

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235057	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/05/2025
NAME OF PROVIDER OR SUPPLIER Majestic Care of Livonia		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46956</p> <p>This citation pertains to Intake M100149283.</p> <p>Based on observation, interview, and record review, the facility failed to complete care plan revisions for one (R702) of three residents reviewed for care plans. Findings include:</p> <p>Review of complaint called into the State Agency (SA) revealed the facility reported an incident of brief inappropriate contact between R702 and R703 on 12/20/24 during which the interaction was reportedly directly witnessed by staff and staff were able to immediately redirect the residents without difficulty.</p> <p>Review of the facility record for R702 revealed an admitted [DATE] with diagnoses including Dementia and Disorientation. The Brief Interview for Mental Status (BIMS) assessment dated [DATE] was scored 7/15 indicating severe cognitive impairment.</p> <p>R702's Care Plan revealed the addition of a Focus area addressing the resident's behavior that was initiated on 12/23/24 and states [R702] relationship-seeks and expresses the desire to find [their] dreamgirl or a wife. Can make sexually inappropriate comments to female peers.</p> <p>On 02/04/25 at 2:05 PM, R702 was observed in the activities room working on a puzzle. R702 was interviewed and when asked if they recalled the situation involving R703 and stated Yes however, their recall or understanding of the situation was not clear and were not able to discuss any additional specifics.</p> <p>On 02/04/25 at 2:35 PM, Physical Therapist (PT) B who was identified as the witness to the 12/20/24 incident involving R702, reported they did recall the incident. PT B stated they intervened immediately when R702 made contact with R703. PT B reported their observation has been that R702's attempts to interact with female residents has declined since the incident.</p> <p>On 02/04/25 at 3:15 PM, additional review of R702's facility record revealed progress notes dated 01/01/25, 01/05/25 and 01/20/25 describing incidents of physical contact between R702 and R703. A nursing progress note dated 12/24/24 documented [R702] needs to be checked and monitored every 30 min.</p> <p>(continued on next page)</p>

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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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 02/05/25 at 9:30 AM, additional review of R702's Care Plan Focus area related to inappropriate contact with females revealed seven of eight Intervention items were put in place following the 12/20/24 incident. No intervention was added following the 01/01/25 incident and no interventions had been added following the 01/20/25 incident.</p> <p>On 02/05/25 at 11:50 AM, R703 was interviewed and asked about the reported incidents involving R702. The resident responded verbally in a pleasant manner but was not able to articulate a coherent response.</p> <p>On 02/05/25 at 12:10 PM, R703's family member/guardian A was interviewed via phone call. Family member A reported they were involved closely with the facility staff and they visit almost daily. They indicated they had been notified by the facility when incidents have occurred.</p> <p>On 02/05/25 at 12:22 PM, Licensed Practical Nurse (LPN) C who authored the 01/05/25 and 01/20/25 progress notes involving R702 was interviewed via phone call and asked their understanding of any supervision requirements for R702. LPN C stated he had an every 30 minute check for a couple weeks but that's been lifted.</p> <p>On 02/05/25 at approximately 1:00 PM, the facility Administrator (NHA) and the facility Director of Nursing (DON) were interviewed and made aware of the concern that although three incidents involving R702 had occurred since the facility reported 12/20/24 incident, only one Care Plan interventions had been added. The NHA acknowledged there were interventions put into place which were improving the situation, but have not been entered onto the Care Plan and expects staff to update care plans with each intervention.</p> <p>Review of the facility policy Comprehensive Care Plan dated 11/01/24 revealed the entry E. The Comprehensive Care Plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS (Minimum Data Set) assessment. The provided policy did not specifically address revision of the Care Plan in response to a significant event or incident that suggests the current Care Plan is not fully effective.</p>		