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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation and interview, the facility failed to ensure appropriate cross-connection prevention resulting in the potential for contamination of ice in the ice machine, affecting all residents. Findings include:On 2/24/26 at 2:30 PM Observed Station 2 pantry ice machine drain line submerged into the pump reservoir without the required air gap to protect the ice.When interviewed during this observation about the required air gap to protect the ice, the Maintenance Director (MD) M said this would be put on the maintenance task list and corrected.

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	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 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), (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to timely submit an MDS (Minimum Data Set) resident assessment for one resident (R77) of one reviewed for resident assessment. Findings include:A review of the surveys facility's task noted, R77's Minimum Data Set (MDS) assessment was triggered for being 120 days overdue. On [DATE] at 2:41 PM, the MDS Coordinator, Licensed Practical Nurse I (LPN I) was asked about R77's overdue assessment and reported, R77 died at the facility and would look to see why it's overdue.A review of R77's medical record progress note revealed, [DATE] 11:19 (PM) General Progress Note Text: @ (at) 9:50am Aide went to give care and notice COC [change of condition) of resident and nurse was notified . @10:31am paramedic called hospital (hospital Physician) pronounced time of death @10:31am .Further review of R77's medical record revealed, R77 was admitted to the facility on [DATE] and readmitted on [DATE], then discharged /expired on [DATE]. R77's primary diagnosis was noted as Acute and Chronic respiratory failure with hypoxia. A review of R77's list of MDS assessments did not reveal a death in facility assessment and was noted in red print overdue assessment above the list of assessments. On [DATE] at 2:47 PM, it was later confirmed by LPN I that R77's death in the facility assessment was not encoded and transmitted to the CMS (Centers for Medicare & Medicaid Services) database until that day ([DATE]), which exceeded the 14-day requirement. The MDS Nurse was asked for a policy regarding the assessment timeline and explained the facility uses the MDS/RAI (Resident Assessment Instrument). A review of CMS's RAI Version 3.0 Manual CH (chapter) 5: Submission and Correction of the MDS Assessments noted, . Tracking Information Transmission: For Entry and Death in Facility tracking records, information must be transmitted within 14 days of the Event Date .

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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. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 1:09 PM, 3:30 PM, and 4:00 PM, R75 was observed to be laying on their back in a medical recliner. No positioning devices were observed in the recliner. R75 had a growth of beard around a quarter inch long. The recliner was faced toward the TV. R75 was not seen to have been returned to their room and was in the same location. A review of the record for R75 revealed the resident was admitted into the facility on [DATE]. Diagnoses included Quadriplegia, Left and Right-Hand Contractures, and Dementia. The active care plan documents, .enjoys a variety of activities . requires assistance with ADLs . has difficulty with communication . A review of the Minimum Data Set (MDS) assessment dated [DATE] revealed severely impaired cognition and dependence on staff for all activities of daily living including rolling left to right in bed, eating, transfers and personal hygiene. R98 On 02/24/2026 at 10:07 AM, R98 reported they needed assistance with getting to the restroom with their walker. R98 reported they used to be able to see figures, but they were now blind and still adapting to their new room. R98 reported they had been moved to their current room due to a plumbing issue. R98 reported their room had its plus and minuses and at moment was waiting for help to get dressed and go to the dining room as they try to be there around 11 AM before lunch. R98 was observed to have lunch in their room. At 4:30 PM, R98 had not been observed to make it into the dining room or out of their room. On 02/25/26 at 1:20 PM, R98 was observed to be seated a table with R14. R98 was dressed and had shoes on. R98 reported they had been sitting there since before lunch and wished to return to their room. R98 asked if their aide was around and could walk them back to their room. Observation of the nurse station and halls revealed no staff were present. At 1:37 PM, R98 remained at the table in the dining room and no staff appeared in the halls or at the nurse station. At 4:06 PM, R98 was observed to be in bed and reported that two ladies from restorative (who walked R98 a few times a week) had helped them to walk back to their room. R98 put their call light on as they needed to go to the bathroom. At 4:12 PM, the Director of Nursing (DON) was walking by entered and answered the call light and assisted R89 to the restroom. No other staff appeared to answer the call light. On 02/26/2026 at 7:59 AM, R98 was observed to be in bed, laying on their right side in a hospital style gown. On 02/26/2026 at 11:49 AM, R98 was in dressed in a hospital style gown. At 12:12 PM, R98 was laying on their right side as noted before breakfast. R98 also reported they had asked the nighttime staff for a t-shirt to wear under their gown and had not received one. R98 did not have a t-shirt on under their hospital style gown. A review of the record for R98 revealed R98 was admitted into the facility on [DATE]. Diagnoses included Legal Blindness, Adjustment Disorder, and Falls. The active care plan documented, .requires assistance with activities of daily living . has vision impairments . offer assistance to activity functions . behavior symptoms of delusions of kitchen staff making food nasty/uneatable . The care plan noted R98 required minimal assistance for most activities of daily living and setup for eating. R63 On 2/24/26 at 3:50 PM, R63 reported that at times the staff can take over an hour to answer call (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	lights. 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 .

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure timely completion and follow up of Medication Regimen Reviews (MRRs) for two residents (R9 and R13) of five reviewed for Medication Regimen Reviews. Findings include:R9A review of R9's medical record revealed they were admitted into the facility on [DATE] with diagnoses which included Alzheimer's Disease, Unspecified Psychosis, and Generalized Anxiety. Further review revealed the resident had a severe cognitive impairment and was independent for Activities of Daily Living. Further review of R9's medical record revealed the following MRR recommendation on 1/14/26, Appropriate diagnosis for indication. Relevant Meds: Risperidone for Bipolar Disorder. Resident does not have listed diagnosis to support the use of these medications for bipolar disorder. Please review chart and add appropriate diagnosis in [electronic medical record] to support therapy. If no appropriate diagnosis exists, recommend discontinuing the medication. On 2/27/26, a review of R9's physician orders revealed the following active order, Risperdal Oral Tablet 1 MG (milligram, Risperidone) Give 1 mg by mouth two times a day for bipolar disorder. Further review of R9's diagnoses did not reveal a diagnosis of bipolar disorder. R13A review of R13's medical record revealed they were admitted into the facility on [DATE] with diagnoses which included Dementia, Depression and Paranoid Schizophrenia. Further review revealed they were moderately cognitively impaired and required moderate assistance for Activities of Daily Living. Further review revealed MRRs with recommendations completed on the following dates: 1/12/26, 12/10/25, 11/12/25, 10/10/25, 8/11/25, 6/12/25, 5/15/25, 4/17/25 and 1/8/26. These recommendations were requested from the facility on 2/27/26 at 9:24 AM. A review of the MRRs provided revealed the following dates were missing and not received by end of survey:12/10/25, 11/12/25, 8/11/25, 6/12/25 and 1/8/25. A review of the facility's Pharmacy Services did not address the timely completion and follow up of Medication Regimen Reviews (MRRs).

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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide food to meet the preferences of two residents (R2, R98) of three reviewed for food palatability. Findings include: R98On 02/24/2026 at 10:07 AM, R98 reported the food was so so and the menu not really good. R98 reported sometime the cereal is hard and the oatmeal did not like regular oatmeal. R98 reported they had complained about the food and feels the food got worse. R98 further reported the alternate was not consistent they did not really like pork or beef. R98 was observed to have lunch in their room. On 02/26/2026 at 9:25 AM, R98 reported the oatmeal was grainy and not sweet enough. No butter was present on the tray. R98 had been served a croissant breakfast sandwich and reported it was hard. The croissant was hard to the touch on both halves and clanked on the plate when tapped. On 02/26/2026 at 10:02 AM, the Dietary Manager reported the eggs provided for the breakfast were liquid eggs formed into squares to accommodate the use for sandwiches and cooked in a steamer. The sausage was precooked food service item which is then heated in an oven. Sausage links were normally served but patties were also served with sandwiches. Oatmeal is cooked every day and had recently been changed out for a different brand. The Dietary Manager further reported the oatmeal is served with brown sugar, regular sugar and butter per the resident preference. R98 was known to have reported concerns with the oatmeal and was given cold cereal and regular sugar for the oatmeal. A review of the record for R98 revealed R98 was admitted into the facility on [DATE]. Diagnoses included Legal Blindness, Adjustment Disorder, and Falls. The active care plan documented, .requires assistance with activities of daily living . has vision impairments . offer assistance to activity functions . behavior symptoms of delusions of kitchen staff making food nasty/uneatable . The care plan noted R98 required minimal assistance for most activities of daily living and setup for eating.R2On 02/24/2026 at 10:23 AM, R2 reported the food was generally nasty and was rarely served something they like to eat. R2 reported they felt they were not being heard. R2 had multiple boxes of dry cereal and additional items in a refrigerator. On 02/26/2026 at 9:14 AM, a test tray was reviewed for breakfast: The breakfast sandwich was made with two slices of toast, a square of egg with cheese and a circular sausage patty. The toast was not crunchy and more sponge like. It was soft and difficult to cut with a knife and fork. The sausage patty was dry and difficult to cut and pulled apart. 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 . A review of the policy titled, Food Production dated 01/01/26 revealed, All food production within the facility shall follow standardized recipes, portion control guidelines, safe food handling practices, and approved menus developed by or in consultation with a registered dietitian. Food shall be prepared in a manner that maintains nutritional value, palatability, and visual appeal while meeting therapeutic and texture-modified diet requirements.

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on interview and record review, the facility failed to ensure the resident's record accurately reflected the resident's care for one resident (R8), of one reviewed. Findings include: A review of R8's medical record revealed the male resident was admitted into the facility on 3/8/23 with diagnoses of Unspecified Intercranial Injury, Anemia, and Hypertension. Further review revealed a severe cognitive impairment, and total dependence for Activities of Daily Living. Further review of R8's medical record revealed the following progress note:9/18/2025 01:52 MD (medical doctor)/NP (nurse practitioner)/PA (physician assistant) Progress Note .Patient is seen and examined at the bedside, pleasant and calm, reports no discomfort or pain, and denies any unusual headaches, dizziness, chest pain, or SOB (shortness of breath). Patient is tracheostomy-dependent. Patient has a status for vaginal ultrasound since there is a possible endometrial CA (a type of cancer that begins as growth of cells in the uterus) .On 2/26/25 at 3:00 PM, the Director of Nursing (DON) was asked about the male resident having a progress note in their medical record noting to have female anatomy. She explained the physician who wrote that progress note is no longer with the facility due to ongoing concerns related to issues such as these. A review of the facility's Documentation in the Medical Record policy revealed the following, .a. Documentation shall be factual, objective, and resident centered .b. Documentation shall be accurate, relevant, and complete, containing sufficient details about the resident's care and/or responses to care .