STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235023	A. Building B. Wing	01/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Majestic Care of Battle Creek	200 E Roosevelt Battle Creek, MI 49037

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38383 This citation pertains to intake MI00148919. Based on observation, interview and record review, the facility failed to notify the provider of a change in condition for one (Resident #1) of two reviewed. Findings include: Review of the medical record reflected Resident #1 (R1) admitted to the facility on [DATE], with diagnoses that included unspecified severe protein-calorie malnutrition, degenerative disease of the nervous system and quadriplegia. The admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/1/24, reflected R1 was rarely/never understood and received nutrition via feeding tube. On 1/3/25 at 2:20 PM, R1 was observed lying in bed, awake. R1 did not verbally respond when spoke to. A bottle of Jevity 1.5 calorie tube feeding formula was infusing at a rate of 55 milliliters (mL) per hour. A bag of water was observed hanging, set for a flush rate of 50 mL every eight hours. On 1/6/25 at 8:59 AM, R1 was observed lying in bed, with their eyes closed. A bottle of Jevity 1.5 calorie tube feeding formula was infusing at a rate of 55 mL per hour. A bag of water was observed hanging, set for a flush rate of 50 mL every eight hours. On 1/6/25 at 3:47 PM, R1 was observed lying in bed with a tube feeding and water flush infusing via Percutaneous endoscopic gastrostomy (PEG tube/an endoscopic medical procedure in which a PEG tube is placed into the stomach, through the abdominal wall, and can be used to provide nutrition and hydration). R1's medical record reflected they were not to receive anything by mouth, thus required hydration, nutrition and medication to be administered via PEG tube. A Progress Note for 12/8/24 at 2:36 PM reflected R1's PEG tube was found dislodged, lying on their abdomen. According to the note, the nurse inserted an 18 French (foley/urinary) catheter with a 10 mL balloon in place of the PEG tube. (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's medical record reflected they were sent to the emergency room (ER) on 12/11/24 (three days later) to have their PEG tube replaced. During a phone interview on 1/6/25 at 11:38 AM, Physician D reported if someone were to call the on-call provider, a verbal order could have been given by phone that may not have been documented by the provider. Physician D stated the nursing notes would say who was contacted. Physician D indicated a provider should have been notified of the situation (R1's PEG tube dislodgment) and a request made for recommendations, even if the notification was made the following day. During a phone interview on 1/6/25 at 2:13 PM, Registered Nurse (RN) C reported they inserted a foley catheter tube in place of R1's PEG tube when it became dislodged. RN C reported Director of Nursing (DON) B was notified of the PEG tube being dislodged, but they could not recall if a text notification had been sent to a provider. RN C reported it was a common thing to happen, and they were not used to notifying the provider of such an occurrence. During an interview on 1/6/25 at 2:24 PM, DON B reported if a PEG tube became dislodged, the expectation was that the nurse would notify the physician and document it. DON B reported being notified that the tube became dislodged and was told the on-call provider had been notified that a foley catheter would be placed. R1's medical record did not reflect that a provider had been notified when the PEG tube became dislodged on 12/8/24, nor any orders pertaining to how to proceed with care. According to the facility's Change in Condition/Physician Notification policy, dated 1/2/24, .When a change in condition is discovered, the nurse will evaluate the resident and notify the resident's physician/NP/PA with pertinent information to discuss care for the resident .The nurse will notify the physician/NP/PA and the resident/resident representative when: .Need to alter medications or treatment .A significant change in the resident's physical, mental, or psychosocial status . According to the facility's Enteral Feeding policy, dated 1/2/24, .It is a policy of this facility to utilize feeding tubes in accordance with current clinical standards of practice, with interventions to prevent complications to the extent possible .Feeding tubes will be utilized according to physician orders .Only tubes designed or intended for enteral feeding will be utilized, except under extenuating circumstances and for the shortest time possible .Direction for staff regarding the conditions and circumstances under which a tube is to be changed will be provided: .When to replace and/or change a feeding tube (generally as ordered/scheduled by the physician, when a long-term feeding tube comes out unexpectedly .) .Instances when a tube can be replaced within the facility and by whom .Instances when a tube must be replaced in another setting .Notification of the practitioner when the need for a tube change arises unexpectedly .