

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 05/28/2025
NAME OF PROVIDER OR SUPPLIER Majestic Care of Livonia		STREET ADDRESS, CITY, STATE, ZIP CODE 28550 Five Mile Road 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 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake MI00152612.</p> <p>Based on observation, interview, and record review, the facility failed to prevent the misappropriation of resident prescribed controlled substance (narcotic) pain medication for one (R901) of three residents reviewed for misappropriation. Findings include:</p> <p>A review of a Facility Reported Incident (FRI) noted an allegation, It was reported that there was a drug diversion.</p> <p>On 5/28/25 at 10:21 AM, R901 was observed lying in bed. R901 was asked about the care at the facility and had no complainants. R901 was then asked if they recalled the incident when their medication was reported missing. R901 stated, Yes. R901 was asked during that time if they went without their pain being treated. R901 stated, I don't remember.</p> <p>A reveiw of R901's medical record revealed, R901 was admitted to the facility on [DATE] with a diagnoses of Metabolic Encephalopathy and End Stage Renal Disease. A review of R901's Minimum Data Set (MDS) assessment noted, R901 with an intact cognition and the requirement of staff to assist with activities of daily living.</p> <p>On 5/28/25 at 10:30 AM, the Director of Nursing (DON) was asked about the incident and explained, it was discovered after a request was made to the pharmacy to refill the medication. The pharmacy reported it was too early for a refill and R901 should not be out of the medication. The DON explained they started an investigation and they discovered one of R901's narcotic medication sleeves were missing along with the count sheet and the staff involded were License Practical Nurse (LPN) A and LPN B.</p> <p>On 5/28/25 at 10:54 AM, LPN B called, a voicemail was unable to be left due to the mail box being full.</p> <p>On 5/28/25 at 10:57 AM, LPN A called, a voicemail was unable to be left due to the mail box being full.</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 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/28/25 at 12:45 PM, the DON confirmed the date the incident occurred was March 13(2025) from the midnight shift into the day shift. LPN A (day shift) was assigned to the unit C medication cart, they completed the shift change/count. LPN B (day shift) was assigned to unit D medication cart, but was running late to work. LPN A then assisted a midnight nurse assigned to unit D medication cart for the shift change/count, collected the keys for that cart and passed on the keys to LPN B when they arrived.</p> <p>A review of the facility's investigation revealed, Incident Summary On 4/13/2025 a medication request was submitted to refill [R901's] norco 10/325 pain medication. A pharmacy alert was triggered for refill-too-soon, prompting further inquiry by the [DON]. Upon review the narcotic count sheet for medication was noted to have a hand-written identification label instead of the pharmacy-provided label sticker. The identification sticker indicated 1 sleeve of 30 norco 10/325. This information as cross referenced with pharmacy documentation which indicated the count of 2 sleeves of 30 pills delivered by pharmacy. This triggered an immediate investigation . findings have identified that it does appear 2 sleeves of 30 pills were delivered to the facility and that subsequently only one sleeve was identified on the narc count sheet. By referencing hand writing, a chain of custody for the medication upon delivery to the facility and a review of schedule, it was identified that the discrepancy between the 2 sleeves of medications being delivered and only 1 sleeve being accounted for on the narcotic count occurred while the medications were under the care and control of [LPN A] . [R901] received pain medication from the facility's emergency backup supply . Other resident narcotics were audited and no abnormalities or discrepancies were identified . Findings and Outcomes; The available evidence indicates a strong potential that [LPN A] is responsible for the missing medication sleeve containing 30 norco 10/325 pills, and no evidence was uncovered that supports alternative theories .</p> <p>A review of the facility's policy titled, Abuse, Mistreatment, Neglect, Exploitation and Misappropriation. dated 9/06/2024, 1. Purpose: To investigate all alleged violations involving abuse, neglect, misappropriation of resident/patient property, exploitation or mistreatment, including Injuries of Unknown Source, in accordance with this policy and to ensure that all individuals who report such incidents and allegations are free from retaliation or reprisal for reporting the incident. Resident/patients have the right to be free from abuse, neglect, exploitation, and misappropriation of resident/patient property. This includes, but is not limited to, freedom from corporal punishment, involuntary seclusion and physical or chemical restraint that is not required to treat the resident's/patient's medical symptoms of Resident/Patient Property is the deliberate misplacement, exploitation, or wrongful temporary or permanent use of a resident's/patient's belongings or money without the resident's/patient's consent .</p> <p>A review of the facility's policy titled Controlled Medication Storage dated 5/20/22, revealed, Policy: To ensure the facility provides separately locked, permanently affixed compartments for storage of controlled drugs Schedule II-V and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Medication(s) included in the Drug Enforcement Administration (DEA) classification as controlled substance are subject to special handling, storage, disposal, and record keeping in accordance with Federal, State and other applicable laws and regulations . 4. Store all controlled substances and other medication(s) subject to abuse in a locked/secure cabinet or drawer, separate from all other medication(s). Schedule II-V medication are maintained within separately locked, permanently affixed compartment . 8. Any discrepancy in controlled medication counts is reported to DON/designee immediately. The DON/designee investigates and makes every reasonable effort to reconcile all reported discrepancies .</p>		