STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235057	A. Building B. Wing	10/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Majestic Care of Livonia	28550 Five Mile Rd Livonia, MI 48154

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32220 This citation pertains to Intake MI00147513. Based on observation, interview, and record review, the facility failed to ensure a resident with a known pressure wound was repositioned timely for one resident (R704) of six reviewed for skin care management. Findings include: On 10/16/24 at 10:52 AM, wound care for R704 was observed with Licensed Practical Nurse (LPN) A and Certified Nurse Assistant (CNA) B. A pillow was removed from the side of R704 and placed at the top of the bed near R704's head. R704 was observed to have an open sacral pressure sore. The wound had a ruby colored base and drainage was noted on the dressing removed by LPN A. R704 was rolled side to side by the two staff during the care of the wound. Upon completion of the wound care the brief was changed and R704 was returned to a supine position on their backside around 11:15 AM. The head of the bed was raised to around twenty or thirty degrees and the pillow at the head was placed into R704's powered wheelchair. CNA B was asked about the ability of R704 to reposition themselves and CNA B reported R704 required assistance to reposition in bed and confirmed R704's position. On 10/16/24 at 11:39 AM and 12:22 PM, R704 was observed to be on their back in bed and their positioned appeared unchanged. A pillow was not observed at the sides of R704 and the pillow remained in the seat of the wheelchair. At 1:10 PM, 2:11 PM, and 2:40 PM, R704 was observed to be on their backside in bed as before. The head of the bed was up higher around 30-45 degrees. A review of the active care plan has actual impaired skin integrity and at risk for additional breakdown documented assist with bed mobility and turn and reposition routinely . The care plan further documented R704 was an extensive two person assist for bed mobility. On 10/16/24 at 2:55 PM, R704 was observed with CNA B. CNA B was asked about placement of a pillow for positioning R704 off their sacral wound and revealed no device or pillow at the sides of R704. CNA B acknowledged the supine position of R704. R704 reported that the wound hurts all the time. On 10:16/24 at 2:58 PM, Nurse Unit Manger E acknowledged the concern for repositioning and indicated they would follow up. On 10/16/24 at 3:45 PM, the identified concern for repositioning of R704 was reviewed with the Director of Nursing (DON). The DON reported it was their expectation R704 be repositioned and acknowledged it should be every two hours. (continued on next page)

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

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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 - Minimal harm or potential for actual harm Residents Affected - Few	A review of the record for R704 revealed R704 was admitted into the facility 11/20/21 with a readmission on 08/04/22. Diagnoses included Paraplegia (paralysis of lower extremities) and Heart Failure. The Minimum Data Set (MDS) assessment dated [DATE] documented intact cognition, a stage three pressure ulcer (non intact skin into first two layers of skin and fatty tissue) and the need for substantial/maximal assistance to roll left and right. A wound care specialist note dated 10/10/24 documented, .Wound #1 Location: sacral Pressure injury - stage 3. Measurement- length 2 cm (centimeters) x width 2 cm depth 1.5 cm, tunneling @ (at) 5 o'clock 0.5 cm. Drainage- heavy sero-sanguinous. Wound bed- Attached / granulation 100%/ beefy Red. Status: stable .continue turning and reposition program, using pillows or turning devices/ pillow boots for off-loading . A review of the facility policy titled, Wound Prevention and Management dated 01/02/24 revealed, Policy: This facility is committed to the prevention of avoidable pressure injuries, unless clinically unavoidable, and to provide treatment and services to heal the pressure ulcer/injury, prevent infection and the development of additional pressure ulcers/injuries . c. Evidence-based interventions for prevention will be implemented for all residents who are assessed at risk or who have a pressure injury present. Basic or routine care interventions could include, but are not limited to: i. Redistribute pressure (such as repositioning, protecting and/or offloading heels, etc.) .