in bed. An interview was completed with Unit Manager LPN TT on 4/27/23 at 12:05 PM. LPN TT was asked when Resident #245 developed a pressure ulcer on their heel and stated, (Resident #285) doesn't have one. LPN TT was informed of skin observation completed with LPN MM and revealed they were unaware of the Resident having any new skin concerns. An observation of Resident #245's left heel was completed with Unit Manager LPN TT at this time. When queried regarding the skin alteration, LPN TT stated, It's a DTI. Definitely a DTI pressure injury. When asked if Resident #245 was at risk for pressure ulcer development, LPN TT confirmed they were. When queried regarding observations of the Resident's heels being directly on the mattress, lack of repositioning, and lack of planned interventions to prevent pressure ulcers, LPN TT was unable to provide an explanation. When queried regarding the frequency in which skin assessments are completed by nursing staff, LPN TT revealed skin assessments are completed weekly and documented in the EMR. When asked if skin observations are also completed when Resident's received showers, LPN TT revealed CNA's observe the skin and report any abnormalities to nursing staff. When asked about documentation of showers, LPN TT revealed showers are documented in the EMR and CNA's also fill out paper shower sheet forms. Resident #245's paper shower sheets were requested at this time. Review of Resident #245's shower documentation revealed the Resident had not received a shower in the past 30 days at the facility. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	An interview was completed with the Director of Nursing (DON) on 4/27/23 at 12:16 PM. When queried if they were aware Resident #245 had a new, facility acquired DTI pressure ulcer identified today during the requested skin observation by this Surveyor, the DON confirmed they had been made aware by facility staff. The DON then stated, It has been almost a week since the last skin assessment was completed. When queried if they were saying that Resident skin is only observed during the weekly skin assessment, the DON did not respond. When asked if Residents skin should be observed when daily care and showers are completed, the DON replied, They should. The DON was then asked if it was acceptable that the area had not been identified by staff, the DON stated, No. The DON was asked how often dependent Residents, such as Resident #245 should be repositioned per standards of care, the DON revealed Residents should be repositioned every two hours. The DON was then asked about observations of Resident #245's heels being directly against the mattress and not being repositioned in bed and was unable to provide an explanation. When queried if they were aware and agreed that it was a concern Resident #245 had developed a facility acquired pressure ulcer and the lack of interventions to prevent pressure ulcers, the DON stated, I know. At 12:44 PM on 4/27/23, an observation of Resident #245's coccyx wound care treatment was completed with LPN MM and CNA KK. Upon entering the room, Resident #245 remained positioned on their back in bed. The facility staff repositioned Resident #245 on their side to complete the dressing change and wound care treatment. The dressing in place on the Resident's coccyx was undated. LPN MM proceeded to remove the dressing and a moderate amount of off-gray colored; foul smelling drainage was noted on the removed dressing. The exposed wound bed had two distinct wound areas. The skin on Resident #285's sacrum/buttocks was red/maroon in color. The area was approximately two and a half inches long and two inches across. A separate, open wound was present directly over the Resident's coccyx. The wound bed was irregularly shaped and approximately the size of a dime. The wound bed had visible tissue loss and depth. The wound bed was pink and white and coated with white/yellow slough with attached edges. Following wound care observation, the following documentation was added in Resident #245's EMR: - 4/27/23 at 12:19 PM: Pressure Ulcer- Weekly Observation . Left heel . Length: 4.5 (cm) . Width 4 (cm) . 2a. Indicate whether this site was acquired during the residents stay or whether it was present on admission: Acquired . 2b. Date acquired: 4/27/23 . What stage does ulcer currently present as? a. DTI (Suspected Deep Tissue Injury -pressure injury with unknown depth often seen as a localized area of discolored, intact skin due to damage of underlying tissue) . middle of left heel non-blanchable and firm . Describe any changes to treatment plan in the last week: Skin prep to be applied to left heel and profo boots to be worn while in bed . - 4/27/23 at 1:22 PM: Pressure Ulcer- Weekly Observation . Coccyx . Length: 5.3 (cm) . Width 5 (cm) . What stage does ulcer currently present as? c. Stage 2 . 5a. Overall Impression: d. Worsening . Drainage . None . Peri- Wound Tissue . intact . Describe wound edges and shape: well-defined . Wound Progress: Progressed . (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 4/28/23 at 8:36 AM, an interview was conducted with the DON. When queried regarding Resident #245's coccyx pressure ulcer, the DON confirmed the wound was a pressure ulcer not MASD. The DON then stated, Nurses assess (skin) weekly and indicated the Resident's skin assessment had not been completed for the week yet. The DON continued, The nurse would have caught it when the assessment was completed. When asked why the change in the wound was not identified and documented by the floor nursing staff who completed daily dressing changes, the DON replied, The nurse noticed the change (in the wound) but didn't change the classification. When asked if they were referring to the wound care treatment being changed from barrier cream to hydrogel on 4/21/23, the DON verified they were. When asked why the treatment order was not changed until 4/21/23 and not implemented until 4/22/23 when the wound (Non-Pressure Ulcer - Weekly Observation) assessment completed on 4/19/23 specified the wound treatment was changed to Hydrogel, the DON did not provide an explanation. When queried why the wound was documented as MASD and not a facility acquired pressure ulcer following the change in the wound, the DON reiterated the nurse did not change the wound classification after identification of the change. When queried if the pressure ulcer was a facility acquired pressure ulcer, the DON confirmed it was. The DON was then asked if stage two pressure ulcers have slough in the wound bed and indicated they did not. When asked why Resident #245's pressure ulcer was documented as a stage two pressure ulcer when the wound bed had visible slough, the DON was unable to provide an explanation. (Note: Stage three pressure ulcers have full thickness tissue loss and slough may be present). Resident #10: On 4/26/23 at 11:30 AM, Resident #10 was observed in their room in bed with their eyes closed. The Resident was positioned on their back with their heels directly on the mattress. An alternating air mattress was in place on the Resident's bed. The alternating air mattress was not making any noise and there were no lights on. Closer inspection of the air mattress controller revealed the power switch was in the off position and the alternating air mattress was turned off. Record review revealed Resident #10 was admitted to the facility on [DATE] with diagnoses which included hemiplegia and hemiparesis (one sided paralysis) following cerebral infarction (stroke), bipolar disorder, epilepsy, dysphagia (difficulty swallowing), and gastrostomy (tube inserted into the stomach through a surgically created opening in the abdominal wall for the insertion of food). Review of the MDS assessment dated [DATE] revealed the Resident was moderately cognitively impaired and required extensive to total assistance to complete all ADL's with the exception of eating. The MDS further revealed the Resident was at risk for pressure ulcer development and had one stage two pressure ulcer. Review of Resident #10's care plans revealed a care plan entitled, Resident has impaired skin integrity right buttocks small, scabbed area left buttocks MASD (Initiated: 3/22/23; Revised: 3/23/23). The care plan included the interventions: - Assess and document skin condition, notify MD of signs of infection (redness, drainage, pain, fever) (Initiated: 3/22/23) - Assess for pain and treat as indicated (Initiated: 3/23/23) - Assist with bed mobility to turn and reposition routinely (Initiated: 3/23/23) - Assist with toileting (Initiated: 3/23/23) (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	- Check for incontinence and provide incontinent care as needed. Notify nurse of any redness or irritation (Initiated: 3/23/23) - Notify MD of worsening or not improvement in wound (Initiated: 3/23/23) - Pressure reducing/redistributing cushion in chair (Initiated: 3/23/23) - Pressure reducing/redistributing mattress on bed (Initiated: 3/23/23) - Wound treatment as ordered (Initiated: 3/23/23) Review of Resident #10's Health Care Provider orders revealed the Resident did not have an active wound care treatment order. The following active orders related to pressure ulcer prevention were in place: - Pressure reduction mattress every shift . (Ordered: 3/22/23) - Pressure reduction cushion to wheelchair every shift . (Ordered: 3/22/23) - Apply house barrier cream to (B [bilateral]) buttocks, coccyx, and peri-area every shift with incontinent episodes. May keep at bedside to be re-applied as needed (Ordered: 3/22/23) There were no orders in the EMR specifying the settings for the Resident's alternating air mattress. Review of documentation in Resident #10's EMR detailed the following: - 3/23/23: Progress Notes . Acute . new admit . seen today to establish care . recently admitted to the hospital for altered mental status, slurred speech, diarrhea, cough and weakness. Pt (patient) treated for aspiration pneumonia . R (Right) buttock wound - wound care to follow . - 4/5/23 at 12:16 PM: Non-Pressure Ulcer Note . Left Buttock . Acquired . 3/22/23 . MASD on left buttock, unable to measure . Apply barrier cream Q (every) shift . pressure reducing mattress . pressure reducing chair cushion . - 4/5/23 at 1:06 PM: Pressure Ulcer Note . Right buttock - stage 2, 2 x 1 x 0 (cm) . Stage 2 (pressure ulcer) . Worsening . - 4/6/23 at 1:08 PM: IDT . Weekly Follow-up . Met with IDT team to discuss progress of resident's wound treatment. Resident currently presents with MASD on left buttock which resident was admitted with. Due to the nature of the wound, measurements were not able to be obtained. Overall, the wound looks unchanged. In addition, also has a stage 2 wound on right buttocks that appears to be worsening, compared to last week's measurements. This week measurements read 2 x 1 x 0 (cm) compared to last week 1.5 x 1 x 0 (cm) . - 4/12/23 at 11:10 AM: Non-Pressure Ulcer Note . left buttock . admitted . resolved . (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	- 4/12/23 at 11:14 AM: Pressure Ulcer - Weekly Observation . Right buttock . Resolved . Stage 2 . Healed . Preventative measures/special equipment . Pressure reducing mattress . On 4/27/23 at 3:02 PM, Resident #10 was observed laying in bed, positioned on their back with their heels directly against the mattress. Upon saying the Resident's name, they opened their eyes. When asked questions, Resident #10 made eye contact but did not provide meaningful responses to questions when asked. The alternating air mattress controller was in the same position at the end of the bed with the power off. At 3:07 PM on 4/27/23, LPN MM was asked to enter Resident #245's room to check the alternating air mattress. When asked what was wrong with the alternating air mattress, LPN MM did not immediately identify that the mattress power was off. When asked if the mattress was on, LPN MM did not respond. After pointing out where the power switch was on the alternating air mattress, LPN MM flipped the switch, the alternating air mattress motor was heard, and the mattress began to inflate. LPN MM then confirmed the mattress had been off. When queried who was responsible to ensure the mattresses were turned on and functioning, LPN MM did not provide a direct answer. On 4/27/23 at 3:10 PM, an interview was completed with Unit Manager LPN TT. When queried regarding facility policy/procedure related to monitoring of alternating air mattress function and staff responsibility, LPN TT replied, Nurses should check. LPN TT was informed of observation of Resident #10's alternating air mattress being off on 4/26/23 and 4/27/23, LPN TT was unable to provide an explanation. When queried what the settings were supposed to be on Resident #10's alternating air mattress, LPN TT revealed they did not know and there was no order/documentation of what the settings are supposed to be set at. An interview was conducted with the DON on 4/28/23 at 8:44 AM. When queried regarding the facility policy/procedure related to monitoring and use of alternating air mattresses, the DON replied, Nurses and CNA's. The DON revealed they were aware of the concerns related to air mattress not being on and lack of orders/staff awareness of settings. The DON then stated, (Air mattress monitoring/settings) are on the TAR task now. When asked if they were saying the task was added, the DON revealed they added the orders/tasks the previous day. The DON stated, We did an order and put it on the TAR and care plans that includes the settings. When queried if the mattress had to be turned on and at appropriate settings in order to provide optimal pressure reduction and relief, the DON confirmed it did. When queried regarding Resident #10's air mattress being observed off on 4/26/23 and 4/27/23 and staff not identifying the mattress being off, the DON stated, There is no excuse. On 5/3/23 at 9:57 AM, Resident #10 was observed in their room in bed. The Resident was positioned on their back with their heels directly against the mattress. Resident #10 smiled and made eye contact when spoke to but did not verbally respond to questions. Resident #21: (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 4/25/23 at 3:14 PM, Resident #21 was observed in their room. The Resident was sitting in a wheelchair with their feet on the floor. Non-slip socks were present on the Resident's feet and their left foot was notably larger than their right and both lower extremities appeared edematous. A family visitor was present in the room. An interview was conducted with Resident #21 and their family member at this time. An alternating air mattress was present on the Resident's bed. The mattress was set to 1000 pounds. When queried if they had any wounds, Resident #21 stated, My butt hurts. With further inquiry, Resident #21's family member revealed they assisted with the Resident's care and stated, Not sure what the sore is. When asked if they had any other wounds, Resident #21 revealed they had a dressing in place on their left foot. Resident #21's wheelchair did not have a pressure reduction pad in place on the wheelchair seat. Resident #21 was asked if they were able to reposition themselves in the wheelchair and revealed they needed staff assistance to move and transfer. When asked how long they had been sitting in their wheelchair, Resident #21 and their family member both revealed the Resident had been in the same position since 12:30 PM. When queried if facility staff had assisted them to reposition in the chair since they had been sitting up, Resident #21 and their family member stated that staff had not repositioned them in their chair. Record review revealed Resident #21 was admitted to the facility on [DATE] with diagnoses which included diabetes mellitus, sleep apnea, arthritis, depression, anxiety, and open wound on their left foot. Review of the MDS assessment dated [DATE] revealed the Resident was cognitively intact and required extensive to total assistance to complete all ADL's with the exception of eating. The MDS further detailed the Resident was at risk for pressure ulcer development but did not have any pressure or venous ulcers but did have wound care treatment/dressings in place related to an infection in their foot. Review of documentation in Resident #21's EMR included the following: - 4/5/23: Pressure Ulcer - Weekly Observation . Left lateral foot stage 3; measures 3 (cm- length) x 4.5 (cm-width) x 0 (cm- depth) . Stage 3 . improving . - 4/12/23: Pressure Ulcer - Weekly Observation . Left lateral foot . Length: 2 (cm) . Width: 1 (cm) . Depth: 0 (cm) . What stage does ulcer currently present as . Stage 2 . Cleanse left lateral foot with wound cleanser apply skin prep to peri wound, apply double layer of Xeroform to wound bed cover with 4x4 wrap with kerlix and secure with tape daily and PRN . improving . - 4/19/23: Pressure Ulcer - Weekly Observa [TRUNCATED]

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 22927 Based on observation, interview and record review, the facility failed to prevent and monitor weight loss for one resident (Resident #70), resulting in the likelihood for continued weight loss and prolonged illness. Findings include: Record review of the facility 'Weight Monitoring' policy dated 3/2023, revealed weight can be a useful indicator of nutritional status. Significant unintended changes in weight (loss or gain) or insidious weight loss (gradual unintended loss over a period of time) may indicate a nutritional problem. 1. The facility will utilize a systemic approach to optimize a resident's nutritional status. This process includes: (a.) Identifying and assessing each resident's nutritional status and risk factors (b.) Evaluating/analyzing the assessment information (c.) Developing and consistently implementing pertinent approaches (d.) Monitoring the effectiveness of interventions and revising them, as necessary. Resident #79: In an interview and observation 04/25/23 1 at 2:56 PM with Resident #79's family member revealed that the resident had lost weight since admission to the facility. The family member revealed that Resident #79 use to be around two hundred pounds and now is below 150 pounds. Resident #79 does have a tube feed tube in his abdomen. Resident #79 walked over to show the surveyor his PEG tube with no dressing in place and crusty material around the opening. The family member stated that Resident #79 is takes food by mouth and that the tube has not been used for a while. Record review on 5/4/2023 of Resident #79's electronic weight log from admission in October 2022 revealed a weight of 176.4 pounds. The Resident #79 was stable through March 3, 2023, weight of 170 pounds. April 5, 2023, weight was documented as 139. That was a 31-pound weight loss within a 34-day time period. The Electronic Medical Record (EMR) documented a 19.4% weight loss in 30 days. Record review of the facility 'Weight Monitoring' policy dated 3/2023, revealed (#5.) A weight monitoring schedule will be developed upon admission for all residents: (a.) Weights should be recorded at the time obtained. Mathematical rounding should be utilized (i.e., if weight is X 0.5 pounds [lbs] or more, round weight upward to the nearest whole pound. If weight is X 0.1 to X 0.4 [lbs] round down to the nearest whole pound). (b.) Newly admitted residents - monitor weight weekly for 4 weeks (c.) Residents with weight loss - monitor weight weekly (d.) If clinically indicated - monitor weight daily (e.) All others - monitor weight monthly (#6.) Weight Analysis: The newly recorded resident weight should be compared to the previous recorded weight. A significant change in weight is defined as: (a.) 5% change in weight in 1 month (30 days) (b.) 7.5% change in weight in 3 months (90 days) (c.) 10% change in weight in 6 months (180 days). (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	In an interview and record review on 05/04/23 at 08:27 AM with Registered Dietician (RD) BB of Resident #79's electronic medical record review of the resident's weight log of 3/3/2023 weight of 170.0 pounds was noted. On record weight of 139.0 that was a 31-pound weight loss in 30 days, and a 35-pound weight loss since admission. RD BB stated that Resident #79 was NPO (nothing by mouth) at the time due to the tube feedings resident was getting. The tube feedings were increased, and he was stable in his weight. On 2/27/2023 he had a video laryngeal test that noted reduced swallow with aspiration risk. The RD BB was getting agitated and seeking out food. He was restless, getting up and down, seeking out food, hanging out at nurse station near food carts. Resident #79 was wanting to eat food items. Weights are once a month when stable. We met in April with the guardian (Father or brother), and he wanted the resident to have regular diet with food items and to hold the tube feedings. The Resident #79's care plan was updated. Record review of Resident #79's care plans pages 1-21, revealed that tube feeding care plan intervention dated initiated 3/3/2023 weigh as ordered and as needed. Record review of nutrition care planned initial date of 10/5/2022 and revision date of 3/3/2023 revealed only one intervention: Diet as ordered; resident is NPO (nothing by mouth) receives nutrition via his G-tube. Record review on 05/04/23 at 11:32 AM of the facility weight loss policy revealed that the resident with the 31-pound weight loss should be weighed weekly, the last documented weight was on 4/13/2023, was 141 pounds, which was 3 weeks ago.

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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. 22927 Based on observation, interview and record review, the facility failed to place tube feed dressings for two residents (Resident #37 and Resident #79) per standards of practice and facility policy, resulting in the likelihood for cross contamination to PEG tube sites and prolonged illness. Findings include: Record review of the facility 'Gastrostomy Site Care' dated 3/2022, revealed that the facility policy to perform gastrostomy site care as ordered and per current standards of practice: Verify there is a physician order for gastrostomy site care, Review the plan of care . (10.) Apply any other PPE (Personal Protective Equipment) as needed to protect self from any exposure to infectious material and to comply with any isolation precautions ordered. (11.) Maintain clean technique. (12.) Remove old dressing if applicable and discard in appropriate container. (13.) Wash hands and don gloves. (14.) Using soap and water, gently clean the area around the tube and continue in an outward circular fashion, ensuring that under the bolster is cleaned. (15.) Assess the area for any excoriation, undue redness, pain, or drainage. Report immediately to the physician if anything noted. Resident #37: Observation and interview on 04/27/23 at 07:00 AM with Licensed Practical Nurse (LPN) S revealed observations of Resident #37's room revealed there to be Enhanced Barrier Precaution signage. PPE caddy or plastic three drawer isolation bin noted outside the room in hallway. Resident Care planned for precautions. LPN S stated that the resident #37 had developed thrush in her mouth and it hurt to eat, and she lost weight, went to the hospital and they put in a tube feeding in her abdomen, observed midline tube feeding in place with no dressing noted. LPN S stated that the resident came back all better, and her skin looked great, no open or red areas were documented when she came back. The tube feeding was continuous and is now not used because she can eat normal. Observation and interview on 05/02/23 at 10:00 AM with Certified Nurse Assistant (CNA) R in Resident #37's room dressed in scrubs, there is no enhanced protective barrier gown on, and the white trash can at the door with lid open with no trash bags noted in the can. CNA R stated that he is giving the resident a bed bath and was observed filling container with water and wash clothes. Surveyor observed and picked up a cell phone from the bed and the CNA R stated that it was his phone not the residents and put the phone in his pocket. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 05/02/23 at 10:10 AM the surveyor went and got the Registered Nurse/Infection control preventionist (RN/ICP) A and walked with the ICP to the resident #37's room. Both surveyor and RN/ICP A observed resident naked upon the bed with G-tube with no dressing in place to new peg tube. Observed CNA R giving bath with gloves and wash cloth in hand, but no gown for barrier. Brief was undone and folded under resident on left side. RN/ICP A stated that there should be a gown on the CNA when giving a bath it is right on the sign on the door. In an interview on 05/02/23 at 10:23 AM with RN/ICP A the peg tube usually does have a dressing on the peg tube site. RN/ICP A stated that he spoke with the unit manager, and there should be dressings on the peg tube sites of residents that have peg tubes. Record review of care plans on 05/02/23 at 11:46 AM for Resident #37 for nutrition/peg tube- care plan revealed: Resident #37 on 4/13/2023 was to have nothing by mouth, due to peg tube. Resident has been observed to have food meal trays for each meal and is taking oral foods. There were no updated care plan interventions for peg tube dressing changes noted. In an interview on 05/02/23 at 12:00 PM with Licensed Practical Nurse/Unit Manager U was notified of the peg tubes not having split gauze dressings in place, she stated that it is the practice to have a dressing in place. Resident #79: In an interview and observation 04/25/23 1 at 2:56 PM with Resident #79's family member revealed that the resident had lost weight since admission to the facility. The family member revealed that Resident #79 use to be around 200 pounds and now is below 150 pounds. Resident #79 does have a tube feed tube in his abdomen. Resident #79 walked over to show the surveyor his peg tube with no dressing in place and crusty material around the opening. The family member stated that Resident #79 is takes food by mouth and that the tube has not been used for a while. In an interview on 05/02/23 at 11:08 AM with Licensed Practical Nurse/Unit Manager TT revealed that the nurses are to have a split gauze dressing to the peg tube site and monitor the sites. In an interview on 05/02/23 t 11:17 AM with Licensed Practical Nurse/Unit Manager U about Peg tube site care revealed that the sites should have split sponge dressing in place by night shift or PRN as needed. Care to the peg tube site is to be cleaned each shift and a dressing is applied. It is on the Medication Administration Record/Treatment Administration Records (MAR/TAR). Record review of Resident #79's Medication Administration Record/Treatment Administration Records (MAR/TAR) March 2023, revealed to change peg tube dressing daily and PRN as needed on the night shift. The treatments to peg tube were all initialed as being performed. Record review of Resident #79's care plans revealed that the nutrition care plan interventions dated 3/3/2023 instructed facility staff to provide local care to G-tube site as ordered and observe for signs and symptoms of infection such as redness, drainage, odor, and tenderness.

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	235132	A. Building B. Wing	05/04/2023

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Majestic Care of Flushing	540 Sunnyside Dr Flushing, MI 48433

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22927 Based on observation, interview, and record review, the facility 1) Failed to ensure adequate staffing for residents' needs for Activities of Daily Living (ADL) care for 4 of 8 Residents in the confidential Resident Council meeting, and for five residents (Resident #14, Resident #18, Resident #33, Resident #37, and Resident #46) 2) Failed to ensure adequate staffing to respond to call lights for residents' needs for 7 of 8 residents in the confidential Resident Council meeting and for three residents (Resident #14, Resident #29, and Resident #45) and 3) Failed to ensure that ensure staff competencies check-off forms were accurate and completed, resulting in the confidential Resident Council meeting voicing concerns of not receiving showers and/or baths consistently and call lights being turned off without staff returning to perform the requested care and staff competencies to be incomplete. Findings include: Record review of the facility 'Call Lights: Accessibility and Timely Response' policy dated 3/2023, revealed: All staff members who see or hear an activated call light are responsible for responding. If the staff member cannot provide what the resident desires, the appropriate personnel should be notified. Process for responding to call lights: (a.) Turn off the signal light in the resident's room. (b.) Identify yourself and call the resident by name. (c.) Listen to the resident request and respond accordingly. Inform the resident if you cannot meet the need and assure him/her that you will notify the appropriate personnel. (d.) Inform the appropriate personnel of the resident's need. (e.) Do not promise something you cannot deliver. (f.) If assistance is needed with a procedure, summon help by using the call light. Stay with the resident until help arrives. Confidential Resident Council Meeting: Interviews on 04/26/23 at 09:52 AM had eight residents and a few stragglers that entered once meeting started. Subjects included courtesy and respect shown by staff toward residents revealed that the staff talk about their personal lives while doing resident care, and they talk about short staffing issue, and some staff use their phones in the resident rooms. The Confidential Resident Council group were asked about the courtesy and respect shown by staff members to residents and Seven (7) out of eight (8) Residents voiced concerns of not enough staff, and that weekend staff is the worst. Residents in the group revealed the facility have call-ins all the time and then pull staff members from a resident care unit the residents end up with one aide and a nurse during the day and afternoon shifts, because they call in and they do not replace the staff member with someone else. The surveyor asked if this effects the care they receive and call light response time? One resident stated that the staff come into the room and shut the call light off and say they will come back, but they do not, so the resident will have to put the light back on. Another resident revealed that the staff tell me that they do not have enough staff to get him up and that they have had bowel accidents in their briefs. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Record review of March 10, 2023, Resident Council meeting notes revealed that residents were concerned that call light response times are getting longer, and they may need more nurses and/or nurse aides. The response section of the notes revealed that there was no response noted from the Department manager about call light response times. Activities of Daily Living: Confidential Resident Council Meeting: Interviews on 04/26/23 at 09:52 AM had eight residents and a few stragglers that entered once meeting started revealed that four out of 8 Resident of the group voiced concerns of not receiving showers consistently and are told that showers should be twice a week, but they tell residents they do not have the staff to give showers. Another resident revealed that he hardly gets a shower at all, staff want residents to wash up in the bathrooms. The four other residents of the group voiced that if they get showers or they complain about it to staff. Resident #18: Record review of Resident #18's electronic medical record revealed the resident was receiving hospice services. In an interview on 04/25/23 at 11:07 AM with Resident #18 revealed that he did not get showers that the staff give him bed baths. Resident #18 stated that he would like to get in the shower. Resident #18 stated that Hospice wash me up, but not every time they come. Resident #18 wanted to know why he could not get into the shower. interview and record review on 05/03/23 at 11:55 AM with Licensed Practical Nurse (LPN/MDS) O, reviewed the shower task and bathing task in the electronic medical record revealed showers/bathing were not documented. Record review of the care plans page 1-25 revealed that hospice was mentioned, but there was not an actual hospice care plan that Identified whom would be giving baths and ADL care and on what days the hospice services would be provided. Resident #37: Record review on 05/03/23 at 11:52 AM of Resident #37's bathing task for 30 days look back revealed total dependence on staff, with none given. Record review on 05/03/23 12:25 PM of Resident #37's shower record task 30 day look back revealed only two showers were given in 30 days on 4/2/23 & 4/26/23. In interview and record review on 05/03/23 at 11:55 AM with Licensed Practical Nurse (LPN/MDS) O, record review of shower and bathing task revealed shower/bath on 4/2/23 & 4/26/23 on a 30 day look back. Resident #46: Record review on 05/03/23 at 09:43 AM of Resident #46 who was admitted on [DATE], electronic medical record of the shower tasks and bathing task revealed little to no documentation of bathing. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Record review of Resident #46's Care plans revealed that there were no interventions of showers noted. In interview and record review on 05/03/23 at 11:55 AM with Licensed Practical Nurse (LPN/MDS) O, of resident #46's showers for 30 days look back revealed no showers in a month, and bathing task revealed four assisted with bathing in a month. There were no refusals and reasons documented in the progress notes as to why the showers were not given. Licensed Practical Nurse (LPN/MDS) O, stated that she knows that there is a bathing bed on wheels located on the East unit that can be used for showers. 22347 Resident Interviews Regarding Showers: During an interview done on 5/3/23 at 11:50 a.m., MDS Coordinator O and this surveyor reviewed Residents #14, and #33 Activities of Daily Living shower/bed bath records. MDS O stated All the documentation should be in the electronic record. Resident #14: During an interview done on 4/27/23 at 10:25 a.m., Resident #14 stated No, I do not get my showers or bed baths weekly. I get one bed bath every other week. Review of the MDS cognitive assessment dated [DATE], revealed the resident #14 was alert and able to make her own healthcare decisions. Review of the Central Hall Shower schedule revealed the resident should have been getting a bath or shower on Tuesdays and Fridays. Review of the resident's electronic record shower/bath record dated 4-4-23 through 5-2-23 revealed, no showers were given in 30 days, only 4 bed baths were given, and no refusals were documented. The resident went from 4/8/23 through 4/17/23 without a bed bath or shower given. During an interview done on 5/3/23 at 11:50 a.m., MDS Coordinator O stated I didn't find any notes in the record why Resident #14) did not get her showers or baths. The bathing preference sheet should be documented the same as the shower/bath sheet. It's the responsibility of the Aides (CNA's) on the floor if the showers don't get done or gets, they get pulled off (Shower Aide get pulled to the floor to work). (Shower Aide X) only works on day's; they (CNA's) should be doing the showers and bath's if she can't get them on their scheduled days. If they (Resident's) refuse, there should be a note put in. The shower Aide gets pulled to the floor about once or twice a week. During an interview done on 4/27/23 at 9:00 a.m., Shower Aide/ CNA X stated I am just the one (shower aide) for the whole facility. I am responsible to do 14 to 15 showers a day. I don't get them all done. I do 8 hours a day. If they (resident showers) don't get done, we don't have the staff, so that means they won't get done. The next shift CNA's are supposed to do them. During an interview done on 4/27/23 at 8:55 a.m., CNA Z stated She (shower aide X) has to do the whole building, all the showers. (continued on next page)

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	235132	A. Building B. Wing	05/04/2023

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview done on 4/27/23 at 8:50 a.m., Nurse, RN U stated We have a lot of call-In's, seconds is our problem. We usually only have 2 CNA's, it's a problem. Honestly, they (resident showers) don't get done. During an interview done on 4/27/23 at 8:45 a.m., Nurse, RN AA stated Management expects us to get them (resident showers) all done. There is one day shift shower aide and seconds doesn't have one. I do get complaints from resident's lately complaining to me they don't get their showers. During an interview done on 4/27/23 at 9:05 a.m. the DON stated, We have one shower Aide now, it just got changed when the census went down (cut staff). During an interview done on 4/27/23 at 9:10 a.m., Resident #33 stated If I do not get my shower, and sometimes they try, I pitch a bitch, that's why I get them. During an interview done on 4/27/23 at 9:05 a.m. the DON stated, We have one shower aide now, it just got changed when the census went down (cut staff). Resident Interviews Regarding Staffing: Review of the facility Nursing Services and Sufficient Staff policy dated 3/23, reported It is the policy of this facility to provide sufficient staff with appropriate competencies and skill sets to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. The facility's census, acuity and diagnoses of the resident population will be considered based on the facility assessment. Providing care includes, but not limited to , assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. During an interview done on 5/3/23 at 8:40 a.m., Resident #45 stated They did not set up my breakfast today (breakfast tray). She (CNA) took the top off and ran out of the room so fast I couldn't tell her anything. I had to go to the bathroom and now my food is cold because she took the top. It still takes them for ever to answer my light, about 45 minutes to an hour. I have had accidents and I get hurt (hurt feelings) and angry. During an interview done on 5/3/23 at 8:50 a.m., Resident #14 stated It has been up to 2 hours to get them to answer my light. I have had accidents and I get angry with them. During an interview done on 5/3/23 at 9:40 a.m., Resident #29 stated It takes them a long time to answer my call light, depends on who is working; about an hour sometimes. Incomplete Orientation Skill Check-off's: During an interview and record review done with the Director of Human Resource/HR DD on 5/4/23 at 10:32 a.m., the following staff members files had incomplete or missing orientation documentation: -Staff Member FF, Nurse, LPN's Licensed Practical Nurse LPN Orientation Competency Checklist dated 4/26/23, did not have a reviewer signature confirming accuracy and completeness. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Staff Member GG, Nurse, LPN's Facility general orientation sheet dated 8/17/22 and Licensed Practical Nurse, LPN Orientation Competency Checklist dated 8/31/23, both did not have a reviewer signature confirming accuracy and completeness. -Staff Member II, Activities Aide's facility general orientation sheet dated 4/12/23, did not have a reviewer signature confirming accuracy and completeness. During an interview done on 5/4/23 at 11:00 a.m., HR DD stated That one's on me, I did not do it, or I did not write it in. -Staff Member B, the Director of Nursing/DON's Assistant Director of Nursing Services Orientation/Competency Checklist (there was no competency for DON) dated 4/18/22, had a reviewer signature (RN), however none of the competency skills had been checked off. There was no dates at all on any skill's that demonstrated review or demonstration. During the interview done on 5/4/23 at 11:15 a.m., HR DD confirmed there was no Director of Nursing competency Checklist in the DON's file. -Contracted Speech Therapist L's facility HR file had no documentation at all of any facility education done (Resident Rights, Abuse, Elder Justice Act, Emergency procedures, etc). During an interview done on 5/4/23 at 11:00 a.m., HR DD stated no, they were not done (staff competency's and general orientation). During an interview done on 5/4/23 at 11:20 a.m., HR DD stated The company said it was not my business about any contracted staff; I asked but they said don't worry about it. I have not had a chance to do an audit. No one from cooperate has done an audit. I had 2 days of training. I don't have accesses to the contracted staff's education of any files with their company. During an interview done on 5/4/23 at 1:20 p.m., Education Nurse, RN A stated The orientation process evolving and changing, HR does the majority of the orientation and I do IC (infection Control). Review of the facility Nursing Services and Sufficient Staff policy dated 3/23, reported The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents needs as identified through resident assessments and described in the plan of care. Review of the facility Orientation policy dated 3/23/23, reported General orientation must be completed prior to the employee's formal contact with facility residents. Checklists will be used to document training and competency evaluations conducted during the orientation process.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 37668 Based on observation, interview and record review, the facility failed to implement and operationalize a comprehensive nursing orientation program to ensure staff competency prior to working independently with residents, resulting in nursing staff providing care to residents without demonstrated and documented competency, medication administration errors, and the likelihood of additional errors, inaccurate and incomplete resident assessments, and the potential in alteration in overall health status for all 92 facility residents. Findings include: A medication pass observation was completed on 5/3/23 at 10:08 AM with Licensed Practical Nurse (LPN) QQ. Prior to beginning the medication pass observation, LPN QQ was asked if they were off of orientation as they had been previously observed training with another facility nurse. LPN QQ indicated they were still on orientation and stated, I'm training with (LPN XX). LPN XX was observed working on a different hall in the facility and passing medications in that hall prior to approaching LPN QQ. When queried if they had their own cart and were passing medications independently, LPN QQ replied, Well yeah. LPN QQ then stated, I am supposed to be with someone and I'm not comfortable being by myself yet. (LPN XX) comes by and checks on me. During the medication pass observation, LPN QQ did not adhere to standards of practice for infection control techniques. LPN QQ was stopped prior to administering an incorrect insulin dose to Resident #248 as well as the incorrect dose of Lovenox (blood thinner) to Resident #250. An interview was completed with LPN QQ following the medication pass observation on 5/3/23. LPN QQ was asked why they were working the cart alone if they had not completed their orientation and were not comfortable passing medications independently and stated, They asked me to. When asked to explain further, LPN QQ relayed that Unit Manager LPN TT had asked them to work the cart because they were short staffed. When queried why they agreed to work the medication cart if they were not ready, LPN QQ replied, (LPN ZZ) was supposed to be helping me and reiterated Unit Manager LPN TT had asked, and they are a new nurse and employee. When queried how long they have been a nurse, LPN QQ stated, I finished school in March for my LPN and revealed this was their first job in healthcare. LPN QQ revealed they had not received much time in clinical during their schooling due to Covid-19. When queried regarding how much orientation they had received, LPN QQ revealed it was approximately three weeks. When queried regarding the facility process for orientation, LPN QQ indicated they were supposed to be working with another nurse. When asked if they had a checklist which the nurse who was orientating them was reviewing with them and checking them off on, LPN QQ revealed they had received a checklist but (LPN MM) who was the main nurse orientating them had not checked anything off on the list. Review of LPN QQ's form entitled, Licensed Practical Nurse LPN Orientation/Competency Checklist . Employment Start Date: 4/5/23 . revealed the form was blank and there was no documentation of competency documentation for any skills and/or processes including medication administration. On 5/3/23 at 11:03 AM, an interview was completed with LPN ZZ. LPN ZZ was asked if they were training/orientating LPN QQ and stated, No, (LPN QQ) is off of orientation. When queried if the facility was short staffed today, LPN ZZ indicated that was the reason (LPN QQ) was asked to take a cart. (continued on next page)

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	235132	A. Building B. Wing	05/04/2023

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/3/23 at 11:08 AM, an interview was conducted with Unit Manager LPN TT. When queried regarding LPN QQ passing medications by themselves, LPN TT stated, When (LPN QQ) came in they were asked if they were comfortable working the (medication) cart. When queried if LPN QQ had completed their orientation, LPN TT replied, No, (LPN QQ) would have orientated with (LPN ZZ) today. When queried why LPN QQ was asked to work the medication cart, LPN TT revealed the facility was short staffed and needed a nurse. When queried if LPN QQ had been orientated and checked off as competent for medication administration, LPN TT revealed they did not know and stated, I don't get them (orientation check offs). LPN TT was shown LPN QQ's blank Orientation/Competency checklist at this time. When asked if nursing staff should be checked off as competent to complete medication administration before they are asked to pass medications and take a cart independently, LPN TT stated, They should have the skills check off completed before, so you know they know how to do it. No further explanation was provided regarding the reason LPN QQ was passing medications without demonstrated and documented competency. On 5/3/23 at 12:12 PM, the Administrator was asked who in charge of staff education and orientation and stated, Human Resources. At 12:22 PM on 5/3/23, an interview was conducted with Human Resources (HR) Staff DD. When queried regarding nursing staff orientation including the Orientation/Competency Checklist, Staff DD stated, I do not do the clinical orientation part. That is (Infection Control Registered Nurse [RN] A). Staff DD was asked to explain what they meant by RN A completing the clinical orientation part, and revealed they were referring to the clinical topics addressed during the first day of in-class orientation before new staff start working with residents. When asked if RN A was done with their role in clinical staff orientation following the first, in-class day of training, Staff DD replied, Yes. Staff DD was asked if the facility had separate nursing check off/competency sheets for medication administration and replied, Have job specific checklists. When asked if medication pass/administration is competency is included in the Licensed Practical Nurse LPN Orientation/Competency Checklist form, Staff DD replied, Yes. Staff DD was asked when orientation is complete and replied, They (nursing staff) are supposed to get it (Orientation/Competency Checklist) back to me before they go (work) on the floor by themselves. When asked who checks new staff off and determines they are competent to complete tasks, Staff DD stated, The nurse they are working with. Staff DD was then asked if nursing staff who are orientating are included as a direct care staff member on the floor and replied, No. Staff DD was then asked if they had RN UU's checklist as they are working independently and were recently hired. Staff DD reviewed the documentation they had for RN UU. Staff DD revealed they did not have a completed Orientation/Competency Checklist for RN UU but did have a signed job description dated 3/22/23. Staff DD was then asked if LPN QQ was still on orientation and replied, Yes. Staff DD was then shown a copy of LPN QQ blank Orientation/Competency Checklist and informed they were asked to work working on a med cart by LPN TT and were passing medications independently. When queried if that was appropriate, Staff DD stated, (LPN QQ) should not be working the cart by themselves. Staff DD continued to say that LPN QQ working the floor was concerning. When queried if there is a facility process where they know which staff have completed their orientation, are checked off, competent and okay to work on the floor alone, Staff DD stated, No. Staff DD was then asked whose responsibility it is to ensure that staff are competent prior to working independently, Staff DD replied, It is not clear. Staff DD was asked who the facility nursing educator is and/or who is in charge of clinical education. Staff DD stated, There is no educator. The unit manager is the educator when they (staff) go to the floor. When queried regarding hands off education and/or skills review/check offs, Staff DD stated, There is no actual hands-on education. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with the [NAME] President (VP) of Operations, Registered Nurse (RN) E on 5/3/23 at 1:04 PM. The Director of Nursing (DON) was off work due to illness and unavailable for interview. VP RN E was made aware of medication pass observations including errors and LPN QQ being stopped prior to administration. VP RN E indicated they were unaware LPN QQ had not completed their orientation and was working the medication cart.

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F 0755 Level of Harm - Actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37668 Based on observation, interview and record review, the facility failed to implement and operationalize processes and procedures to ensure monitoring, accountability, and pharmacological oversight of controlled medications in the Med-bridge and North Hall of the facility per professional standards of practice. This deficient practice resulting in lack of appropriate storage, securement, reconciliation, administration, and disposal and/or return of controlled medications including lack of accurate comprehensive documentation and reconciliation of Methadone (prescription opioid medication frequently used to treat individuals with opioid dependence) brought into the facility, and the likelihood for inappropriate medication use and administration, accidental exposure, and diversion which has the potential to effect all 92 residents residing in the facility. Findings include: A tour of the North Hall Medication Cart with Licensed Practical Nurse (LPN) MM on 4/26/23 at 8:33 AM. Within the medication cart, an unlabeled medication cup filled with pills was observed in the locked narcotic drawer. When queried what the medications in the cup were, LPN MM replied that the medications were for Resident #247. When asked why the medications were in the drawer, LPN MM revealed they had pulled the meds to administer to the Resident but they were not in their room, so they put them in the drawer. When queried what medications were in the cup, LPN MM indicated the medication cup contained the Resident's morning medications. When asked if there were any narcotic/controlled medications, LPN MM revealed the medication up contained a Norco (controlled, narcotic medication for pain) and Gabapentin (controlled medication used to treat nerve pain). When queried if they had documented the medications as administered on Resident #247's Medication Administration Record (MAR), LPN MM indicated they had. Resident #247's Controlled Medication Administration Count Documentation Record was reviewed and reconciled with LPN MM at this time. The paper Controlled Medication Count Documentation Record form for Resident #247's for Norco 7.5/325 milligram (mg) and Gabapentin 300 mg did not match the number of pills in the Resident's bubble pill package. For both medications, there was one less pill in the blister pack than on the Controlled Medication Administration Count Documentation Record. When queried why the number of pills did not match (reconcile) with the number on the Controlled Medication form, LPN MM revealed they had not documented the medication on the Controlled Medication form. All Resident's narcotic medications within the cart were counted and reconciled with LPN MM at this time. The following discrepancies were identified: - Norco 5/325 mg blister pack for Resident #250. Controlled Medication Administration Count Documentation Record specified there should be 22 pills in the Resident's medication blister pack. The medication blister pack only contained 21 pills. - Norco 7.5/325 mg blister pack for Resident #251. Controlled Medication Administration Count Documentation Record specified there should be 3 pills in the Resident's medication blister pack. The medication blister pack only contained 2 pills. - Norco 5/325 mg blister pack for Resident #245. Controlled Medication Administration Count Documentation Record specified there should be 22 pills in the Resident's medication blister pack. The medication blister pack only contained 21 pills. (continued on next page)

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	235132	A. Building B. Wing	05/04/2023

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 0755 Level of Harm - Actual harm Residents Affected - Few	- Clonazepam (controlled medication used treat/prevent seizures and anxiety) Disintegrating Tablets 0.25 mg for Resident #248. Documentation Record specified the Resident should have 30 tablets. There were 29 individually wrapped tablets in the medication cart. - Norco 7.5/325 mg blister pack for Resident #248. Controlled Medication Administration Count Documentation Record specified there should be 52 pills in the Resident's medication blister pack. The medication blister pack only contained 51 pills. - Norco 5/325 mg blister pack for Resident #246. Controlled Medication Administration Count Documentation Record specified there should be 3 pills in the Resident's medication blister pack. The medication blister pack only contained 2 pills. When queried regarding the discrepancies on the Controlled Substance Shift Inventory forms and the narcotic/controlled medications present in the medication cart, LPN MM stated, Gave the meds but didn't sign them out (on form). When asked why they did not sign out the medications, LPN MM revealed they were going to sign the medications out later. When queried regarding the facility policy/procedure pertaining to administration of controlled substances and documentation, LPN MM revealed they were supposed to sign out the medications on the form. When queried how another nurse would know the medication had been administered when it was not signed out, an explanation was not provided. A review and reconciliation of the North Hall Controlled Substance Shift Inventory form for April 2023 was completed with LPN MM at this time. When asked about the form, LPN MM revealed the form is utilized to count the total number of controlled medication blister packs in the cart. The form included documentation sections for Date, Time, Total # of RX (prescription) at start of shift . (+) Received from Pharmacy, (-) Emptied by Nurse, Total at End of Shift, Initial Signed: Means no discrepancies on blister packs, Outgoing Nurse, Incoming Nurse, # Turned into DNS (Director of Nursing Services). The following inaccuracies and discrepancies were identified upon review of the Controlled Substance Shift Inventory form for April 2023: - 4/6/23 at 6:00 PM: Total # of RX (prescription) at start of shift = 34; Received from Pharmacy = (+) 0; Emptied by Nurse: (-) 3; Total at End of Shift: 34 . The date was initialed as having no discrepancies. - 4/7/23 at 6:00 AM: Total # . at start of shift = 35; Received from Pharmacy = (+) 0; Emptied by Nurse: (-) 1; Total at End of Shift: 34 . The date was initialed as having no discrepancies. - 4/8/23 at 6:00 PM: Total # . at start of shift = 36; Received from Pharmacy = (+) 0; Emptied by Nurse: (-) 5; Total at End of Shift: 36 . The date was initialed as having no discrepancies. - 4/8/23 at 10:00 PM: Total # . at start of shift = 36; Received from Pharmacy = (+) 0; Emptied by Nurse: (-) 0; Total at End of Shift: 31 . The date was initialed as having no discrepancies. - 4/9/23 at 6:00 AM: Total # . at start of shift = 31; Received from Pharmacy = (+) 0; Emptied by Nurse: (-) 0; Total at End of Shift: 30 . The date was initialed as having no discrepancies. (continued on next page)

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F 0755 Level of Harm - Actual harm Residents Affected - Few	- 4/11/23 at 6:00 PM: Total # . at start of shift = 35; Received from Pharmacy = (+) 0; Emptied by Nurse: (-) 0; Total at End of Shift: 32 . The date was initialed as having no discrepancies. - 4/12/23 at 6:00 AM: Total # . at start of shift = 31; Received from Pharmacy = (+) 0; Emptied by Nurse: (-) 14; Total at End of Shift: 18 . - 4/12/23 at 6:00 PM: Total # . at start of shift = Blank; Received from Pharmacy = Blank; Emptied by Nurse: Blank; Total at End of Shift: Blank . The date was initialed as having no discrepancies. - 4/16/23 at 6:00 AM: Total # . at start of shift = 21; Received from Pharmacy = (+) 2; Emptied by Nurse: (-) Blank; Total at End of Shift: 22 . The date was initialed as having no discrepancies. - 4/21/23 at 6:00 PM: Total # . at start of shift = 38; Received from Pharmacy = (+) 6; Emptied by Nurse: (-) 1; Total at End of Shift: 27 . The date was initialed as having no discrepancies. The following incomplete/missing documentation was noted on the Controlled Substance Shift Inventory Form: - No documentation of Total # of RX (prescription) at start of shift on: 4/10/23 at 6:00 PM and 4/12/23 at 6:00 PM. - No documentation under section of form titled: Initial Signed: Means no discrepancies on blister packs on: 4/6/23 at 6:00 AM, 4/9/23 at 6:00 PM, 4/11/23 at 6:00 AM, 4/1/23 at 6:00 AM, 4/13/23 at 10:00 PM, 4/14/23 at 6:00 AM, 4/14/23 at 6:00 PM, 4/25/23 at 6:00 AM, 4/15/23 at 6:00 PM, and 4/26/23 at 6:00 AM. - No documentation of Total at end of shift on 4/12/23 at 6:00 PM and 4/13/23 at 6:00 PM. - No signature and/or initials of Outgoing Nurse and/or Incoming Nurse on 4/24/23 at 10:00 PM. - No signature and/or initials of Incoming Nurse on 4/26/23 at 6:00 AM. An interview and review of the North Hall Controlled Substance Shift Inventory form for April 2023 was completed with the Director of Nursing (DON) at 9:30 AM on 4/26/23. When queried regarding the facility policy/procedure related to controlled/narcotic medication administration and documentation, the DON stated, Should be signed out on the form. The DON revealed they were aware LPN MM had not documented administration of controlled medications. When queried regarding the medication cup filled with pills, including narcotic/controlled medications, in the cart drawer, the DON stated, They (meds) should have been wasted. The Controlled Substance Shift Inventory form was reviewed with the DON including identified inaccuracies. The DON verified the inaccuracies and incomplete documentation. When asked who is responsible for monitoring the form and ensuring periodic reconciliation of controlled medication inventory, the DON replied, My unit managers are supposed to be doing it. With further inquiry, the DON revealed the current process was not working and would need to be changed. When asked how they were able to identify and prevent loss and/or diversion of medications with the current documentation, the DON was unable to provide an explanation. (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 0755 Level of Harm - Actual harm Residents Affected - Few	A tour of the North Hall Medication room was conducted with Unit Manager LPN TT on 4/28/23 at 9:09 AM. During the tour, a black box was observed towards the back left side in a cabinet above the sink. The box was sitting on an open plastic bag with the front of the box facing the cabinet door. There was no identification present on the top of the bag/open box. Upon removal of the box from the cabinet, it was noted to be an opened and unlocked black metal lockbox. The lockbox appeared worn and had a key lock. The locking mechanism on lockbox was engaged causing the box to be opened with the key lock remaining in the locked position. The locking mechanism had visible wear and appeared damaged. The box contained two packages of very old appearing Tic Tacs, a Bridge benefit card for Witness AAA, and 15 bottles. LPN TT was asked what the bottles were and indicated they did not know. Upon touching the bottles to identify the contents, the bottles were noted to be sticky, and the contents were identified as liquid methadone. There were eight empty bottles and seven bottles of liquid methadone (prescription opioid drug) labeled for administration to Resident #253 in the lockbox. The label on each bottle specified, (Resident #253) . Methadone . Dosage: 200 mgs (milligrams) . Detailed inspection of the medication bottles revealed each of the seven bottles of liquid methadone specified the same dosage was in the container; however, there was a different amount of liquid in each bottle. LPN TT was queried regarding Resident #253, and they revealed the Resident no longer resided in the facility but was unsure of their discharge date . There was no documentation and/or reconciliation of how much methadone was originally brought into facility. LPN TT was asked when and how much medication was brought into the facility. LPN TT revealed they did not know. LPN TT was asked to have the DON come to the medication room. When queried who audits and monitors the medication storage room, LPN TT did not provide a response. LPN MM entered the medication room at this time and were asked if they knew anything about the Methadone. LPN MM did not respond. Resident #253's face sheet including their admission/discharge date s was requested. A paper was noted on the bottom of the outside of the open bag which had been positioned under the lock box. Review of the paper detailed, Security Bag . Instructions . 4 . Remove adhesive backing and fold at line indicated to create tamper evident seal . Other: Lockbox with methadone. Box is locked. No Key . The form was undated and contained illegible signatures of staff members. When asked whose signatures were on the form, LPN TT revealed they did not know. After arriving at the medication room, the DON was queried regarding the Methadone including the reason the medication was in the medication room. The DON examined the unlocked black metal lock box and was unable to provide an explanation. When queried regarding the facility policy/procedure for securement of controlled substances, the DON revealed narcotic/controlled medications are supposed to be accessible only to licensed nurses. When asked if narcotic/controlled substances should be double locked, the DON replied, Yes. When asked if all controlled medications which enter the facility should be accounted for, the DON responded that they should be. The DON was then asked why the Security Bag . Instructions . form indicated bag was sealed and the box was locked with no key when the bag was not sealed, and the box was clearly unlocked. The DON was unable to provide an explanation. A review of Resident #253's face sheet was completed at the time. Per the face sheet, Resident #253 was admitted to the facility on [DATE] and discharged on [DATE]. When queried if the lockbox had been in the facility since 9/14/22 when the Resident was admitted , LPN TT indicated they believed it came with the Resident when they were admitted . When asked why it was not sent home with the Resident when they were discharged , neither the DON nor LPN TT were able to provide an explanation. When queried how they knew the total amount of Methadone that was present in the box when the Resident was admitted , the DON stated, I don't know and indicated they would look for documentation. When asked what should have happened with the Methadone when it was brought into the facility, the DON revealed the medication should have been counted and documented by two nurses and returned to the Resident upon discharge and/or sent home with family if available/appropriate. No explanation was provided when asked why that did not occur. When queried why each bottle with liquid Methadone had a different amount of liquid but the label indicated it contained the same dosage, the DON was unable to provide an explanation. (continued on next page)

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	235132	A. Building B. Wing	05/04/2023

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F 0755 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #253's medical record revealed the Resident was originally admitted to the facility on [DATE] with diagnoses which included depression, alcohol use, abdominal hernia, hepatitis C, and drug abuse surveillance. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was cognitively intact and required extensive assistance to complete all Activities of Daily Living (ADL's) with the exception of eating. Review of Resident #253's Michigan Admission Agreement . EXHIBIT G . Inventory of Resident's Belongings . Date: 9/30/22 . Name of Facility Staff Performing Inventory: (Admission Staff YY) . List of Resident's Personal Belongings . In patients' chart . A list of Resident #253's personal belongings was not noted in their medical record. A Controlled Medication Administration Count Documentation Record for Methadone 200 mg was also not present in the medical record. Review of documentation in Resident #253's medical record revealed the following: - 9/14/22 at 11:31 PM: General Progress Note .Writer was given report from (Hospital). Resident was brought in alone about 17:15 via ambulance. Ambulance gave writer residents property lock box that had medications and other property such as Tic Tacs, which was witnessed by second nurse being locked in med room . (Authored by LPN BBB) - 11/3/22 at 2:05 PM: General Progress Note . Resident was discharge . leave with two EMT driver. Resident took all belong with (them) . (Authored by LPN MM) Review of staff list provided by the facility revealed LPN BBB was not listed as an employee. On 4/28/23 at 2:30 PM, Resident #253 was attempted to be contacted at the phone number listed on the facility provided face sheet. The phone number did not belong to Resident #253. (continued on next page)

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F 0755 Level of Harm - Actual harm Residents Affected - Few	A detailed review of Resident #253's face sheet revealed Witness AAA was listed as an emergency contact. Witness AAA was contacted on 4/28/23 at 2:40 PM. When queried if they had Resident #253's current contact information, Witness AAA revealed they were with the Resident and gave them the phone. An interview was completed at this time. When queried if they recalled their stay at the facility, Resident #253 verbalized they did. When asked if they had taken their home methadone with them when they were admitted to the facility, Resident #253's voice raised and began speaking in an upset tone. The Resident stated, They stole it at (Hospital). I never got it back. It was in my lock box. Resident #253 continued, I filed a complaint with the hospital. I can get in trouble at the Meth clinic. When asked what they meant regarding the Meth Clinic, Resident #253 revealed they were going to a Methadone clinic as part of their recovery from intravenous (IV) drug use and that the Methadone had very specific rules and regulations related to Methadone. Resident #253 then stated, Have to keep it (Methadone) in a lock box. I had to buy a new one (lock box). Resident #253 was asked if they were aware the Methadone and lockbox were at facility and stated, No. I thought they stole it at the hospital. Resident #253 questioned, You mean it's at the facility? When queried if they recalled what was in the lockbox when they went to the facility, Resident #253 stated, Been a long time but six or seven bottles (of Methadone). Resident #253 then stated, They (Methadone bottles) are 200 milligrams (each). I take 100 mg in the morning and 100 mg at night. When queried if all the bottles have the same amount of liquid in them when they receive them from the Methadone clinic and replied, Yes, why. Resident #253 was then asked if there was a reason all the bottles with Methadone in them had different amounts of liquid in the bottles and stated, They all have the same amount in them when I get them. They must have taken some out off the top. With further inquiry, Resident #253 stated, My nurse there goes to the Methadone Clinic with me. Resident #253 was asked if they were saying a nurse who worked at the facility and cared for them went to Methadone clinic with them, Resident #253 replied, I don't want to get them in trouble. When queried if the box was locked when they last had it, Resident #253 stated, Yes. I still have the key. I want it back. Resident #253 reiterated they can get in trouble at the Methadone clinic. Resident #253 stated, I have to keep track of it all. I didn't know they had it (at the facility). I want it back. When asked if there were any empty bottles in lock box, Resident #253 replied, Yes, I have to take the empty bottles back to the (Methadone) clinic. With further inquiry, Resident #253 revealed they are supposed to keep the empty bottles locked up in the lock box and take the entire lock box with them when they go to Methadone Clinic. Resident #253 verbalized they were upset their lockbox was at the facility, they did not know, and had filled a complaint against the hospital. The Resident expressed how difficult it was for them to stop doing drugs, how the Methadone Clinic had helped them, and the difficulties they experienced when they did not have their lockbox and Methadone to return to the clinic. When queried why they thought the hospital had taken their lockbox and Methadone, Resident #253 revealed they asked a nurse at the facility about it and were told it was not there. When asked the name of the nurse who had told them that, Resident #253 provided a physical description but was unable to recall the nurse's name. Resident #253 verbalized they were very upset that the facility did not return their property to them. On 5/1/23 at 10:34 AM and 5/4/23 at 2:10 PM, the Methadone Clinic listed on Resident #253's prescription bottles were contacted and a message with return number was left for Supervisor CCC. A return phone call was not received. LPN BBB's contact information was requested from Human Resources Staff DD on 5/3/23 at 12:22 PM but not received by the conclusion of the survey. No further documentation related to reconciliation of Resident #253's Methadone was provided prior to the conclusion of survey. (continued on next page)

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	235132	A. Building B. Wing	05/04/2023

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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 0755 Level of Harm - Actual harm Residents Affected - Few	Review of facility provided policy/procedure entitled, Medication Administration (Revised 3/23) revealed, Policy: Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection . 17. Sign MAR after administered. For those medications requiring vital signs, record the vital signs onto the MAR. 18. If medication is a controlled substance, sign narcotic book . Review of facility provided policy/procedure entitled, Controlled Substance Administration & Accountability (No Date) detailed, Policy: It is the policy of this facility to promote safe, high quality patient care, compliant with state and federal regulations regarding monitoring the use of controlled substances. The facility will have safeguards in place in order to prevent loss, diversion or accidental exposure . 1. General Protocols: a. Controlled substances are stored in a separate compartment of an automated dispensing system or other locked storage unit with access limited to approved personnel . All controlled substances (Schedule II, III, IV, V) are accounted for in one of the following ways . ii. All controlled substances obtained from a non-automated medication cart or cabinet are recorded on the designated usage form. Written documentation must be clearly legible with all applicable information provided. iii. All specially compounded or non-stock Schedule II controlled substances dispensed from the pharmacy for a specific patient are recorded on the Controlled Drug Record supplied with the medication or other designated form as per facility policy . h. The Controlled Drug Record (or other specified form) serves the dual purpose of recording both narcotic disposition and patient administration. i. The Controlled Drug Record is a permanent medical record document and in conjunction with the MAR is the source for documenting any patient-specific narcotic dispensed from the pharmacy . j. The charge nurse or other designee conducts a daily visual audit of the required documentation of controlled substances. Spot checks are performed to verify . i. Controlled substances that are destroyed are appropriately documented; and ii. Medications removed from either the automated dispensing system or medication cart/cabinet have a documented physician order . 2. Storage and Security . b. Areas without automated dispensing systems utilize a substantially constructed storage unit with two locks and a paper system for 24-hour recording of controlled substance use . Obtaining/Removing/Destroying Medications . d. Two licensed staff must witness any disposal or destruction of a controlled substance and document same on the Drug Disposition Record, Controlled Drug Record, or via the automated dispensing system . 9. Inventory Verification . b. For areas without automated dispensing systems, two licensed nurses account for all controlled substances and access keys at the end of each shift . e. Any discrepancies which cannot be resolved must be reported immediately as follows: i. Notify the DON, charge nurse, or designee and the pharmacy; ii. Complete an incident report detailing the discrepancy, steps taken to resolve it, and the names of all licensed staff working when the discrepancy was noted; iii. The DON, charge nurse, or designee must also report any loss of controlled substances where theft is suspected to the appropriate authorities such as local law enforcement, Drug Enforcement Agency, State Board of Nursing, State Board of Pharmacy and possibly the State Licensure Board for Nursing Home Administrators. f. Staff may not leave the area until discrepancies are resolved or reported as unresolved discrepancies .

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22927 Based on interview and record review, the facility failed to ensure that informed consents were obtained for psychotropic medications prescribed for four residents (Resident #1, Resident #46, Resident #79, and Resident #84), resulting in Residents #1, #46, #79, and #84 being administered antipsychotic medication without appropriate consent and risk-versus-benefit analysis of the medications explained to the resident and/or the responsible party with the increased likelihood for serious side effects and adverse effects. Findings include: Record review of the facility 'Use of Psychotropic Medication' policy dated 3/2023, revealed residents are not given psychotropic drugs unless the medication is necessary to treat a specific condition, as diagnosed ad documented in the clinical record, and the medication is beneficial to the resident, as demonstrated by monitoring and documentation of the resident's response to the medication. A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. Psychotropic drugs include but are not limited to the following categories: antipsychotic's, antidepressants, anti-anxiety, and hypnotics. (#5.) Residents and/or representatives shall be educated on the risk and benefits of psychotropic drug use, as well as alternative treatments/non-pharmacological interventions. Record review of the facility 'Gradual Dose Reduction of Psychotropic Drugs' policy dated 3/2023, revealed residents who use psychotropic drugs receive gradual dose reductions and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Record review of the facility 'Psychotropic & Sedative/Hypnotic Utilization by Resident' list generated by the pharmacy services, revealed that Residents #1, #46, #79 and #84 were on the list. Resident #1: Record review of Resident #1's physician orders recap report revealed Cymbalta antidepressant 30 mg oral every day, Risperdal oral 0.25mg and 0.50mg for a total of 0.75mg twice daily for anti-psychotropic, and Xanax 0.25mg two tablets every 12 hours as needed for anxiety. Record review of Resident #1's April 2023 Medication Administration Record (MAR) revealed Resident #1 received medications of Cymbalta antidepressant 30 mg oral every day, Risperdal oral 0.25mg and 0.50mg for a total of 0.75mg twice daily for anti-psychotropic, and Xanax 0.25mg two tablets every 12 hours as needed for anxiety from staff nurses. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview and record review on 04/28/23 at 08:53 AM with social worker G about psychotropic medication consent and risk-versus Benefits statements for Risperdal. Social worker G stated that the facility normally get consent when the medication is started. Record review of physician orders for Resident #1 revealed Risperdal started/active 3/16/2023 per physician order, actual medication start date the nurses should be getting the consent prior to administering the medication. Record review of the electronic medical record with social worker G found no consent in the electronic medical record. Social worker G stated there should be a consent because it is an antipsychotic, to be discussed with risk vs benefits and resident/responsible party educated. Not found in the electronic medical record, social worker G looked throughout the medical record. Record review and interview on 04/28/23 at 09:05 AM with social worker G revealed that no consent was found in the former social workers office. The Social worker G did not return with any consent forms for the resident #1. Resident #46: Record review of Resident #46's physician orders revealed Lexapro antidepressant 10 mg oral every day, Lamictal antipsychotic 50mg oral twice daily for schizoaffective disorder, Seroquel antipsychotropic oral 100mg and 25mg for a total of 125mg at bedtime for schizoaffective disorder, and Seroquel 50mg oral every day for schizoaffective disorder. Record review of Resident #46's care plans pages 1-16, revealed 'Behavioral' care plan dated 1/30/2023 with interventions of: Administer medications as ordered, and document behaviors. There were no interventions of antipsychotic medications or non-pharmaceutical interventions. Record review of the 'New Admission' care plan dated 1/30/2023 noted no interventions. Record review of 'Risk of Complications' care plan dated 1/30/2023 revealed interventions of labs as ordered and medications and treatments per physician orders. There were no interventions noted in the care plans to assess and monitor for side effects of psychotropic medications. In an interview on 05/03/23 at 09:00 AM with social worker G revealed that she did not know if there are consents for any of the new residents with antipsychotic medications, because the old Social Worker did those and maybe there is a book in her office or something. Record review of Resident #46's physician orders revealed that there are quetiapine (Seroquel) 50mg every day and 125mg at HS. Lamictal 50mg daily for schizoaffective disorders daily. Record review of Resident #46's electronic medical record with social worker G revealed that there was no consent found for antipsychotic medications noted. Resident #46's new order for Seroquel antipsychotic added on 5/2/2023, revealed there was no updated care plan noted. Record review on 05/03/23 at 09:38 AM with social worker G reviewed of the care plan revealed that there was no antipsychotic medication care plan or interventions for signs and symptoms of monitoring effects. Resident #79: Record review of Resident #79's physician orders recap report revealed Trazadone antidepressant 100 mg G-tube at bedtime every day for insomnia, Seroquel 400mg twice daily via G-tube for anxiety, and Ativan 0. 5mg three times daily via G-tube for anxiety. (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	05/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #79's April 2023 Medication Administration Record (MAR) revealed Resident #79 received Trazadone antidepressant 100 mg G-tube at bedtime every day for insomnia, Seroquel 400mg twice daily via G-tube for anxiety, and Ativan 0.5mg three times daily via G-tube for anxiety. Record review and interview on 04/28/23 at 09:06 AM with social worker G of Resident #79's medical record revealed that there were no consents found for Seroquel, Trazadone or Ativan. There are just no consents that were done, it looks like they were not started, previous social worker walked out in January 2023, and the one prior to that had walked out also. Record reviews on 04/28/23 at 09:12 AM with the social worker G the state surveyor requested antipsychotic medication consents for residents residing on the East Hall unit: Resident #7 was ordered Zyprexa 5mg for schizophrenia on 10/26/2022. The last consent that was found for Resident #7 was in 2019. Resident #18 was ordered Depakote 250mg for bipolar twice daily on 12/17/2022. The record review of the medical record revealed there to be no consent. Resident #17 was ordered Depakote 500mg for mood twice daily. Record review of the medical record revealed there to be no consent. Resident #43 was ordered Depakote 125mg for bipolar disorder twice daily on 6/24/2022, and Seroquel 25mg at bedtime for bipolar disorder was ordered on 10/28/2022. The record review of the medical record revealed there to be no consent. Record review of the medical record revealed there to be no consent. 37668 Resident #84: On 4/25/23 at 12:29 PM, Resident #84's room door was closed. Upon knocking and entering the room, an overwhelming foul body odor was instantly noted. Resident #84 was observed in their bed with their eyes open. The Resident had an unkept and ungroomed appearance. An interview was completed at this time. When queried regarding the medications they receive in the facility, Resident #84 revealed they did not know and just take what the nursing staff give them. Record review revealed Resident #84 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included repeated falls, diabetes mellitus, and dementia without behavioral disturbance. Review of the MDS assessment dated [DATE] revealed the Resident was cognitively intact and required total assistance for bathing and limited assistance with transferring, dressing, and toilet use. Review of Resident #84's Health Care Provider (HCP) orders and Medication Administration Record (MAR) documentation revealed the Resident had received the following psychotropic drugs: - Seroquel Oral Tablet 50 mg (Quetiapine Fumarate; antipsychotic medication frequently used to treat Bipolar, caution use in individuals with dementia), Give 1 tablet by mouth two times a day for Dementia (Start: 2/9/23; Discontinued: 2/24/23) (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Quetiapine Fumarate (Seroquel) Tablet 50 mg; Give 1 tablet by mouth two times a day for bipolar (Start Date: 3/17/23; Discontinued: 4/19/23) Review of Resident #84's Electronic Medical Record (EMR), including all scanned documentation, revealed no consent for Seroquel. There was also not documentation demonstrating the Resident had been seen and/or evaluated by a Mental Health Provider. Psychoactive medication consent documentation for Resident #84 was requested via email from the facility Administrator on 5/3/23 at 8:35 AM. An interview and review of Resident #84's EMR was completed with Social Worker H on 5/3/23 at 8:51 AM. When queried regarding Resident #84's psychotropic medications including consent for Seroquel, Social Worker H stated, No consent. When asked if the Resident had been seen and evaluated by psychiatric services/mental health provider in the facility, Social Worker H stated, No. When asked why the Resident was not seen and evaluated for medication management, Social Worker H indicated the Nurse Practitioner in the facility will manage medications. When asked why the indication for Seroquel use in February 2023 was listed as Dementia when Seroquel is not an appropriate treatment for dementia, Social Worker H did not provide an explanation. When asked why the indication for use of Seroquel was listed as Bipolar in March and April 2023 when the Resident did not have a diagnosis of bipolar, Social Worker H was unable to provide an explanation. An interview was conducted with Social Worker H and Unit Manager Licensed Practical Nurse (LPN) TT on 5/4/23 at 10:50 AM. When queried regarding facility policy/procedure related to psychotropic medications including consents and who obtains the consents for the medications, Social Worker H stated, I'm not following up with Residents on psych meds. When asked who is following up and obtaining consents, Social Worker H replied, I was told by the Administrator that it was nursing. LPN TT was then asked if nursing staff obtain consents and follow up with Residents receiving psychoactive medication and stated, No, I was told it was Social Work. An interview was completed with the Director of Nursing (DON) on 5/4/23 at 11:58 AM. When asked who is responsible to obtain consents and follow up for Residents receiving psychotropic medications, the DON stated, Definitely Social Work.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37668 Based on observation, interview and record review, the facility failed to ensure a medication error rate of less than 5% when three medication errors were observed for three residents (Resident #248, Resident #249, and Resident #250) from a total of 25 observations, resulting in a medication error rate of 12%. This deficient practice resulted in the likelihood for adverse medication effects including hypoglycemia (decreased blood sugar), hypotension (low blood pressure), bleeding, and decreased medication efficacy related to incorrect administration dosage. Findings include: Resident #248: A medication pass observation for Resident #248 was completed on [DATE] at 10:08 AM with Licensed Practical Nurse (LPN) QQ. Per LPN QQ, Resident #248's blood glucose level was 212 and required subcutaneous (SQ- injection into fatty tissue under skin) insulin per sliding scale. Review of the Resident's sliding scale insulin order revealed Resident #248 should receive six units of Insulin Aspart (rapid active insulin for treatment of hyperglycemia- elevated blood glucose levels) for a blood glucose level of 212. LPN QQ was observed preparing Insulin Aspart for Resident #248. The insulin vial contained a sticker which detailed the date of the vial was opened and [DATE] was written on the insulin vial. LPN QQ removed seven units of insulin from the vial and walked towards the Resident's room. LPN QQ was stopped prior to administration and asked how many units of insulin were in the syringe. LPN QQ replied, Six without looking at the syringe. An observation of the insulin syringe was completed with LPN QQ at this time and LPN QQ confirmed there were seven units of insulin in the syringe. LPN QQ revealed they were unfamiliar with the lines on the insulin syringes. LPN QQ disposed of the insulin and the syringe. LPN QQ proceeded to draw six units of Insulin Aspart from the same vial of insulin. After drawing up the insulin, LPN QQ began walking towards the Resident room. LPN QQ was observed setting the prepared insulin, in the syringe, directly on the top of the transmission-based isolation cart outside of Resident #248's room without a barrier to don Personal Protective Equipment (PPE). Prior to entering Resident #248's room, LPN QQ was stopped and queried regarding infection control policies/procedures related to medication administration and injection, LPN QQ indicated they had not thought about it and proceeded to dispose of the insulin and syringe. LPN QQ then prepared the insulin for administration. Resident #250: (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10:21 AM on [DATE], a medication pass observation for Resident #250 was completed with LPN QQ. LPN QQ was observed removing medications from the medication cart for Resident #250 including a prepackaged syringe of Lovenox (anticoagulant- blood thinner medication) 40 mg (milligrams) / 0.4 mL (milliliters) and proceeded to walk towards Resident #250's room to administer the medications. Review of Resident #248's medication orders revealed the Lovenox order was for Lovenox 30mg/0.3mL SQ injection. Prior to administrating the Lovenox injection to Resident #248, LPN QQ was stopped. When queried what Resident #248's ordered dose of Lovenox was, LPN QQ did not provide a response and was asked to review the Resident's medication order. After reviewing the order, LPN QQ confirmed the order was for Lovenox 30 mg/0.3 mL and the prefilled syringe they were going to administer was Lovenox 40 mg/0.4 mL. When asked why they did not confirm the dose of the medication, LPN QQ revealed they were unaware any other residents were receiving Lovenox and had grabbed the prefilled Lovenox syringe from the medication cart. An interview was conducted with the [NAME] President (VP) of Operations, Registered Nurse (RN) E on [DATE] at 1:04 PM. The Director of Nursing (DON) was off work due to illness and unavailable for interview. VP RN E was made aware of medication pass observations including errors and LPN QQ being stopped prior to administration. VP RN E indicated they would address the concern and ensure education completion. Resident #249: A medication pass observation was conducted with LPN MM on [DATE] at 9:53 AM for Resident #249. LPN MM contacted the Resident's health care provider prior to administration due to the medications being administered late. As LPN MM was removing medications from the medication cart for administration to the Resident including Dyazide (combination diuretic and antihypertensive medication) 37XXX,d+[DATE] mg, Norvasc (medication used to treat high blood pressure) 5 mg, and Cozaar (medication used to treat high blood pressure) 100mg, they asked LPN OO to obtain the Resident's vital sign measurements. LPN OO took the wrist blood pressure cuff off the top of the cart. After the medications were removed from the cart and placed in the medication cup from administration, LPN OO returned and informed LPN MM that Resident #249's blood pressure was ,d+[DATE] and their pulse rate was 70 beats per minute. LPN MM indicated they needed to contact the Resident's health care provider prior to administration as there were no parameters for administration in the medication orders. LPN MM contacted the Health Care provider and received an order to hold the Resident's Dyazide, Norvasc, and Cozaar doses. LPN MM was observed removing the Norvasc and Cozaar from the medication cup and proceeded to hand the cup of medications to LPN OO to give to the Resident. Both staff were stopped and asked how many pills were in the medication cup. Both LPN MM and LPN OO returned to the medication cart and LPN MM began counting the pills. When asked if they had removed the Dyazide from the medication cart, LPN MM verified they had not removed the pill and proceeded to remove it from the cup. LPN MM and LPN OO were asked why the medications were given to LPN OO to take to the Resident when they had not removed/verified the medications, LPN MM replied they were training LPN OO. No further explanation was provided. (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	05/04/2023

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of facility policy/procedure entitled, Medication Administration (Reviewed/Revised: ,d+[DATE]) revealed, Policy: Medications are administered by licensed nurses . as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection . Policy Explanation and Compliance Guidelines . 10. Review MAR (Medication Administration Record) to identify medication to be administered. 11. Compare medication source (bubble pack, vial, etc.) with MAR to verify resident name, medication name, form, dose, route, and time . 12. Identify expiration date. If expired, notify nurse manager. 13. Remove medication from source, taking care not to touch medication with bare hand. 14. Administer medication as ordered in accordance with manufacturer specifications .

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	235132	A. Building B. Wing	05/04/2023

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 37668 Based on observation, interview and record review, the facility failed to operationalize policies and procedures to ensure medication storage, labeling, and disposal per professional standards of practice for four of five medication carts and two of two medication rooms resulting in medications without resident identifiers, opened and undated medications, expired medications and medical supplies, and the potential for all Residents receiving medications from those medication carts, to receive medications with altered efficiency. Findings include: A tour of the North Hall Medication Cart was completed with Licensed Practical Nurse (LPN) MM on 4/26/23 at 8:33 AM. The following were present in the medication cart: - Glucose Control Solutions; Dated as Opened 7/20/22 - Carboxymethyl 0.5% Solution Eye Drops; Labeled for administration to Resident #249; Opened and undated - Proair HFA 8.5 gm (gram) inhaler; Open and undated; Labeled for administration to Resident #247 - Ipratropium Bromide HFA inhaler; Open and undated; Labeled for administration to Resident #247 - Proair HFA 8.5 gm (gram) inhaler; Open and undated; Labeled for administration to Resident #248 - Proair HFA 8.5 gm (gram) inhaler; Open and undated; Labeled for administration to Resident #21 - Cetirizine HCL tablets, 90 Count bottle; Expiration date on bottle was unreadable - Aranesp injection (medication used to help body produce/increase red blood cells) 100mcg (micrograms)/1 mL (milliliter); Opened and undated; Labeled for administration to Resident #244 - Insulin Glargine 100 units/mL; Open and undated; Labeled for administration to Resident #248 - Insulin Glargine 100 units/mL; Open and undated; Labeled for administration to Resident #249 - Insulin Aspart 100 units/mL; Open and undated; Labeled for administration to Resident # 249 - Insulin Aspart 100 units/mL; Open and undated; Labeled for administration to Resident #248 LPN MM was queried how long insulin is able to be used for after being opened and replied, 30 days. When queried regarding facility policy/procedure pertaining to dating medication, LPN MM revealed all medications are supposed to dated when opened. When asked why the medications were not dated when opened, LPN MM did not provide an explanation. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In the locked narcotic drawer of the medication cart, an unlabeled medication cup filled with pills was observed. When queried what the medications in the cup were, LPN MM replied that the medications were for Resident #247. When asked why the medications were in the drawer, LPN MM revealed they had pulled the meds to administer to the Resident but they were not in their room, so they put them in the drawer. When queried what medications were in the cup, LPN MM revealed the medications included Norco (controlled, narcotic medication for pain) and Gabapentin (controlled medication used to treat nerve pain). When queried if they had documented the medications as administered on Resident #247's Medication Administration Record (MAR), LPN MM indicated they had. Resident #247's Controlled Medication Administration Count Documentation Record was reviewed and reconciled with LPN MM at this time. Resident #247's Controlled Medication Count Documentation Record forms for Norco 7.5/325 mg and Gabapentin 300 mg did not match the number of pills in the Resident's bubble pill package. For both medications, there was one less pill in the blister pack than on the Controlled Medication Administration Count Documentation Record. A tour of the North Long Hall Medication Cart was completed with LPN XX on 4/26/23 at 11:00 AM. The following items were noted in the medication cart: - Three Ipratropium Bromide 0.5 mg and Albuterol Sulfate 3 mg; 3 mL vials; Opened and undated; Labeled for administration to Resident #63. - EvenCare Glucose Control solutions; Open and undated A tour of the North Hall Medication room was conducted with Unit Manager LPN TT on 4/28/23 at 9:09 AM. The following were observed in the North Hall Medication Room: - 18-gauge safety needles; Quantity two; Expired: 1/2023 - Micro kill Bleach wipes; Quantity: 117; Expired: 1/2023 - Two bottles of liquid Drug Buster were present in the same cabinet as laboratory supplies (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In a cabinet above the sink in the medication room, a black box was observed towards the back left side. The box was sitting on an open plastic bag with the front of the box facing the cabinet door. There was no identification present on the top of the bag/open box. Upon removal of the box from the cabinet, it was noted to be an opened and unlocked lockbox. The box contained eight empty bottles and seven bottles containing liquid methadone (prescription opioid drug) labeled for administration to Resident #253. The label on each bottle specified, (Resident #253) . Methadone . Dosage: 200 mgs (milligrams) . Detailed observation of the medication bottles revealed each of the seven bottles containing liquid methadone contained different amounts of liquid in them. When asked, LPN TT revealed Resident #253 no longer resided in the facility but was unsure of their discharge date . A paper was present on the bottom of the outside of the open bag which detailed, Security Bag . Instructions . 4 . Remove adhesive backing and fold at line indicated to create tamper evident seal . Other: Lockbox with methadone. Box is locked. No Key . The form contained illegible signatures of staff members. There was no documentation and/or reconciliation of how much methadone was originally brought into facility. LPN TT was asked when and how much medication was brought into the facility. LPN TT revealed they did not know. LPN TT was asked to have the Director of Nursing (DON) come to the medication room. LPN MM entered the medication room at this time and were asked if they knew anything about the Methadone. LPN MM did not respond. A copy of Resident #253's facesheet was requested at this time. After arriving at the medication room, the DON was queried regarding the Methadone including the reason the medication was in the medication room. The DON examined the unlocked black lock box but was unable to provide an explanation. When queried regarding the facility policy/procedure for controlled substances, the DON revealed narcotic/controlled medications are supposed to be accessible only to licensed nurses. When asked if narcotic/controlled substances should be double locked, the DON replied, Yes. A tour of the East Hall Medication room was completed with LPN ZZ on 4/28/23 at 10:57 AM. Upon entering the room, a sink was present in the medication room. There was no hand soap and/or paper towels in the medication room. When asked, LPN ZZ indicated the room had been repainted and repaired but the soap and paper towel dispenser were not replaced. The following items were observed in the medication room: - Tuberculin Purified Protein Derivative Multidose 5 TU (US test units)/ 0.1 mL; 1 mL Vial; Dated as opened on 1/6/23 - Tuberculin Purified Protein Derivative Multidose 5 TU (US test units)/ 0.1 mL; 1 mL Vial; Dated as opened on 5/17/23 When queried how long the Tuberculin Purified Protein Derivative is able to be used for after being opened, LPN ZZ revealed they thought it was good for 30 days. When queried how the vial dated as opened on 5/17/23, LPN ZZ was unable to provide an explanation. When queried why the vial dated as opened on 1/6/23 was still in the medication refrigerator if it was only good for 30 days after being opened, LPN ZZ confirmed the medication was not longer able to be used but did not provide further explanation. 22927 (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 04/25/23 at 02:20 PM of a Small brown refrigerator in Infection Control office with immunization/vaccines noted in the refrigerator revealed a thermometer temperature of 30-31 degrees. Below freezing temp. Immunization/vaccines within the refrigerator included: Prevnar 20 injectable 0.5ml IM expiration date of 4/2024 unused, Prevnar 20 injectable 0.5ml IM expiration date of 8/2024 unused, Prevnar 13 injectable 0.5ml IM expiration date of 6/2024 unused, Pneumovax 23 injectable IM expiration date of 6/2024 unused, observed a full unopened bottle of Tuberculin Purified Protein Derivative, diluted Aplisol solution with expiration date of 5/2024 stored in the door of fridge and one opened with cap off, partially used Aplisol solution with no open dated and loose on bottom of fridge on lowest level, rolling about. Observed Influenzas vaccine (afluria Quadrivalent) 5ml multi-dose bottle opened with cap off, undated and in a zip lock style bag on the bottom of the refrigerator. Interview and observation in the Infection Control office on 04/26/23 07:20 AM with Registered Nurse/Infection Control Preventionist (RN/ICP) A observed a small dorm size brown refrigerator on the floor. RN/ICP A Opened the refrigerator to reveal fridge temperature was 31 degrees (below freezing temperature). RN/ICP A stated that the temperature for vaccines is 34 degrees to 45 degrees and that the vaccines should not be stored in the door of the refrigerator. Review of the vaccines within the refrigerator with RN/ICP A stated that the vaccine was used for the TB clinic and was stored there after. The Influenza vaccine was from the October 2022 flu clinic for employees, the TB solutions were also used. The Prevnar injections are from residents that discharged or refused the vaccine. RN/ICP A revealed that the immunization/vaccines can be returned to the pharmacy. Surveyor asked about what about the refrigerator temperature and the need to keep the vaccines at a stable temperature or they become ineffective. No response was given. Observation on 04/26/23 at 07:30 AM of the Central short hall medication cart with Licensed Practical Nurse (LPN) SS and the Director of Nursing (DON) revealed that there were loose tablets of: 2 small orange round colored tablets found in the bottom drawer used for the extra (over flow supply) punch cards, one mid-size pink round tablet found in the middle drawer of the cart were medications in use are placed, and one oblong light green small tablet with score mark was also found in the middle drawer of the cart. Record review of the narcotic medication sheets randomly selected revealed that Resident #81's Gabapentin 300 mg tablets were noted to have 20 tablets left on the sign out sheet and there were 19 observed on the punch out card, The surveyor asked were the missing tablet was and LPN SS stated that it's in the resident, I gave it this morning, but I did not sign it out. The DON stood next to the cart, heard the nurse's answer, and stated that is not the way we do it. Observation of medication drawers revealed a non-sampled Resident Albuterol aerosol treatments were opened with no date noted to box or opened foil packet. Record review of the Central short hall medication cart Narcotic count sheets noted multiple plank initial spaces and counts. Observation and interview on 04/26/23 at 07:50 AM on the East Unit medication cart with Licensed Practical Nurse S, of med the cart revealed that cart was already cleaned out of loose pills. (continued on next page)

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	235132	A. Building B. Wing	05/04/2023

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation of medication drawers revealed Resident #46 powder inhaler fluticasone propate 250mcq/50mcq 60 dose inhaler, noted with fifty-seven doses left on dial, no open date noted on inhaler or storage bag. Observation nasal mist inhalants; Non-sampled male residents Fluticasone 50mcq top removed with red tape from pharmacy opened and used, no open dated noted on bottle or on the blue pharmacy container bottle; Non-sampled female residents Fluticasone 50mcq top removed with red tape from pharmacy opened and used, no open dated noted on bottle or on the blue pharmacy container bottle; Non-sampled female residents Fluticasone 50mcq top removed with red tape from pharmacy opened and used, no open dated noted on bottle or on the blue pharmacy container bottle. Non-sampled male residents Fluticasone 50mcq top removed with red tape from pharmacy opened and used, no open dated noted on bottle or on the blue pharmacy container bottle. Record review of the facility 'Storage of Medications' policy dated 4/2019 revealed that facility stores all drups ad biologicals in a safe, secure, and orderly manner. Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed. Record review of the facility 'Controlled Substances' policy dated 4/2019, revealed that upon administration the nurse administering the medication is responsible for recording: (1.) Name of resident receiving the medication. (2.) name, strength, and dose of the medication. (3.) Time of administration. (4.) Method of administration. (5.) Quanity of the medication remaining; and (6.) Signature of the nurse administering medication. At the end of each shift controlled medications are counted at the end of each shift. The nurse coming on duty and the nurse going off determine the count together.

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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** 22347 Based on observation, interview and record review, the facility 1) Failed to ensure that food preparation and kitchen equipment were maintained in a sanitary manner and in good working condition, and 2) Failed to ensure that the kitchen refrigerators and freezers maintained a daily temperature log, resulting in an increased potential for food borne illness with possible hospitalization and with the potential to affect the census of 54 residents who consume nutrition from the facility kitchen. Findings include: During the initial kitchen tour on 4/25/23 at 9:50 a.m , accompanied Dietary Aide's B and C, the following was observed: -The whole kitchen floor was observed to have food, papers and dust on it. There was a black dust pan sitting near the refrigerator with dirt and food in it. -The resident microwave was found to have dried food on the bottom and top of the inside. -Several small flying black bugs were observed flying around in the dish room and by the 2 white handwashing sinks. During an interview done on 4/25/23 at 9:58 a.m., Dietary Aide C stated, We still have the black bugs in here, they are coming from the corner of the dish room. -20 individual cups of juice were found in the 4 door refrigerator, with no dates at all on them or the tray they were sitting on. During an interview done on 4/25/23 at 10:00 a.m., Dietary Aide C stated, They need to label it (the tray of juices); it's just the two of us this morning, we had a call in. -The large metal can opener was observed to have dried food particles on the blade area. -Both of the white hand washing sinks had empty paper towel holders. During an interview done on 4/25/23 at 10:28 a.m., Dietary Aide B stated Only housekeeping can fill the paper towel containers. -The ovens were found to have an excessive amount of dried/backed on food in side on the sides and bottom. -The [NAME] trap had a large amount of dried [NAME] and food found in it. During an interview done on 4/25/23 at 10:10 a.m., Dietary Aide C stated I don't know who cleaned it ([NAME] trap) last. (continued on next page)

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	235132	A. Building B. Wing	05/04/2023

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-2 clean and ready for use silver metal pan's were found stacked inside of one another and wet inside. -Several black flying tiny bugs were noted flying around in the dish room and near the back white handwashing sink. -The front black grill of the juice machine had dust on it. -In the dry storage freezer, 2 gallon ice cream containers that were open and partly used with no dates on them (open and use-by dates). Review of the facility Dish Machine water temperature log dated April 2023, and Three-Compartment Sink Log dated April 2023, had no documentation after the date 4/17/23. Review of 3 kitchen Refrigerator Temperature Log's dated April 2023, all were incomplete regarding daily log, and one had only 3 temperatures taken for the whole month of April. Review of the kitchen Freezer Temperature Log dated April 2023, revealed no documentation after 4/19/23. During an interview done on 4/25/23 at 10:03 a.m., Dietary Aide B stated We should be filling out the temp log's (temperature log's) daily. During an interview done on 4/27/23 at 2:50 p.m., Infection Control Nurse, RN A said kitchen refrigerator and freezer temperature log's have to be filled out daily at shift start and end. According to the 2017 FDA Food Code: Section 3-501.17, Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking. (A) Except when PACKAGING FOOD using a REDUCED OXYGEN PACKAGING method as specified under S 3-502.12, and except as specified in (E) and (F) of this section, refrigerated, READY-TO EAT, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and held in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded when held at a temperature of 5 C (41 F) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1. 4-202.11 Food-Contact Surfaces. (A) Multiuse FOOD-CONTACT SURFACES shall be: (1) SMOOTH; (2) Free of breaks, open seams, cracks, chips, inclusions, pits, and similar imperfections; (3) Free of sharp internal angles, corners, and crevices; (4) Finished to have SMOOTH welds and joints; (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	4-602.11 Equipment Food-Contact Surfaces and Utensils. (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be cleaned: (5) At any time during the operation when contamination may have occurred.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37668 Based on observation, interview and record review, the facility failed to institute and operationalize policies and procedures to ensure comprehensive administrative oversight of facility programs and knowledge of residents' conditions and care needs for all 92 residents residing in the facility. This deficient practice pertains to multiple levels of facility management and oversight and resulted in a lack of administrative knowledge of resident care practices and needs within the facility including but not limited to lack of knowledge of pressure ulcers (wounds caused by pressure), Preadmission Screening and Resident Review (PASRR) completion, the provision of Activity of Daily Living (ADL) care, safe medication administration and storage, oversight and the assurance of the provision of nutritional services in a safe and sanitary manner, competent and sufficient staffing to meet resident needs, and the likelihood psychosocial distress, utilizing the reasonable person concept, and decline in the overall health and well-being for all 92 facility residents. Pressure Ulcers: Review of the CMS-802 Resident Matrix form provided by the facility indicated there were four Residents had pressure ulcers. Per the CMS-802 form, one of the four pressure ulcers were facility acquired. Review of the CMS-672 Census and Conditions form, seven residents had pressure ulcers and two of the seven were facility acquired. A list of Residents with pressure ulcers was requested from the facility Administrator on 4/25/23 at 12:00 PM. The Administrator was asked to delineate if the pressure ulcer status (admitted with or acquired) on the list. At 1:31 PM on 4/25/23, the Administrator provided a list of residents with pressure ulcers in the facility. The list did not identify if the resident was admitted with a pressure ulcer or if the pressure ulcer was facility acquired. On 4/25/23 at 3:36 PM, the Administrator provided a list of eight Residents (#'s 21, 37, 248, 250, and two unsampled residents) with pressure ulcers. Per the list, only one Resident (#37) had a facility acquired pressure ulcer. During the survey, the following concerns were identified: - The facility did not have a policy/procedure in place for monitoring and ensuring alternating air mattress functionality and settings. - The facility did not implement planned and/or appropriate interventions to prevent pressure ulcer development per standards of care. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- Resident #245 was found to have two facility acquired pressure ulcers, including an unstageable Deep Tissue Injury (DTI - pressure injury with unknown depth due to damage to underlying tissues) pressure ulcer on their heel and stage two (partial thickness loss of tissue presenting as a shallow open ulcer with a red/pink wound bed, without slough) on their coccyx. The pressure ulcers had not been identified and/or documented by facility nursing staff. - Resident #250 was found to have a DTI pressure ulcer on the lateral aspect of their right heel and a DTI on the right foot, near the base of their toe. Medication Administration and Storage: During the survey process, the facility did follow standards of care related to medication administration and storage. Improperly stored narcotic medications, unlabeled medications, undated medication, and expired medications were observed in the facility. It was determined the facility did not have comprehensive procedures in place pertaining to nursing orientation and staff were working with residents independently and passing medications without documented competency. The facility medication administration error rate during the survey was 12%. An interview was conducted with the Administrator on 5/4/23 at 1:20 PM. When queried regarding the concerns identified by the survey team related to ADL care, pressure ulcers, medication administration/storage, orientation process, and staffing, the Administrator replied, Ongoing issues in this building. When queried how they were addressing the ongoing issues, the Administrator indicated they think the facility is improving. No further explanation was provided. When asked if they had identified staffing as a concern, the Administrator replied, I think it was more of a concern before, but we staff pretty well. Upon entering the facility at 8:00 AM, there was one nurse and one Certified Nursing Assistant (CNA) working on the North and Medbridge Halls of the facility which houses 24 residents. When asked if they were aware, the Administrator did not reply. When queried if they felt that was adequate staffing, the Administrator stated, We are always looking at staffing and getting feedback. The Administrator did not provide a response to the question asked. When queried regarding ADL care, the Administrator stated, I think they (staff) do it, but I don't think it is documented. When asked why they thought that the Administrator did not provide an explanation but stated, I think that is an area of improvement we could improve on. When asked what they were doing to improve it, the Administrator indicated the Director of Nursing (DON) completes audits. The Administrator was unable to state what is being audited, the frequency of audits, and/or corrective actions taken to improve resident care and resident care outcomes. 22347 PASARR's: Review of the facility list of facility residents who do not have timely PASARR's dated 4/27/23, given to this surveyor on 4/28/23 at 11:20 a.m., from the Director of Nursing revealed a total of 10 resident's out of a total census of 96 residents whose PASARR was not done at all or late to be done. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview done on 4/28/23 at 8:15 a.m., Social Worker H stated About November or December (of 2022) when I got here (started at the facility), I had no access to get into OBRA (Budget Reconciliation Act) to do the PASARR's. I contacted OBRA web site when I got here. The social worker before me who had left was still in the system. Neither of us (2 facility social workers) have access to get in and do the PASARR's, so they (the facility resident's) are behind. I did not get an answer from OBRA, so about 1 month ago I called them, and they said they would work on it (no documentation regarding OBRA contacts, notes or names were available). I did tell the Administrator when I got here and again in the IDT (Interdisciplinary Team) meetings that I still could not get in; she (the Administrator) said she would work on it at that time. I last told the Administrator about 1 month ago again I could not get in. During an interview done on 4/28/23 at 8:45 a.m., the Administrator stated They (Social Workers at facility) said they could not get in (to OBRA system to do PASARR's) so I emailed (cooperate staff). The same person trained the social workers about 5 months ago. I was not aware they still could not get into the system; no one came and told me. I will email cooperate again right now. During an interview done on 4/28/23 at 9:30 a.m., VP (Vice President) of Operations E stated I just talked to (Cooperate) and she is going to get them access. During an interview done on 5/2/23 at approximately 10:00 a.m., Social Worker H said she had still not gotten access to do resident's PASARR's. ADL's & Staff Orientation Check-Off Lists: Resident #14: During an interview done on 4/27/23 at 10:25 a.m., Resident #14 stated No, I do not get my showers or bed baths weekly. I get one bed bath every other week. Review of the MDS cognitive assessment dated [DATE], revealed the resident #14 was alert and able to make her own healthcare decisions. Review of the Central Hall Shower schedule revealed the resident should have been getting a bath or shower on Tuesdays and Fridays. Review of the resident's electronic record shower/bath record dated 4-4-23 through 5-2-23 revealed, no showers were given in 30 days, only 4 bed baths were given, and no refusals were documented. The resident went from 4/8/23 through 4/17/23 without a bed bath or shower given. During an interview done on 5/3/23 at 11:50 a.m., MDS Coordinator O stated I didn't find any notes in the record why Resident #14) did not get her showers or baths. The bathing preference sheet should be documented the same as the shower/bath sheet. It's the responsibility of the Aides (CNA's) on the floor if the showers don't get done or gets, they get pulled off (Shower Aide get pulled to the floor to work). (Shower Aide X) only works on day's; they (CNA's) should be doing the showers and bath's if she can't get them on their scheduled days. If they (Resident's) refuse, there should be a note put in. The shower Aide gets pulled to the floor about once or twice a week. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview done on 4/27/23 at 9:00 a.m., Shower Aide/ CNA X stated I am just the one (shower aide) for the whole facility. I am responsible to do 14 to 15 showers a day. I don't get them all done. I do 8 hours a day. If they (resident showers) don't get done, we don't have the staff, so that means they won't get done. The next shift CNA's are supposed to do them. During an interview done on 4/27/23 at 8:55 a.m., CNA Z stated She (shower aide X) has to do the whole building, all the showers. During an interview done on 4/27/23 at 8:50 a.m., Nurse, RN U stated We have a lot of call-In's, seconds is our problem. We usually only have 2 CNA's, it's a problem. Honestly, they (resident showers) don't get done. During an interview done on 4/27/23 at 8:45 a.m., Nurse, RN AA stated Management expects us to get them (resident showers) all done. There is one day shift shower aide and seconds doesn't have one. I do get complaints from resident's lately complaining to me they don't get their showers. During an interview done on 4/27/23 at 9:05 a.m. the DON stated, We have one shower Aide now, it just got changed when the census went down (cut staff). During an interview done on 4/27/23 at 9:10 a.m., Resident #33 stated If I do not get my shower, and sometimes they try, I pitch a bitch, that's why I get them. During an interview done on 4/27/23 at 9:05 a.m. the DON stated, We have one shower aide now, it just got changed when the census went down (cut staff). Resident Interviews Regarding Staffing: Review of the facility Nursing Services and Sufficient Staff policy dated 3/23, reported It is the policy of this facility to provide sufficient staff with appropriate competencies and skill sets to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. The facility's census, acuity and diagnoses of the resident population will be considered based on the facility assessment. Providing care includes, but not limited to , assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. During an interview done on 5/3/23 at 8:40 a.m., Resident #45 stated They did not set up my breakfast today (breakfast tray). She (CNA) took the top off and ran out of the room so fast I couldn't tell her anything. I had to go to the bathroom and now my food is cold because she took the top. It still takes them for ever to answer my light, about 45 minutes to an hour. I have had accidents and I get hurt (hurt feelings) and angry. During an interview done on 5/3/23 at 8:50 a.m., Resident #14 stated It has been up to 2 hours to get them to answer my light. I have had accidents and I get angry with them. During an interview done on 5/3/23 at 9:40 a.m., Resident #29 stated It takes them a long time to answer my call light, depends on who is working; about an hour sometimes. Incomplete Orientation Skill Check-off's: (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview and record review done with the Director of Human Resource/HR DD on 5/4/23 at 10:32 a.m., the following staff members files had incomplete or missing orientation documentation: -Staff Member FF, Nurse, LPN's Licensed Practical Nurse LPN Orientation Competency Checklist dated 4/26/23, did not have a reviewer signature confirming accuracy and completeness. -Staff Member GG, Nurse, LPN's Facility general orientation sheet dated 8/17/22 and Licensed Practical Nurse, LPN Orientation Competency Checklist dated 8/31/23, both did not have a reviewer signature confirming accuracy and completeness. -Staff Member II, Activities Aide's facility general orientation sheet dated 4/12/23, did not have a reviewer signature confirming accuracy and completeness. During an interview done on 5/4/23 at 11:00 a.m., HR DD stated That one's on me, I did not do it, or I did not write it in. -Staff Member B, the Director of Nursing/DON's Assistant Director of Nursing Services Orientation/Competency Checklist (there was no competency for DON) dated 4/18/22, had a reviewer signature (RN), however none of the competency skills had been checked off. There was no dates at all on any skill's that demonstrated review or demonstration. During the interview done on 5/4/23 at 11:15 a.m., HR DD confirmed there was no Director of Nursing competency Checklist in the DON's file. -Contracted Speech Therapist L's facility HR file had no documentation at all of any facility education done (Resident Rights, Abuse, Elder Justice Act, Emergency procedures, etc). During an interview done on 5/4/23 at 11:00 a.m., HR DD stated no, they were not done (staff competency's and general orientation). During an interview done on 5/4/23 at 11:20 a.m., HR DD stated The company said it was not my business about any contracted staff; I asked but they said don't worry about it. I have not had a chance to do an audit. No one from cooperate has done an audit. I had 2 days of training. I don't have accesses to the contracted staff's education of any files with their company. During an interview done on 5/4/23 at 1:20 p.m., Education Nurse, RN A stated The orientation process evolving and changing, HR does the majority of the orientation and I do IC (infection Control). Kitchen: During the initial kitchen tour on 4/25/23 at 9:50 a.m , accompanied Dietary Aide's B and C, the following was observed: -The whole kitchen floor was observed to have food, papers and dust on it. There was a black dust pan sitting near the refrigerator with dirt and food in it. -The resident microwave was found to have dried food on the bottom and top of the inside. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Several small flying black bugs were observed flying around in the dish room and by the 2 white handwashing sinks. During an interview done on 4/25/23 at 9:58 a.m., Dietary Aide C stated, We still have the black bugs in here, they are coming from the corner of the dish room. -20 individual cups of juice were found in the 4 door refrigerator, with no dates at all on them or the tray they were sitting on. During an interview done on 4/25/23 at 10:00 a.m., Dietary Aide C stated, They need to label it (the tray of juices); it's just the two of us this morning, we had a call in. -The large metal can opener was observed to have dried food particles on the blade area. -Both of the white hand washing sinks had empty paper towel holders. During an interview done on 4/25/23 at 10:28 a.m., Dietary Aide B stated Only housekeeping can fill the paper towel containers. -The ovens were found to have an excessive amount of dried/backed on food in side on the sides and bottom. -The [NAME] trap had a large amount of dried [NAME] and food found in it. During an interview done on 4/25/23 at 10:10 a.m., Dietary Aide C stated I don't know who cleaned it ([NAME] trap) last. -2 clean and ready for use silver metal pan's were found stacked inside of one another and wet inside. -Several black flying tiny bugs were noted flying around in the dish room and near the back white handwashing sink. -The front black grill of the juice machine had dust on it. -In the dry storage freezer, 2 gallon ice cream containers that were open and partly used with no dates on them (open and use-by dates). Review of the facility Dish Machine water temperature log dated April 2023, and Three-Compartment Sink Log dated April 2023, had no documentation after the date 4/17/23. Review of 3 kitchen Refrigerator Temperature Log's dated April 2023, all were incomplete regarding daily log, and one had only 3 temperatures taken for the whole month of April. Review of the kitchen Freezer Temperature Log dated April 2023, revealed no documentation after 4/19/23. (continued on next page)

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	235132	A. Building B. Wing	05/04/2023

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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview done on 4/25/23 at 10:03 a.m., Dietary Aide B stated We should be filling out the temp log's (temperature log's) daily. During an interview done on 4/27/23 at 2:50 p.m., Infection Control Nurse, RN A said kitchen refrigerator and freezer temperature log's have to be filled out daily at shift start and end. Call Lights and Food Assistance: Resident #14: Review of the face Sheet, MDS dated [DATE] and diagnosis sheet, revealed Resident #14 was [AGE] years-old, admitted to the facility on [DATE], dependent on staff for all activities of daily living. The resident's diagnosis included, respiratory failure, diabetes, Depressive Disorder, Anxiety, Restless Leg Syndrome, high blood pressure and embolism and thrombosis of arteries of the lower extremities. The resident had a artificial breathing tube (trach) and was a full code. Review of the MDS cognitive assessment dated [DATE], revealed the resident was alert and able to make her own healthcare decisions. During an interview done on 4/25/23 at 12:48 a.m., Resident #14 said staff take over an hour to answer her call light and stated, I had wet myself because they don't answer my call light. I get angry, there is nothing much I can do, I can tell the nurse. I cough so, so much and they won't come, it's scary. It has been up to 2 hours to get them to answer my light. I have had accidents and I get angry with them. It depends on who is working, how long it takes to answer my light. Resident #29: Review of the Face Sheet, MDS dated ,d+[DATE], and care plans dated 2019 revealed, Resident #29 was [AGE] years-old, alert, and able to make her own healthcare decisions, admitted to the facility on [DATE], had a tracheostomy, and dependent on staff for Activities of Daily Living. The resident's diagnosis included, chronic respiratory failure, diabetes, depression, tracheostomy, muscle weakness, stenosis of the larynx and high blood pressure. Review of the MDS dated ,d+[DATE], revealed the resident was alert and able to make her own healthcare decisions. During an interview done on 5/3/23 at 9:40 a.m., Resident #29 stated It takes them a long time to answer my call light, depends on who is working; about an hour sometimes. Resident #30: Review of the Face Sheet, Minimum Data Set (MDS, dated [DATE]), and diagnosis sheet revealed Resident #30 was [AGE] years-old, admitted to the facility on [DATE], alert and dependent on staff for all Activities of Daily Living including food set-up. The resident's diagnosis included, stroke, diabetes, heart disease, chronic kidney, heart failure, spastic hemiplegia of the left side (required assistance with cutting foods up), anxiety and major depression. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the resident's cognitive assessment dated [DATE], revealed he was alert and able to make his own healthcare decisions. Observation made on 4/25/23 at approximately 1:00 p.m., revealed Resident #30 was in room in bed. The resident had a chicken breast on his lunch plate, and it was not eaten. When this surveyor asked him why he had not eaten his chicken he stated, I can't use my left arm, and no one cut it up for me. The resident verbalized he wanted to eat the chicken, but was unable to cut it up to eat; no one set-up his meal tray for him when they delivered his tray. Resident #45: Review the Face Sheet, Minimum Data Set (MDS, dated [DATE]), care plans dated 1/24/23 through 4/27/23, revealed Resident #45 was [AGE] years-old, admitted to the facility on [DATE], was alert and making her own healthcare decisions, required staff assistance with all Activities of Daily Living and was blind in right and left eyes. The resident's diagnosis included, Right and Left eye blindness (category 5, only see's close-up shadows), glaucoma secondary to eye disorder, stroke, high blood pressure, chronic heart and lung disease, diabetes, chronic kidney disease, difficulty walking, epilepsy, and muscle weakness. During a second interview done on 5/3/23 at 8:40 a.m., Resident #45 was observed sitting on her bed with her breakfast tray in front of her and it had not been set-up for her. The resident stated They did not set-up my breakfast today. She (staff) took the top off and ran out of the room so fast I couldn't tell her anything. I had to go to the bathroom and now my food is cold because she took the top. It still takes them forever to answer my light, about 45 minutes to an hour. I have had accidents and I get hurt and angry. It takes them over an hour to answer my light, there are no staff. Review of the facility Call Lights: Accessibility and Timely Response policy (un-dated), reported The purpose of this policy is to assure the facility is adequately equipped with a call light at each resident's bedside, toilet, and bathing facility to allow residents to call for assistance. Call lights will directly relay to a staff member or centralized location to ensure appropriate response. This policy does not address an appropriate approved time response. During an interview done on 5/2/23 at 3:23 p.m., the Administrator said 30 minutes was appropriate for staff to answer resident's call light's. During the interview done on 5/2/23 at 3:25 p.m., the Director of Nursing stated 3 to 5 minutes is appropriate for staff to answer resident's call lights. Main Dining Observation: On 4/25/23 at 12:00 p.m., 6 residents were observed sitting in the main dining room at tables waiting for their noon meal trays to arrive. 6 of 6 residents did not have any drinks or snacks at all while waiting. No coffee, drinks, or snacks were observed in the main dining room or in the dining room kitchenette. During an interview done on 5/2/23 at 11:55 a.m., Activity Aide P stated I don't know why they don't have drinks or coffee before meals. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview done on 5/2/23 at 12:00 p.m., Director of Activities Q stated Last week there was a lot of confusion with the kitchen staff, that's why we didn't have drinks. Inaccurate Facility Food Menu: Observation made on 4/25/23 at the noon meal, Resident's #30 and #45 both had chicken breast on their food tray's. Observation of the menu dated Week 1 revealed on 4/25/23, Marinated chicken, Sugar Snap Peas, Potatoes and Dinner Roll/bread, Chocolate Chip cookie, were to be served. Resident's #30 and #45, did not have snap peas, a dinner roll or chocolate chip cookies on their tray's. Review of the facility daily menu for 4/26/23's noon meal reported Meatloaf, Honey Roasted Carrots, Mashed Potatoes, Poppy Seed Dinner Roll (and) Lemon Bar. During a test tray gotten on 4/26/23, the noon meal the surveyor team was served had meatloaf, potatoes, and lemon bar. The tray was missing a vegetable and the poppy seed roll.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22927 Based on observation, interview and record review, the facility failed to implement a comprehensive Infection Control program that included: 1) Failure to properly store Immunization/vaccines, 2) Failure to log employee illness and analysis for three months, 3) Failure to clean a glucometer after using on a resident and before using on another resident, 4) Failure to have enhanced barrier precautions and cross contamination during wound dressing change for Resident #37, and 5) Failure to ensure PEG tube dressings for Resident #37 and Resident #79, resulting in the likelihood for ineffective Immunization/vaccines therapy, lack of analysis of employee illness, and the likelihood of cross contamination of organisms from improper glucometer cleaning and for open wounds, with likeliness of prolonged illness and hospitalization s. Findings include: Record review of the facility 'Standard Precautions Infection Control' policy with copyright date 2022, revealed all staff are to assume that all residents are potentially infected or colonized with organism that could be transmitted during the course of providing resident care services. Therefore, all staff shall adhere to Standard Precautions to prevent the spread of infection to residents, staff, and visitors. Immunization/vaccine storage: Record review of the facility 'Medication Storage' policy dated 3/2023, revealed It is the policy of the facility to ensure all medications housed on our premises will be stored in the pharmacy and/or medication rooms according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security. (6.) Refrigerated Products: a.) All medications requiring refrigeration are stored in refrigerators located in the pharmacy and at each medication room. b.) Temperatures are maintained within 36-46 degrees F. Charts are kept on each refrigerator and temperature levels are recorded daily by the charge nurse or other designee. c.) In the event that a refrigerator is malfunctioning, the person discovering the malfunction must promptly report such finding to Maintenance Department for emergency repair. (8.) Unused Medications: The pharmacy and all medication rooms are routinely inspected by the consultant pharmacist for discontinued, outdated, defective, or deteriorated medications with worn, illegible, or missing labels. These medications are destroyed in accordance with our Destruction of Unused Drugs Policy. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation on 04/25/23 at 02:20 PM of a Small brown refrigerator in Infection Control office with immunization/vaccines noted in the refrigerator revealed a thermometer temperature of 30-31 degrees. Below freezing temp. Immunization/vaccines within the refrigerator included: Prevnar 20 injectable 0.5ml IM expiration date of 4/2024 unused, Prevnar 20 injectable 0.5ml IM expiration date of 8/2024 unused, Prevnar 13 injectable 0.5ml IM expiration date of 6/2024 unused, Pneumovax 23 injectable IM expiration date of 6/2024 unused, observed a full unopened bottle of Tuberculin Purified Protein Derivative, diluted Aplisol solution with expiration date of 5/2024 stored in the door of fridge and one opened with cap off, partially used Aplisol solution with no open dated and loose on bottom of fridge on lowest level, rolling about. Observed Influenzas vaccine (afluria Quadrivalent) 5ml multi-dose bottle opened with cap off, undated and in a zip lock style bag on the bottom of the refrigerator. Interview and observation in the Infection Control office on 04/26/23 07:20 AM with Registered Nurse/Infection Control Preventionist (RN/ICP) A observed a small dorm size brown refrigerator on the floor. RN/ICP A Opened the refrigerator to reveal fridge temperature was 31 degrees (below freezing temperature). RN/ICP A stated that the temperature for vaccines is 34 degrees to 45 degrees and that the vaccines should not be stored in the door of the refrigerator. Review of the vaccines within the refrigerator with RN/ICP A stated that the vaccine was used for the TB clinic and was stored there after. The Influenza vaccine was from the October 2022 flu clinic for employees, the TB solutions were also used. The Prevnar injections are from residents that discharged or refused the vaccine. RN/ICP A revealed that the immunization/vaccines can be returned to the pharmacy. Surveyor asked about what about the refrigerator temperature and the need to keep the vaccines at a stable temperature or they become ineffective. No response was given. Enhanced barrier precautions with resident care: Record review of the facility 'Enhanced Barrier' policy 3/2023, it is the policy of the facility to implement barrier precautions for the prevention of transmission of multidrug-resistant organisms. Enhanced barrier precautions refer to the use of gown and gloves for the use during high-contact resident care activities for residents known to be colonized or infected with MDRO (Multi Drug Resistant Organism) as well as those at increased risk of MDRO acquisition 9. e.g., residents with wounds or indwelling medical devices). During the Infection Control task on 04/27/23 at 02:26 PM with Registered Nurse/Infection Control Preventionist (RN/ICP) A Standard precautions are used for residents with antibiotic use. In morning meetings, the Interdepartmental Team (IDT) discuss the residents on antibiotics daily Registered Nurse/Infection Control Preventionist (RN/ICP) A stated that the facility implemented enhanced barrier precautions that started in 2022, and use it for residents with Foley's/catheters, tube feed/peg tubes, wounds, MDRO's and infections. All nursing staff meeting with education was held on 4/20/2023 and we covered the enhanced barrier precautions. Infection control Surveillance- RN/ICP A rounding is not documented, that does need to get addressed. The infection control nurse stated that he does not document the rounding and relies on department heads to round in their own departments. He does not review each department rounding sheets or collect them. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employee illness: RN/ICP A stated that he has not been getting employee call information for January 2023 through April 2023, and that he did not get a report for the last Quality Assurance meeting. RN/ICP A stated that the facility had a scheduler that would report employee illness and employee call ins. The facility has an employee call in form with sign & Symptoms that needs to be filled out for each employee call-in/call-off. RN/ICP A stated that he stopped getting the employee call in forms back in December 2022, and was only getting COVID positive call-in forms for employees. Record review of the Employee Illness three ring binder with RN/ICP A revealed there to be only one employee call in sheet for the months of January 2023, February 2023, March 2023 found in the binder, all other employee call in forms were dated for the year of 2022. Resident #37: Observation and interview on 04/27/23 at 07:00 AM Observed Licensed Practical Nurse (LPN) S at Nursing station and then at treatment cart got into the cart and retrieved wound dressing supplies, walked to the resident's room. Surveyor observed soft green boots in chair behind the curtain, not on the resident. LPN S pulled the over bed table to the left side of bed, placed barrier cloth, and supplies onto the barrier. Closed the bathroom door and pulled on gloves. LPN S and Certified Nurse Assistant (CNA) VV, observed room [ROOM NUMBER] private room, Resident #37 noted laying on her back in bed. Observation of room revealed there to be Enhanced Barrier Precaution signage. PPE caddy or plastic three drawer isolation bin noted outside the room in hallway. Resident Care planned for precautions. Observed mid-line abdominal peg tube with no dressing in place. LPN S stated that the wounds started at the facility in March 2023 as a buttocks blister and then progressed from one wound to 4: Left Buttocks, left posterior leg (between ankle and knee), left heel, and right posterior leg (between ankle and knee). LPN S stated that Resident #37 had developed thrush in her mouth and it hurt to eat, and she lost weight, went to the hospital and they put in a tube feeding in her abdomen, observed midline tube feeding in place with no dressing noted. LPN S stated that the resident came back all better, and her skin looked great, no open or red areas were noted when she came back. The tube feeding was continuous and is now not used because she can eat normal. LPN S and CNA VV positioned resident onto her right side and lowered the brief. Removed the old dressing dated 4/25/2023. Surveyor observed a stage II open wound with scant drainage noted. The LPN S removed her gloves, went to the wall, and used hand sanitizer and pulled on large gloves. Surveyor noted long artificial fingernails, estimated over a three-fourths inch in length. LPN S then pulled the curtain, so the door was covered, went to the over bed table, and opened packages of 4x4 gauze used wound cleaner spray to spray the 4x4's, tuned to the residents back side and plotted the left buttocks opened wound bed area and then did a pat dry with dry 4x4 gauze. Applied Hydrogel from container onto the wound itself and covered with a sacral shaped foam boarder pink dressing. With the same gloves the LPN then moved to the lower posterior left leg wound and removed the old dressing dated 4/25/2023. Surveyor observed a Stage II or III with slough in center with red/pink edges, clear to tan drainage was noted to the bottom sheet of the bed and on the old dressing removed. The bed had brown moisture rings noted on the bottom sheet where the leg rests on the sheet. The surveyor observed LPN S remove her gloves go to the wall and use hand sanitizer, pull on gloves and open packages of 4x4 gauze, spray the 4x4 gauze and blot the wound bed, yellow stringy slough was noted in wound bed loose, not attached to the edges, drainage noted to gauze. Hydro gel applied directly into the wound (clear gel) and covered with a 4x4 foam boarder dressing. LPN S then went to the left heel, unwrapped a roll of gauze from around the left foot/heel, noted to have edema to foot +2, CNA VV pressed on the left foot edema area. Pink foam boarder dressing was peeled back, and the surveyor observed a dark to black area covering the left-out aspect of the heel. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation and interview on 05/02/23 at 10:10 AM the surveyor went and got the Registered Nurse/Infection control preventionist (RN/ICP) A and walked with the ICP to the resident #37's room. Both surveyor and RN/ICP A observed resident naked upon the bed with G-tube with no dressing in place to new peg tube. Observed CNA R giving bath with gloves and wash cloth in hand, but no gown for barrier. Brief was undone and folded under resident on left side. RN/ICP A stated that there should be a gown on the CNA when giving a bath it is right on the sign on the door. IN an interview on 05/02/23 at 10:23 AM with RN/ICP A the peg tube usually does have a dressing on the peg tube site. RN/ICP A stated that he spoke with the unit manager, and there should be dressings on the peg tube sites of residents that have peg tubes. Tube Feeding dressings for Residents #37 and #79: Record review of the facility 'Gastrostomy Site Care' dated 3/2022, revealed that the facility policy to perform gastrostomy site care as ordered and per current standards of practice: Verify there is a physician order for gastrostomy site care, Review the plan of care . (10.) Apply any other PPE (Personal Protective Equipment) as needed to protect self from any exposure to infectious material and to comply with any isolation precautions ordered. (11.) Maintain clean technique. (12.) Remove old dressing if applicable and discard in appropriate container. (13.) Wash hands and don gloves. (14.) Using soap and water, gently clean the area around the tube and continue in an outward circular fashion, ensuring that under the bolster is cleaned. (15.) Assess the area for any excoriation, undue redness, pain, or drainage. Report immediately to the physician if anything noted. Resident #37: Observation and interview on 04/27/23 at 07:00 AM with Licensed Practical Nurse (LPN) S revealed observations of Resident #37's room revealed there to be Enhanced Barrier Precaution signage. PPE caddy or plastic three drawer isolation bin noted outside the room in hallway. Resident Care planned for precautions. LPN S stated that the resident #37 had developed thrush in her mouth and it hurt to eat, and she lost weight, went to the hospital and they put in a tube feeding in her abdomen, observed midline tube feeding in place with no dressing noted. LPN S stated that the resident came back all better, and her skin looked great, no open or red areas were documented when she came back. The tube feeding was continuous and is now not used because she can eat normal. Observation and interview on 05/02/23 at 10:00 AM with Certified Nurse Assistant (CNA) R in Resident #37's room dressed in scrubs, there is no enhanced protective barrier gown on, and the white trash can at the door with lid open with no trash bags noted in the can. CNA R stated that he is giving the resident a bed bath and was observed filling container with water and wash clothes. Surveyor observed and picked up a cell phone from the bed and the CNA R stated that it was his phone not the residents and put the phone in his pocket. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation and interview on 05/02/23 at 10:10 AM the surveyor went and got the Registered Nurse/Infection control preventionist (RN/ICP) A and walked with the ICP to the resident #37's room. Both surveyor and RN/ICP A observed resident naked upon the bed with G-tube with no dressing in place to new peg tube. Observed CNA R giving bath with gloves and wash cloth in hand, but no gown for barrier. Brief was undone and folded under resident on left side. RN/ICP A stated that there should be a gown on the CNA when giving a bath it is right on the sign on the door. In an interview on 05/02/23 at 10:23 AM with RN/ICP A the peg tube usually does have a dressing on the peg tube site. RN/ICP A stated that he spoke with the unit manager, and there should be dressings on the peg tube sites of residents that have peg tubes. Record review of care plans on 05/02/23 at 11:46 AM for Resident #37 for nutrition/peg tube- care plan revealed: Resident #37 on 4/13/2023 was to have nothing by mouth, due to peg tube. Resident has been observed to have food meal trays for each meal and is taking oral foods. There were no updated care plan interventions for peg tube dressing changes noted. In an interview on 05/02/23 at 12:00 PM with Licensed Practical Nurse/Unit Manager U was notified of the peg tubes not having split gauze dressings in place, she stated that it is the practice to have a dressing in place. Resident #79: In an interview and observation 04/25/23 1 at 2:56 PM with Resident #79's family member revealed that the resident had lost weight since admission to the facility. The family member revealed that Resident #79 use to be around 200 pounds and now is below 150 pounds. Resident #79 does have a tube feed tube in his abdomen. Resident #79 walked over to show the surveyor his peg tube with no dressing in place and crusty material around the opening. The family member stated that Resident #79 is takes food by mouth and that the tube has not been used for a while. In an interview on 05/02/23 at 11:08 AM with Licensed Practical Nurse/Unit Manager TT revealed that the nurses are to have a split gauze dressing to the peg tube site and monitor the sites. In an interview on 05/02/23 t 11:17 AM with Licensed Practical Nurse/Unit Manager U about Peg tube site care revealed that the sites should have split sponge dressing in place by night shift or PRN as needed. Care to the peg tube site is to be cleaned each shift and a dressing is applied. It is on the Medication Administration Record/Treatment Administration Records (MAR/TAR). Record review of Resident #79's Medication Administration Record/Treatment Administration Records (MAR/TAR) March 2023, revealed to change peg tube dressing daily and PRN as needed on the night shift. The treatments to peg tube were all initialed as being performed. Record review of Resident #79's care plans revealed that the nutrition care plan interventions dated 3/3/2023 instructed facility staff to provide local care to G-tube site as ordered and observe for signs and symptoms of infection such as redness, drainage, odor, and tenderness. 37668 (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	05/04/2023

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 5/4/23 at 7:46 AM, an observation of Licensed Practical Nurse (LPN) MM and LPN OO was completed. LPN OO was observed entering Resident #249's room with the Point of Care (POC) glucometer. The glucometer was in a plastic basket which contained a bottle of glucose monitoring strips, alcohol wipes, and lancets (disposable, single use needle used to puncture finger for blood glucose testing). LPN OO set the container down directly on the Resident's overbed table and proceeded to remove the glucometer and set it directly on the table. LPN OO then removed a strip from the bottle, inserted it in the glucometer, and obtained the Resident's blood glucose level. After completing the POC test, LPN OO removed the test strip with Resident #249's blood and placed the glucometer back in the basket on top of the lancets. LPN OO exited the room and handed basket containing the glucometer to LPN MM. LPN MM was observed placing the glucometer directly in the drawer on the medication cart without cleaning. When queried, LPN MM revealed LPN OO was a new nurse and they were orientating them. An interview was conducted with LPN MM and LPN OO at 7:54 AM 5/4/23. When queried if the same glucometer was used for multiple facility residents, LPN MM revealed it was. When queried regarding facility policy/procedure regarding glucometer use and cleaning after use, LPN MM revealed it is supposed to be cleaned with a wipe. When asked why it was not cleaned after Resident #249's blood glucose was tested and prior to being placed in the cart, neither LPN MM nor LPN OO provided an explanation. When asked if the lancets observed in the basket were used for any resident requiring blood glucose POC monitoring, LPN MM revealed they were and that the basket contained all the glucometer supplies. LPN MM was then asked why the entire basket was taken into the room when it contains supplies that are utilized for multiple residents. LPN MM did not provide an explanation. An interview was completed with Unit Manager LPN TT on 5/4/23 at 7:55 AM. When asked the procedure for obtaining and completing POC blood glucose testing including what supplies are taken into the resident room, LPN TT replied, I would take it (glucometer) in a cup and lay it on a clean towel. When asked if it was appropriate to take the basket containing the glucometer, alcohol pads, and lancets into an individual residents room, LPN TT replied, You'd be contaminating it right. LPN TT was then asked if the glucometer needs to be cleaned, after a POC test is completed and prior to being returned to the cart and stated, Yeah and let it dry. LPN TT was informed of observation of LPN MM and LPN OO taking all the supplies into Resident #249's room and not cleaning the glucometer after use and stated, They just don't pay a damn bit of attention. An interview was conducted with Infection Control Registered Nurse (RN) A on 5/4/23 at 11:42 AM. When queried if blood glucometers should be cleaned after a POC resident test is completed, RN A replied they should be. When asked if the glucometer should be placed directly on a Resident's overbed table, RN A stated, Should always have a barrier. When asked if the basket stored in the medication cart containing the glucometer, alcohol wipes, and lancets should be taken into a resident room and set directly on their overbed table for POC testing completion, RN A replied it should not all be taken into a resident room. When informed of observation of glucometer and supplies, RN A revealed they were aware of the concern and had previously identified staff not using appropriate infection control when completing POC testing.