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	01/16/2026

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

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** Based on observation, interview and record review, the facility failed to ensure Advance Directives were accurately completed for four (R8, R9, R39 and R52) of four reviewed. Findings include:Resident #8 (R8) Review of the medical record revealed R8 was admitted to the facility [DATE] with diagnoses that included chronic respiratory failure, diabetes mellitus, chronic obstructive pulmonary disease (COPD), morbid (severe) obesity, tracheostomy, gastro-esophageal reflux, dependence on supplemental oxygen, depression, heart failure, hypertension, bipolar disorder, dysphagia (difficulty swallowing), visual blindness bilaterally, schizophrenia, celiac disease (an autoimmune disorder where gluten damages the small intestine), and atrial fibrillation. Review of the most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of [DATE], revealed R8 had a Brief Interview for Mental Status (BIMS) of 15 (cognitively intact) out of 15. During observation and interview on [DATE] at 12:32 p.m. R8 was observed lying in bed. R8 explained that she had been a resident at the facility since 2023. Review of R8's Michigan Do-Not-Resuscitation Order document, revealed R8 had signed the document on [DATE] which stated I have discussed my health status with my physician, (name of physician), and I request that in the event my heart and breathing should stop, no person shall attempt to resuscitate me. Review of physician order entered [DATE] revealed an order Full Code (meaning resuscitation would be started if R8's heart and breathing were stop). On [DATE] at 09:31 a.m. Director of Nursing (DON) B explained that the facility nursing staff completed the Michigan Do-Not-Resuscitation Order document with the residents. DON B explained that the nursing staff would make sure that the document is accurate and then would obtain an appropriate physician order for DNR (Do not Resuscitate). DON B was asked to review R8's Michigan Do-Not-Resuscitation Order form and confirmed that R8 had signed the document on [DATE] that she did not want resuscitation to be conducted if her heart and breathing were to stop. DON B could not explain why R8's physician orders did not accurately reflect R8's wishes to not have resuscitation performed, as documented on her Michigan Do-Not-Resuscitation Order document. Resident #39 (R39) Review of the medical record revealed R39 was admitted to the facility [DATE]/2025 with diagnoses that included severe protein-calorie malnutrition, cachexia (a severe complex metabolic condition causing involuntary and significant loss of muscle mass and fat), hypertension, congestive heart failure (CHF), depression, chronic obstructive pulmonary disease, dysphagia (difficulty swallowing), (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	dependence on supplemental oxygen, idiopathic pulmonary fibrosis (disease causing irreversible scarring in the lungs), heroin poisoning, alcohol abuse, chronic viral hepatitis C, insomnia, and anxiety. Review of the most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of [DATE], revealed R39 had a Brief Interview for Mental Status (BIMS) of 14 (cognitively intact) out of 15. During observation and interview on [DATE] at 09:51 a.m. R39 was observed lying down in bed. R39 explained that he had been a resident at the facility since august of 2025. Review of R39's Michigan Do-Not-Resuscitation Order document, dated [DATE], did not have dates for the two witness signatures. In an interview on [DATE] at 09:15 a.m. Social Worker (SW) E explained that she was responsible to review all resident Michigan Do-Not-Resuscitation Order documents. SW E explained that she would review the documents to ensure that they are completed accurately. SW E confirmed that R39's Michigan Do-Not-Resuscitation Order document did not contain dates that the witnesses had signed the document. SW E could not explain why the signatures did not contain dates of signature on the witness line of the document. Resident # 52 (R52) Review of the medical record revealed R52 was admitted to the facility [DATE] with diagnoses that included traumatic subdural hemorrhage (brain bleed), Alzheimer's disease, cerebral infarction (stroke), gastro-esophageal reflux, depression, hyperlipidemia (high fat content in blood), and hypotension. Review of the most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of [DATE], revealed R52 had a Brief Interview for Mental Status (BIMS) of 05 (severe cognitive impairment) out of 15. During observation and interview on [DATE] at 11:10 a.m. R52 was observed sitting in her wheelchair, in the dining room. R52 could not explain how long she had been a resident at the facility. Review of R52's Michigan Do-Not-Resuscitation Order document, dated [DATE], did not have dates for the two witness signatures. In an interview on [DATE] at 09:24 a.m. Social Worker (SW) E confirmed that R52's Michigan Do-Not-Resuscitation Order document did not have dates for the two witness signatures. SW E could not explain why the document had not been completed accurately. In an interview on [DATE] at 09:31 a.m. Director of Nursing (DON) B confirmed that R52's Michigan Do-Not-Resuscitation Order document did not have dates for the two witness signatures. DON B could not explain why the document had not been completed accurately. R9: Review of the medical record reflected R9 admitted to the facility on [DATE], with diagnoses that included bipolar type schizoaffective disorder and dementia. The Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of [DATE], reflected R9 scored seven out of 15 (severe cognitive impairment) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 9:22 AM, R9 was observed lying awake, in bed. R9's medical record reflected a Do-Not-Resuscitate document (DNR-no cardiopulmonary resuscitation/CPR in the event of cardiac or respiratory arrest), which was signed by a Responsible Party on [DATE] and the Physician on [DATE]. The two witness signatures on the document were undated. In an interview on [DATE] at 9:15 AM, Social Worker (SW) E acknowledged that the witness signatures on R9's DNR document were undated. SW E indicated the significance of witness signatures was to ensure the decision was theirs (person signing DNR document) and nobody else's. In an interview on [DATE] at 9:31 AM, Director of Nursing (DON) B reviewed R9's DNR document and reported the witness signatures were undated. DON B reported their expectation was for witness signatures on a DNR document to be dated.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to obtain consent for psychotropic medication use for one (R23) of five reviewed. Findings include: Review of the medical record reflected R23 admitted to the facility on [DATE], with diagnoses that included fracture of lower end of right femur and chronic obstructive pulmonary disease (COPD). The admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/22/25, reflected R23 scored 13 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool) and was coded as receiving antianxiety medication. On 01/16/2026 at 9:14 AM, R23 was observed seated in a wheelchair, in their room, combing their hair. A Physician's Order, dated 12/16/25, reflected R23 was to receive 15 milligrams (mg) of buspirone (antianxiety medication) three times daily for anxiety. The medical record did not reflect a consent for buspirone. In an interview on 01/15/2026 at 11:13 AM, Director of Nursing (DON) B reported if consents were needed, the nurse generally obtained them upon admission. DON B reported antianxiety medications were a classification of medication they would obtain consent for. In an interview on 01/15/2026 at 12:35 PM, DON B reported R23's buspirone consent had been missed.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to 1) document clinical rationale for duplicate psychotropic medication therapy for one (R23) of five reviewed; and 2) ensure appropriate monitoring of antipsychotic medication use for one (R41) of five reviewed.Findings include:R23: Review of the medical record reflected R23 admitted to the facility on [DATE], with diagnoses that included fracture of lower end of right femur and chronic obstructive pulmonary disease (COPD). The admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/22/25, reflected R23 scored 13 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool) and was coded as receiving antidepressant medication. On 01/16/2026 at 9:14 AM, R23 was observed seated in a wheelchair, in their room, combing their hair. A Physician's Order, dated 12/16/25, reflected R23 was prescribed 75 milligrams (mg) of Amitriptyline Hydrochloride (HCl) (antidepressant medication) by mouth, at bedtime, for depression. A Physician's Order, dated 12/16/25, reflected R23 was prescribed 150 mg of Venlafaxine HCl Extended Release (ER) (antidepressant medication) by mouth, daily, for depression. The list of diagnoses in R23's medical record did not include depression. In an interview on 01/15/2026 at 11:13 AM, regarding duplicate psychotropic medication therapy, Director of Nursing (DON) B reported the facility continued R23's medications from the hospital, and she did not see a diagnosis of depression in R23's diagnoses list. Regarding the expectation for documentation pertaining to duplicate psychotropic medication therapy, DON B reported they would expect to see the diagnosis listed, but some residents had a couple of medications in the same drug class that had been in their regimen for years. During the interview, documentation pertaining to clinical rationale for duplicate antidepressant therapy was requested. On 01/15/2026 at 12:35 PM, DON B reported anxiety and depression were listed in the Nurse Practitioner's Progress Note for 12/18/25. DON B acknowledged the diagnoses were listed as part of the medication orders that were referenced within the Progress Note. R41: Review of the medical record reflected R41 admitted to the facility on [DATE], with diagnoses that included hyperglycemia (high blood sugar), dementia with anxiety; depression, anxiety disorder, dysthymic disorder, obsessive compulsive disorder and altered mental status. The Quarterly/5-day Medicare MDS, with an ARD of 10/30/25, reflected R41 scored four out of 15 (severe cognitive impairment) on the BIMS and received antipsychotic medication. On 01/14/2026 at 2:45 PM, R41 was observed walking in their room, without an assistive device. A Physician's Order, dated 12/22/25, reflected R41 was to receive 12.5 mg of Quetiapine Fumarate (Seroquel-an antipsychotic medication), by mouth, at bedtime. On 01/16/2026 at 10:24 AM, review of R41's medical record reflected their most recent laboratory blood tests were a complete blood count (CBC) and comprehensive metabolic panel (CMP) on 7/9/25. In an interview on 01/16/2026 at 11:18 AM, DON B reported the most recent laboratory blood tests she saw for R41 were the CBC and CMP for July 2025. DON B stated she could ask the facility's pharmacy if there were any recommended laboratory tests for a resident receiving Quetiapine. On 01/16/2026 at 12:13 PM, DON B reported the facility's Pharmacist stated a hemoglobin A1c (a blood test that measures the average amount of sugar in the blood over the past few months) should be monitored within six months of starting Seroquel (Quetiapine) and every six months after.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a medication error rate less than 5% when 2 of 25 medications were not administered in accordance with physician's orders for 1 (R40) of 4, resulting in a medication error rate of 8%.Findings include: Review of the medical record revealed R40 was admitted to the facility on [DATE] with a diagnosis of type 2 diabetes. Review of the Physician's Order dated 1/2/26 revealed an order for insulin aspart (rapid acting insulin) FlexPen 100 units/mL (milliliter) inject 10 units subcutaneously three times daily before meals for diabetes mellitus. Review of the Physician's Order dated 1/2/26 revealed an order for Metformin HCl 500 milligrams (mg) give 1 tablet by mouth one time a day for diabetes. During an observation on 01/15/2026 at 8:24 AM, Licensed Practical Nurse (LPN) G removed R40's insulin aspart FlexPen from the medication cart, dialed the pen to 5 units and pushed the injection button. When asked to describe the process, LPN G reported they primed the insulin pen with 5 units as they always do. LPN G did not have a needle on the insulin pen during priming. When entering R40's room, it was noted R40 had already finished breakfast and no longer had a breakfast tray in their room. LPN G administered 10 units of insulin aspart and metformin 1000 mg to R40. The insulin pen was primed incorrectly and administered after breakfast instead of before. The incorrect dose of Metformin was administered. On 01/16/2026 at 8:22 AM, an observation of the medication cart with Unit Manager (UM) H confirmed R40 only had Metformin 1000 mg available. In an interview on 01/16/2026 at 8:24 AM, Director of Nursing (DON) B reported a needle should be applied to the insulin pen before priming to ensure the insulin gets through the needle. According to the Cleveland Clinic, to prime an insulin pen, Attach a new pen needle to the insulin pen. To attach the pen needle, pull the paper tab off the pen needle, screw the new needle onto the pen, and remove the outer cap of the needle. You'll need the outer cap to remove the needle from the pen when you're done with the injection. Remove the inner cap. Prime the insulin pen. Priming means removing air bubbles from the needle. It ensures that the needle is open and working. You must prime the pen before each injection. To prime the insulin pen, turn the dosage knob to the 2 units indicator. With the pen pointing upward, push the knob all the way. At least one drop of insulin should appear. You may need to repeat this step until a drop appears. (https://my.clevelandclinic.org/health/treatments/17923-insulin-pen-injections)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide timely routine and emergency dental services for two (R4 and R6) of four reviewed for dental services. Findings include:Resident #6On 1/14/26 at 1:05 pm, R6 was observed asleep, sitting up in a wheelchair. R6 did not arouse when greeted. Review of the clinical record revealed R6 was admitted into the facility on 2/25/25 with diagnoses that included: vascular dementia, severe, with psychotic disturbance, major depressive disorder, and cerebral infarction (stroke). According to the Minimum Data Set (MDS) assessment dated [DATE], R6 scored 4/15 on the Brief Interview for Mental Status exam (which indicated severely impaired cognition). In a telephone interview on 1/14/26 at 2:36 pm, with Family Member (FM) R, it was reported that R6 had not been seen for dental services in approximately 2 years and had not had a pair of dentures in a year and a half. A review of R6's physician orders revealed three orders stating May be seen by Podiatrist, Dentist, Optometrist, Audiologist, Psychiatrist/Psychologist, dated 2/25/25, 7/25/25 and 10 /24/25. A review of the clinical record revealed a consent for dental services with 360 Care, signed by R6's responsible party on 2/27/25. Despite a consent for services and an active physician order for dental services, no record of R6 receiving dental services was found. In an interview on 1/15/26 at 2:13 PM, Social Service Director (SSD) E reported that based on his admission date and a valid consent for services, that she would have expected that R6 would have been seen by Dental services already. SSD E denied any knowledge of R6 needing dentures and was unable to provide any documentation of R6 having received dental services. A review of the facilities policy titled Dental Services updated 11/25, documented in part All residents/patients will have access to dental services as part of comprehensive care.Emergency dental care must be arranged promptly when clinically indicated. Resident #4 (R4) Review of the medical record revealed R4 was admitted to the facility 09/19/2025 with diagnoses that included osteomyelitis (inflammation or infection of the bone) of left ankle and foot, hypertension, osteomyelitis, type 2 diabetes, muscle weakness, lack of coordination, non-pressure chronic ulcer of left foot, depression, diabetic foot ulcer, and absence of left toes. Review of the most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/24/2025, revealed R4 had a Brief Interview for Mental Status (BIMS) of 15 (cognitively intact) out of 15. During observation and interview on 01/14/2026 at 02:05 p.m. R4 was observed sitting on the side of his bed. R4 explained that he had occasional dental pain but had not seen a dentist at the facility. R4 also explained that he had not been offered the option of being provided with dental services. Review of R4's medical record did not reveal a consent for dental services. R4's medical record did (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reveal a physician order, entered 09/19/2025, which stated: may be seen by Podiatrist, Dentist, Optometrist, Audiologist, Psychiatrist, and Psychologist. R4's medical record did not demonstrate any documentation that he had been provided with dental services since date of admission. In an interview on 01/15/2026 at 02:13 p.m. Social Worker (SW) E explained that residents are offered dental services upon admission. SW E explained that residents would sign a consent for ancillary services and that the consent would be placed in the residents medical record. SW E explained that the resident would then be seen during the next dental visit. SW E could not locate a consent for dental services in R4's medical record. In an interview on 01/15/2026 at 03:18 p.m. Social Worker (SW) E provided a document entitled Attending Physician Request for Services/Consultation was signed on 1/07/2026. The dental section of the document revealed a x in the box entitled mouth pain. SW E confirmed that this document was a request for service but was not a consent to be provided dental services. SW E explained that dental services had not been provided for R4's dental pain, as to date.

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure a Binding Arbitration Agreement was explained to the resident in a form and manner they understood for one (R23) of three reviewed.Findings include:Review of the medical record revealed R23 was admitted to the facility on [DATE] with diagnoses that included anxiety and depression. The Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/22/25 revealed R23 scored 13 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). R23 was their own decision maker. R23 signed the Arbitration Agreement on 12/19/25 and Director of Marketing and Admissions (DOMA) F signed as the authorized facility representative. On 01/16/2026 at 9:26 AM, R23 was observed sitting in a wheelchair in their room. R23 reported they did not recall discussing or signing an Arbitration Agreement. When explained that the Arbitration Agreement included giving up their right to litigation in a court proceeding and using the arbitration process instead, R23 reported they would not have signed that. In an interview on 01/16/2026 at 9:29 AM, DOMA F reported the Arbitration Agreement was part of the main admission agreement. When asked how arbitration was explained, DOMA F reported they explain to the resident/representative that if they were ever unhappy with anything and can't come to an agreement with the facility, then a third party was invited in. DOMA F reported they also explain the agreement is voluntary. DOMA F reported they do not explain anything about giving up the right to litigation in a court proceeding. In an interview on 01/16/2026 at 10:32 AM, Nursing Home Administrator (NHA) A reported the Arbitration Agreement was optional. When asked if it was expected for staff to explain that the agreement waives their right to a court proceeding, NHA A reported they believed it was written in the agreement. NHA A reported the Arbitration Agreement was more of a legal thing and they would not expect a nursing home employee to understand all of it.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure staff utilized appropriate personal protective equipment (PPE) for two residents (R6 and R31) of two reviewed for Transmission-Based Precautions.Findings include: R6:Review of the medical record revealed R6 was admitted into the facility on 2/25/25 with diagnoses that included: vascular dementia, severe, with psychotic disturbance, major depressive disorder, and cerebral infarction (stroke). According to the Minimum Data Set (MDS) assessment dated [DATE], R6 scored 4/15 on the Brief Interview for Mental Status exam (which indicated severely impaired cognition). A review of R6's progress notes revealed, on 1/8/26 Resident tested positive for covid today. On 1/14/26 at approximately 12pm, a droplet precaution sign was observed on the exterior of R6's room door. Social services director (SSD) E was observed entering R6's room with only a surgical mask on and without performing any hand hygiene. In an interview on 1/16/26 at 2:37 pm, SSD E reported being aware of the droplet precautions in place for R6 and that she should have slowed down and read it (the precautions signage on the door). R31: Review of the medical record reflected R31 admitted to the facility on [DATE], with diagnoses that included chronic obstructive pulmonary disease (COPD). The Annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/17/25, reflected R31 scored 12 out of 15 (moderate cognitive impairment) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). According to the medical record, R31 returned from the hospital on 1/13/26 and was positive for COVID-19. On 01/14/2026 at 1:15 PM, a droplet precaution sign was observed on the exterior of R31's room door, which reflected everyone must clean their hands before entering and when leaving the room and make sure their eyes, nose and mouth were fully covered before room entry. Housekeeper D was observed in R31's room, wearing a gown, gloves, surgical mask and face shield. When asked if they knew why the droplet precaution sign was on R31's room door, Housekeeper D reported R31 had COVID-19. When asked what type of mask they were supposed to wear in R31's room, Housekeeper D stated they believed they were to wear an N95 mask. Housekeeper D acknowledged they were not wearing an N95 mask and could not state why. In an interview on 01/16/2026 at 2:29 PM, Director of Nursing (DON) B reported the expectation was to wear a gown, gloves, N95 mask and face shield for contact with COVID-19 positive residents.