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	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Majestic Care of Livonia	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)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake 2617467Based on observation, interview, and record review, the facility failed to honor a resident's right to refuse a shower and treated the resident with respect for one resident (R25) of two residents reviewed for the right to a dignified existence. Findings include:A review of a complaint called into the State Agency revealed on 9/5/25 R25, after refusing, was allegedly forced to shower from a Certified Nursing Assistant (CNA) K.On 2/25/26 at 10:00 AM, R25 was observed in their room watching television. R25 was able to respond to basic questions by nodding their head and saying yes although there were notable speech difficulties as evident by mumbled speech related to diagnosis of Down Syndrome. R25 was interviewed about alleged shower incident on 9/5/25. When asked about taking showers, R25 shook their head yes and mumbled some unintelligible words, unable to give specific information about incident and what happened. A review of the Electronic Medical Record (EMR) revealed R25 was admitted into the facility on [DATE] with diagnoses including Down Syndrome; Major Depressive Disorder; and Moderate Intellectual Disabilities. Further review revealed Minimum Data Set (MDS) assessment dated [DATE] revealed R25 had a Brief Interview for Mental Status (BIMS) score of 3 out of 15 indicating a severely impaired cognition. Further review of R25's medical record revealed a care plan for behaviors with a focus that revealed stated (name of R25) exhibits behavior symptoms of: . History of refusing showers/activities of daily living and care.On 2/26/25 at 12:15 PM, two attempts were made to contact staff who had witnessed the alleged incident via phone with voice messages left. Staff members (CNA's J and K) did not return the call prior to end of survey.A review of the facility investigation report dated 9/5/25, documented interviews with staff involved in incident which included an interview with CNA J who was assigned R25 that day. Per interview CNA J asked another CNA K to assist with giving R25 their shower. CNA J observed R25 state I don't want to take a shower; I don't want to take a shower. CNA K responded to R25, you're going to take this shower. CNA K then asked CNA J to get R25 clothes from the bedroom. CNA J returned to the shower room and observed R25 wearing wet clothes and soap was on their face.The investigation report revealed, CNA J asked for assistance giving R25 a shower. CNA K stated they agreed to help R25 and upon walking into the shower room the shower was on (running) and shooting water out wetting R25 before the CNA could grab the shower head. CNAK stated CNA J stepped out to go get R25 clothes. R25 did not wait for staff to assist and walked to their room with wet clothes on. The investigation report revealed an interview with Licensed Practical Nurse (LPN) L confirming the following: CNA J stated CNA K had started wetting the resident with their clothes still on. LPN L observed R25 in shower room with clothes still on, soiled shirt on the floor. The resident was at the sink with their pants down. LPN L reported the incident to the Nursing Home Administrator (NHA).On 2/26/25 at 2:10 PM, CNA B was asked about the incident on 9/5/25 regarding R25's shower. CNA B stated they were assisting a resident in the room across from the shower room when they heard R25 telling another CNA, No shower (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	repeatedly. CNA B also stated they heard a CNA tell R25, you are going to take a shower.On 02/26/2026 at 2:40 PM, in an interview with the Nursing Home Administrator (NHA) regarding the incident on 9/5/25. The NHA stated the nursing assistant and resident were very familiar with each other and had no other concerns with care issues. When asked about resident right to refuse a shower, the NHA stated that all residents have the right to refuse showers or care and be respected.A review of the facility's Resident Rights policy revealed the following: Resident rights. The resident has the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility.Self-determination. The resident has the right to, and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to a. The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part B. The resident has the right to make choices about aspects of his or her life in the facility that are significant to the resident.

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intakes 2728688 and 2728168. Based on observation, interview, and record review, the facility failed to ensure timely care was provided to meet the needs for five residents (R2, R36, R63, R75, R98) of 19 whose care was reviewed. Findings include: R2 On 02/24/2026 at 10:23 AM, R2 and a family member via the phone, reported on the afternoon and night shifts there are times their call light was on more than thirty minutes without being answered. R2 and the family member noted there is a camera in the room for recording. R2 played a video of empty hallways in the late afternoon and nighttime hours. When the call light is not answered R2 may have to get up out of bed on their own. R2 was observed to be dressed and seated in a powered wheelchair and readily moved about the room and in and out of the room. A review of the record for R2 revealed R2 was admitted into the facility on [DATE]. Diagnoses included Right Sided Paralysis, Stroke and Heart Disease. The active care plan documented, .requires assistance with activities of daily living . exhibits behaviors of non-compliance . The Minimum Data Set (MDS) assessment dated [DATE] documented intact cognition with a 14/15 Brief Interview for Mental Status (BIMS) score and the need partial to moderate assistance for sit to standing, and setup to go from lying to sitting position . R36 On 02/24/2026 at 11:29 AM, R36 was observed to be up in a powered wheelchair, dressed and with their feet in PRAFO (pressure relief ankle foot orthosis) style heel boots. R36 reported their legs were paralyzed but they were independent once up in their powered wheelchair. R36 reported they had not been receiving timely wound care and the dressings on their feet had not been changed in two weeks. R36 also noted concerns about the care received from certain certified nursing assistants (CNA) and had asked not to be cared for by two of them. R36 went on to say they felt the facility did not replace workers that had called off for their assigned shift and those left displayed poor attitude when working short. R36 reported they were incontinent of urine due to the paralysis and required assistance to change their brief. On 02/25/2026 at 11:56 AM, R36 was overheard to ask a staff member Who is my aide? On 02/25/26 at 1:26 PM, R36 was seated in their powered wheelchair in the threshold of the doorway to their room. R36 was heard to say to no particular staff that they were waiting for assistance. Three staff were observed in the area of which one had walked by R36 and not acknowledged R36. At 1:40 PM, R36 rolled out of doorway and up to the nurse's station to request assistance. On 02/25/26 at 1:44 PM, a resident had a meal tray from lunch on the seat of their rolling four wheeled walker and remarked they were taking to the kitchen as they were tired of looking at it and having to do the staff's job. R36 had returned to the threshold of their room and activated the call light. On 02/25/26 at 1:50 PM, station manager C overheard R36 exclaim they had been waiting thirty minutes for assistance and walked down from the nurse station and R36 indicated they needed to be changed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/25/2026 at 4:36 PM, Certified Nurse Assistant (CNA) F reported call-in's have been a problem, but the staff work together as needed. A review of the record for R36 revealed R36 was admitted into the facility on [DATE]. Diagnoses included Paraplegia and Schizophrenia. The active care plan documented, .requires assistance with activities of daily living .has episodes of incontinence of bladder, bowels; exhibits behavior symptoms of making false accusations on staff of not providing ADL (activities of daily living) Care . exhibits behavior symptoms of Acting out, becoming upset with staff for not stopping care for other residents, wants immediate attention . On 02/26/2026 at 12:36 PM, the Director of Nursing (DON) was asked about the plan of care for R36 and reported they had received alerts about refused showers and was aware of the R36s needs for assistance with care. The DON also noted R36 has come up in behavior meetings as not always truthful in regard to requests for care. The DON indicated R75 picks and chooses the times they want to get up and go to the dining room or bathroom and is able to use the call light to make their needs known. R75 On 02/24/2026 at 9:31 AM, R75 was observed to be on their back in bed, with the head of the bed up around 45-60 degrees and dressed in a hospital style gown. The tray table was over the bed. R75 answered in the affirmative to any questions asked. R75 wore a hand splint of the right hand and held a stuffed carrot in the left hand. The hands both had contractures. A low air loss mattress was in place. At 1:53 PM, lunch service had been completed and R75 continued in the same position as before except with the head back on the pillow with the face more toward the ceiling. At 2:38 PM, R75's positioned was unchanged; At 2:55 and 4:33 PM, R75 remained on their back in bed with the heels on the bed. The head of the bed was around 20-30 degrees. No devices were observed at the sides or under the legs. On 02/25/2026 at 7:25 AM, R75 was on their back and buttocks in bed, with the head of the bed up around 20-30 degrees and dressed in a t-shirt wearing a plaid bib. The stuffed carrot in the left hand and splint on the right hand. At 10:50 AM, and 12:46 PM, R75 was observed to be dressed and on their back in a recliner in the dining room asleep. The head was up around 30-45 degrees and the carrot in the left hand and a splint on the right hand. R75 feet looked to have foot drop and the heels rested on the footrest. No pillows or similar devices at the sides. R75 awakened to their name and slowly and slightly nodded yes to questions. At 1:25 PM, 3:45 PM, and 4:03 PM, R75 observed to be in bed. R75 was on their back in bed with a wedge on the right side but not on the wedge so as to offload pressure from the back and buttocks areas. The feet looked to be elevated on a device or pillow. On 02/26/2026 at 7:25 AM, R75 was observed to be on their back in bed and dressed in a hospital style gown. A wedge device had been placed on the right side of the bed but R75 was not on it in order to offload pressure from the back and buttocks. A pillow was at the foot of the bed to left of the R75's feet which appeared to rest on the bed surface. On 02/26/2026 at 12:09 PM, R75 was observed to be on their back in a recliner in dining room faced toward the TV. At 1:09 PM, 3:30 PM, and 4:00 PM, R75 was observed to be laying on their back in a medical (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/24/26 at 2:33 PM, R63 light was observed to be activated with the light on over the door. R63 was asked how long their light had been activated. R63 reported about five minutes. At 2:36 PM, staff was observed to ask R63 what they needed, R63 stated, I need my brief changed. At 2:38 PM, staff was observed to go to the nurse's station and then returned to R63's room and turned off the call light. R63 was overheard requesting to keep the light on, due to the staff not coming back once the light has been turned off. On 2/24/26 at 2:40 PM, R63 explained that staff often turn off the light without providing the need. A review of R63's medical record revealed, R63 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis of Displaced Bimalleolar (ankle) Fracture of Right lower leg. Further review noted R63 to be assessed as cognitively intact and required assistance from staff to complete activities of daily living. A review of the facility policy titled Comprehensive Care Plans revised 05/16/24 revealed. To develop and implement a comprehensive person-centered care plan for each resident/patient, consistent with resident/patient rights, that includes measurable objectives and timeframes to meet a resident's/patient's medical, nursing, and mental and psychosocial needs that are identified in the resident's/patient's comprehensive assessment. A review of the facility policy titled, Call Lights dated 01/02/24 revealed, .All staff members are responsible for responding. If the staff member cannot provide what the resident desires, the appropriate personnel will be notified to provide requested services in a timely manner .