STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235132	A. Building B. Wing	05/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Majestic Care of Flushing	540 Sunnyside Dr Flushing, MI 48433

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 - Some	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** 40330 This Citation relates to Intake Number MI00143452. Based on observation, interview, and record review, the facility failed to ensure resident rights pertaining to dignified care for six residents (R3, R13, R24, R39, R55, and R72) and six Confidential Group residents (C1, C2, C3, C4, C5, and C6). This deficient practice resulted in a lack of dignified dining for R55, untimely call light answering for R3, R13, R39, and R72, six confidential group residents, and a lack of dignity related to privacy for R24. Findings include: R39 Review of R39's Minimum Data Set (MDS) assessment, dated [DATE], revealed R39 was admitted to the facility on [DATE], with diagnoses including heart failure and respiratory failure. The assessment revealed R39 required set up with eating, and was dependent for toileting, bed mobility, and transfers. The Brief Interview for Mental Status (BIMS) assessment revealed a score of ,d+[DATE], which showed R39 was cognitively intact. During an interview on [DATE] at 12:57 p.m , R39 stated the facility was short staffed, and she was left wet at times, as her call light was not answered timely or was out of reach. R39 stated, I am a check and change, and I wake up soaking wet .I can't reach my call light to put it on. The girl [unnamed nursing staff] does not come [to answer the call light] and it is often out of my reach and does not work properly . R39 conveyed this made her feel frustrated. R39 was in a bariatric hospital bed, and showed Surveyor how the call light was tightly wrapped around the enabler bar on her right side, and how she could not reach it with her right arm. Licensed Practical Nurse (LPN) F was on the hall and was asked where R39's call light should be placed. LPN F observed R39's call light wrapped out of reach around the right enabler bar, and clipped R39's call light to her hospital gown. LPN F verified R39's call light should be on her gown, in her reach, as she used her call light. Surveyor verified R39's call light was working at that time. R72 (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235132	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/22/2024
NAME OF PROVIDER OR SUPPLIER: Majestic Care of Flushing		STREET ADDRESS, CITY, STATE, ZIP CODE: 540 Sunnyside Dr Flushing, MI 48433	

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R72's MDS assessment, dated [DATE], revealed R72 was admitted to the facility on [DATE], with diagnoses including heart failure, kidney disease, and cancer, unspecified. R72 required set up with eating, maximal assistance for bed mobility, and declined transfers. The BIMS assessment revealed a score of , d+[DATE], which showed R72 was cognitively intact. During an interview on [DATE] at 1:16 p.m., R72 reported they waited two to three hours for their call light to be answered, when they need to have a bowel movement, or needed items in their room, as they had a urinary catheter. R72 conveyed this made them feel frustrated, and this was too long to wait for assistance. R 72 stated, I wish they could be quicker. R72 showed Surveyor how his legs had pitting edema, and reported this was why he was dependent upon staff, as he could not get out of bed due to the marked bilateral edema. The Director of Nursing (DON) was made aware. R13 Review of R13's MDS assessment revealed R13 was admitted to the facility on [DATE], with diagnoses including heart failure, kidney disease, and depression. The assessment revealed R13 required set up with eating, maximal assistance with bed mobility, and was dependent for transfers. The BIMS assessment revealed a score of ,d+[DATE], which showed R13 was cognitively intact. During an interview on [DATE] at approximately 2:45 p.m., R13 reported she had to wait for hours for her call light to be answered and get on or off the bedpan, reporting staff would turn off the call light at night and sometimes not return. R13 clarified she needed a mechanical lift for transfers, and she had to wait to go to bed frequently, as the lifts were not fully changed, and she felt staff should charge them regularly. R13 reported this resulted in feelings of frustration. R24 Review of R24's MDS assessment, dated [DATE], revealed R24 was admitted to the facility on [DATE], with diagnoses including heart failure, atrial fibrillation (heart rhythm disorder), seizure disorder, and manic depression (bipolar disorder). The assessment revealed R24 required set-up for eating, and moderate assistance for toileting and transfers. R24 was frequently incontinent of bladder and always incontinent of bowel. The BIMS assessment revealed a score of ,d+[DATE], which showed severe cognitive impairment. Review of R24's Care Plan, accessed [DATE], revealed R24 had severe intellectual disabilities. During an observation on [DATE] at approximately 2:45 p.m., R24 was observed with her room door open, exposed below the waist and uncovered, wearing a black T-shirt and an incontinence brief, with no privacy curtain closed, while two nursing staff were providing personal care for her roommate, behind a curtain. Two staff walked by, approximately four minutes later, and closed the outer room door. At approximately 2:50 p.m. , the two staff exited the room, and left the outer door open, and did not pull R24's privacy curtain. This left R24 exposed from the door to her room, in view of persons walking by in the hallway, with her incontinence brief showing. Approximately nine minutes later, a staff person walked by and covered R24. R24 did not resist being covered with a sheet, and said, Sheet only. R24 was observed with the sheet covering her a few more minutes and did not attempt to remove it. R24 was unable to be interviewed due to being distracted by her roommate. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on [DATE] at 10:05 a.m., R24 was observed in their bed, covered with a blanket. Surveyor observed R24 resting in her bed a few minutes from the hallway. R24 kept the blanket in place and did not attempt to remove the blanket. R3 Review of the Electronic Medical Record (EMR) revealed R3 had a BIMS score of ,d+[DATE], which showed she was cognitively intact. During an interview on [DATE] at approximately 3:40 p.m., R3 reported there were not enough staff in the facility, especially on the weekends, including this past Friday when there was only one aide on her hall for a few hours. R3 stated they waited 30 minutes frequently and 40 minutes a few times for care, which resulted in incontinence, which frustrated her. Confidential Group Residents: During the confidential group meeting to review resident council on [DATE] at approximately 1:45 p.m., the following residents reported extended call wait times: C1: It happens quite regularly. I needed a brief change and I was really wet and I said, 'I need it changed,' and I pressed the button. After an hour, they said, I will be back, and then said she waited five hours. C1 stated, I felt like a piece of crap, as I'm lying in it [urine]. C1 added there were times they wanted to get up for an activity, and there was no one to put them on the lift and transfer them. C1 reported they recently missed a birthday party activity, as there were no staff to get them up. C2: I wait an hour and a half, the weekend before last, and I was in bed, I am totally incontinent and it made me feel like a second-class citizen. C2 added, Sometimes we have one aide for 28 residents on East [hall] and they don't do anything at shift change, and they pass waters, and call lights are not being prioritized. C2 added he had heard them say they only had one aide for 40 residents on the Central Hall a few times. C3: I don't even use my call light, as they explained it was not answered. C4's Family Member (FM) stated: There is only one aide on East Hall sometimes, and I have discussed this with [The Nursing Home Administrator - NHA]. C4's FM reported, Staff shut the call light off and say they will come back later, and they don't come back at all. They forget about it, and stated, It annoys me. C4's FM stated, She [C4] is waiting too long. [C4] sat in it [urine/stool] five hours three months ago, and I was really mad. C4's FM denied them having a new skin concern or pressure injury. C5: Said they had observed the nursing staff sometimes did not charge the lifts for the residents to use, which concerned them for the other resident's safety and well-being. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	C6: I will be in the bathroom waiting a long time. Just the other day, it was afternoon. I was ready to get up and no one came. C6 added, I tried to walk, and I can't walk out alone, and said she could not fasten her pants. She added, I felt rotten, and said, The longest I have been in there was three hours, which was confirmed by their roommate. Regarding her roommate, C6 stated, I have seen her want to get up, and there is not enough staff to get her up, including for an activity she had reportedly recently missed. During an interview on [DATE] at approximately 1:00 p.m., the NHA and the Scheduler, Staff R, were asked about the resident reported extended call wait times, and if there was a system to track call wait times, such as call wait logs. The NHA confirmed there was no system in place to track call light response times and denied awareness of extended call light wait times. Staff R acknowledged there had been staffing concerns about three months prior, but said they were not aware of current concerns. Staff R reported when they were short staffed, it was due to call-ins. When asked about residents reporting one aide for 28 to 40 residents, both the NHA and Staff R denied this, and reported the CNA's were telling the residents this, but it was not accurate. Review of the policy, Call Lights: Accessibility and Timely Response, copyright 2023, The Compliance Store, revealed, The purpose of this policy is to assure the facility is adequately equipped with a call light at each residents' bedside, toilet, and bathing facility to allow residents to call for assistance. Call lights will directly relay to a staff member or centralized location to ensure appropriate response. Policy explanation and Compliance Guidelines: 1. All staff will be educated on the proper use of the resident call system, including how the system works and ensuring resident access to the call light. 2. All residents will be educated on how to call for help by using the resident call system .5. Staff will ensure the call light is within reach of resident and secured, as needed .8. Staff will report problems with a call light or call light system immediately to the supervisor and/or maintenance director and will provide immediate or alternative solutions until the problem will be remedied .10. All staff members who see or hear and activated call light are responsible for responding .11 .f. If assistance is needed with a procedure, summon help by using the call light. Stay with the resident until help arrives. 34568 Resident #55 (R55) On [DATE] at 11:20 a.m. R55 was observed sitting in his wheelchair in the hallway. R55 repeatedly asked multiple staff members to be changed prior to the lunch meal. The Assistant Director of Nursing (ADON) A noticed R55 and he once again requested to be changed. ADON A asked Certified Nurse Aide (CNA) N to assist R55. CNA N became frustrated and stated, I'm not going to change him now because he will end up wanting to stay in bed and he needs to stay up for meals. When ADON A requested again that R55 be assisted back to his room, CNA N stated, I am the only person on the floor and I'm answering all the call lights and helping everyone. I don't have time for this! It was noted that this was in direct view and hearing of R55. Review of the facility's Quality of Life - Dignity policy, undated, read in part, .Residents are treated with dignity and respect at all times .

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38471 This Citation pertains to Intake Number MI00143579 Based on interview and record review the facility failed to administer and document medications per professional standards of practice for two residents (Resident #58 and Resident #293) reviewed for accuracy of medication administration, resulting in misappropriation of Resident #58's narcotics and erroneous medication documentation and administration. Findings include: Resident #58: On 5/21/2024 at 4:33 PM, the North Hall medication cart was inspected in the presence of Nurse B. The controlled substance book was reviewed for accuracy and a discrepancy was found with Resident #58's Tramadol 50 HCL (hydrochloride) MG (milligrams) as one pill was not accounted for. The facility was dispensed 30 pills by their pharmacy, and he was administered one pill on an as needed basis. The following was listed on the controlled substance form: 5/15 at 0125- 29 remaining 5/15 at 800- 28 remaining 5/15 at 2100- 27 remaining 5/16 at 2100 - 26 remaining 5/17 at 2100- 24 remaining 5/18 at 2100- 23 remaining 5/20 at 2100- 22 remaining 5/21 at 800 - 21 remaining The nurse (V) that administered/documented on 5/17/2024 is where the inconsistency was found, as it went from 26 remaining when administered on 5/16 at 2100 to 24 remaining on 5/17/2024 at 2100. Nurse B and the ADON (Assistant Director of Nursing) were alerted to the discrepancy and reviewed the controlled logs and agreed the count was inaccurate. This writer, ADON and Nurse B counted Resident #58's Tramadol pills remaining in the blister pack, and it was 24 pills remaining as indicated on the narcotic form (which verified the pill was missing). It can be noted Nurse V signed out on the MAR that one pill was administered at 1952 on 5/17/2024. While on the controlled substance log, she wrote one pill given at 2100 but docked two from the quantity remaining section. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/22/2024 at approximately 11:25 AM, a review was completed of Resident #58's medical record and it indicated he admitted to the facility on [DATE] with diagnoses that included Congestive Heart Failure, Sleep Apnea, Peripherial Vascular Disease, Sarcopenia and Hypertension. Further review was completed and yielded the following results: Physician Order: Tramadol HCL Tablet 50 MG- give 1 tablet by mouth every 6 hours as needed for moderate and severe pain. Controlled Substance Shift Inventory: On 5/18/2024 at 6:00 AM two nurses signed which meant there were no discrepancies with their narcotic count to include blister packs. On 5/22/2024 at 11:37 AM, an interview was conducted with the DON (Director of Nursing) regarding the unaccounted-for Tramadol pill for Resident #58, and he stated after their investigation the medication is still unaccounted for and there was no documentation that it was wasted. The DON explained the morning of the 5/18/24 during the reconciliation the error should have been caught. He stated the nurse involved is Nurse V and since been suspended pending further investigation. Resident #293: On 5/21/2024 at 10:56 AM, an interview was conducted with the complainant regarding Resident #293's Melatonin. The complainant explained Nurse V attempted to administer the resident Melatonin without an order for it. Resident #293 refused to take the medication as she was not going to take a medication she was not prescribed. On 5/21/2024 at 1:45 PM, an interview was conducted with the DON regarding the allegation of Nurse V attempting to administer Resident #293 Melatonin and her subsequent refusal of the medication. The DON shared Nurse W alerted him that Resident #293 handed her a pill cup that had Melatonin in it from the previous shift. The DON attempted to speak with the resident regarding the incident, but she refused. Resident #293 did provide a statement to Nurse W and stated Nurse V offered the medications to her and she declined them. The DON reported there were 2-3 MG Melatonin pills in the cup and Nurse V was interviewed and stated the resident was complaining about not being able to sleep and requested something to assist. This writer and the DON reviewed Resident #293's progress notes and saw Nurse V back dated two entries regarding the reasoning for administration of the Melatonin. The times of the progress notes did not correlate with the time the medication order was inputted into the system (2245 on 3/14/2024). Review was completed of the MAR (Medication Administration Record) and it was found Nurse V again attempted to back date the MAR entry for the Melatonin administration but was unsuccessful. As it was documented as being administered on 3/15/2024 at 1643 which was a day after the medications was requested by Nurse V for Resident #293. The DON stated the nurse was disciplined for untimely documentation and following policy/procedure. On 5/21/2024 at approximately 2:00 PM, a review was completed of Resident #293's medical record and it revealed the resident was admitted to the facility on [DATE] with diagnoses that included, Osteomyelitis, Hypertension, Heart Failure and Gastro-Esophageal Reflux Disease. Resident #293 was discharged from the facility on 4/13/2024. Further review yielded the following results: (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Progress Notes: 3/15/2024 at 16:59 (Late entry effective 3/15/2024 at 00:58): Resident stated she was having anxiety and trouble sleeping. On provider notified via phone call due to none listed on PCC dashboard. On call was notified of situation and gave permission for a one-time order for Melatonin. 3/15/2024 at 17:14 (Late Entry effective 3/15/2024 at 01:09): Called on call and stated that 5mg Melatonin was all gone and was 2-3mg on to take. On call stated it was ok to give 2 3mg due to not having 5mg. MAR (Medication Administration Record) March 2024: Ramelteon (Hypnotic)- Oral tablet 8 MG- give one table every 24 hours as need for at bedtime. Ordered on 3/6/2024 and discontinued on 3/18/2024. -The as needed medication was only administered one time in March 2024 and that was by Nurse V at 2250. Melatonin Tablet 5 MG- Give 1 tablet by mouth one time only for insomnia for 1 day. Ordered on 3/14/2024 at 2245. -The medication was administered per the MAR on 3/15/2024 at 1643. It can be noted it is unknown why on 3/14/2024 Resident #293 would be administered Ramelteon at 2250 but five minutes before (at 2245) an order was received to administer the resident Melatonin for insomnia. Furthermore, after Nurse V was interviewed by the facility only then did she add the documentation related to the Melatonin and still erroneously charted a medication as given on the incorrect date but also the resident never ingested the medications. Facility Internal Investigation: Nurse V Statement 3/15/2024: 2200 Resident was complaining about not being able to sleep. Resident requested something to help her sleep. 2300 Resident given medication around this time. Resident took all medication given. Nurse doesn't know name of on call provider. Melatonin ordered after ramelt was administered earlier and not working. Nurse W Statement 3/15/2024: Nurse entered resident room and resident handed nurse a cup of white, circular pills that looked like they could be Melatonin. Resident state they were offered to her by the night shift nurse, and resident declined medication. Care Team Corrective Action Form 3/14/2024 for Nurse V: Timely documentation and following proper policy and procedure. Signed by Nurse V (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nurse V Human Resource File: -11/2/2023: Gross negligence in performance of job duties related to medication administration. -12/202023: One on One Inservice record for not signing out medication or treatment. -4/27/2023: Administered resident insulin when resident is not diabetic nor was there an order. -5/22/2024: Suspended pending investigation for narcotic diversion. Nurse V historically has documented medication administration violations located within her file. Although she was deemed competent in medication administration by the facility on 5/1/2023, she continuously shows a lack of professional standards in providing care to multiple facility residents as it related to medication administration. Review was completed of the facility policy entitled, Administering Medications, revised April 2019. The policy stated, .If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall initial and circle the MAR space provided for that drug and dose . The individual administering the medication initials the resident's MAR on the appropriate line after giving each medication and before administering the next ones. Review was completed of the facility policy entitled, Documentation in Medical Record. The policy stated, Each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation. The policy was not dated.

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F 0686 Level of Harm - 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** 38471 This Citation pertains to Intake Number MI00143579. Based on observation, interview, and record review the facility failed to provide pressure ulcer care per health care provider order and prevent the deterioration of Resident #74's unstageable coccyx wound and Resident #290 and #292's wound dressings not being completed per standards of clinical practice, resulting in Resident #74's wound care treatment not being completed as ordered, wound worsening, infection, and sepsis and Resident #290's and #292's foot wounds not being dated and labeled per nursing standards of practice. Findings Include: Resident #74: During initial tour on 5/20/2024, Resident #74 was observed resting in bed and did not appear to be in any distress. On 5/21/2024 at approximately 2:00 PM, a review was conducted of Resident #74's medical record and it revealed the resident initially admitted to the facility on [DATE] with diagnoses that included, Sepsis, Chronic Kidney Disease, Anemia, Myocardial Infarction and Hypertension. Resident #74 was dependent on facility staff to meet all her care needs. Further review of the resident record yielded the following: Discharge Hospital Records: .Pressure Ulcer 2/12/24 Coccyx (buttocks) .cleanse/irrigate with NS (normal saline). Apply skin prep periwound. Apply Mepilex silicone border dressing to wound bed. Date, initial, and designate T for treatment or P for prevention on Mepilex. Roll back edges every shift to assess and cleanse wound bed. Re-secure with skin prep. Change Mepilex Q3 days & prn . Treatment Administration Record (TAR): - Allevyn Sacrum External Pad- Apply to sacrum topically every day shift every 3 day(s) for wound cleanse with ns, pat dry and cover. Ordered on 2/22/24 and discontinued on 2/29/2024. - Wound Treatment- Coccyx- Cleanse site with saline or wound wash. Gently pat dry. Apply dime size amount of triad cream and spread thin layer. May leave in place and reapply in thin layers for 3 days. Remove with A&D ointment on day 4 and reapply triad as per previous instructions. Ordered on 2/23/2024. Review was completed of the TAR and indicated Resident #74's Allevyn treatment was not completed on 2/22/24, 2/25/24 and 2/28/24. The TAR had numerical indicators for the three dates listed that coded for other/see progress note. The progress notes for each date the dressing was due to be completed stated: (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	2/22/2024: No subsequent progress note related to the treatment. 2/25/2024: No Allevyn dressing. 2/28/2024: There was no explanation listed in the progress note as to why this treatment was not completed. It is unclear as to why Resident #74 had two different wound care treatment orders from 2/22/2024 to 2/29/2024 (when Allevyn was discontinued) when the wound care practitioner ordered Triad on 2/22/2024. On 5/21/2024 at 10:56 AM, an interview was conducted with the complainant regarding wounds at the facility. It was shared community acquired wounds at the facility were worsening as wound care was not being completed as ordered. They reported Resident #74's wound was supposed to be packed and it was only being completed when the Wound Nurse Practitioner rounded. They stated Resident #74's wound worsened and became infected due to facility neglect. Further review was completed of Resident #74's wound progressing from admission to transfer to the emergency roiagnom on [DATE]. Nursing Admission Assessment 2/20/2024: The assessment indicated Resident #74 admitted to the facility with the following skin conditions .Sacrum- Full thickness wound 4.5cm x 6.3cm. moist . She has wounds 3. Sacrum-unusual shaped full thickness wound across coccyx 4.5cm x 5.3cm. Regions cleaned with NS (normal saline) pat dry and cover with foam gentle Allevyn as were found upon admission . She is also totally dependent for all ADL as she is totally paralyzed . Care Plan: (Resident #74) was admitted with pressure ulcer to sacrococcygeal area and L (left) heel closed .Assess and document skin condition, notify MD of signs and infection (redness, drainage, pain, fever) .Notify MD of worsening or not improvement in wound .wound treatment as ordered . Nursing Progress Notes: 2/22/2024 at 11:56: Coccyx - unstageable. 2.5 x 1.6 x 0 (measurements)First Observation, no reference. Serous (Drainage). Small. (Drainage Amount). No (Odor). fragile with deep purple discoloration. Attached. triad as per order in TAR. pressure reducing mattress low air loss mattress. NP first rounding observation . 2/29/25024 at 11:03: Coccyx - unstageable 4.0x1.4x 0 (measurements) .Unstageable. Worsening. Serosanguineous (Drainage). Small (Drainage Amount). Yes (Odor)strong malodorous . 3/7/2024 at 13:53: Coccyx - St (stage) 4.4. x 5.01.1. admitted . Stage 4. Worsening. Serosanguineous (Drainage). Moderate (Drainage Amount). Yes (Odor)slight malodorous smell. Fragile. Macerated . deterioration . (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Majestic Care of Flushing		STREET ADDRESS, CITY, STATE, ZIP CODE 540 Sunnyside Dr Flushing, MI 48433	

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F 0686 Level of Harm - Actual harm Residents Affected - Few	3/14/2024 at 12:40: Coccyx - unstageable 4.7 x 5.5 x 0 (measurements) .Unstageable .Worsening .Moderate (Drainage Amount) .Yes .(Odor)slight malodorous smell .fragile .not attached .poor . 3/14/2024 at 13:18: Resident with probable sepsis VS (vital signs): bp:94/60 HR 111 WBC over 20 HGB 7.8, okay to sent out per DON (Director of Nursing) ADON on call notified of transfer . 3/15/2024 at 00:00: WBC 20, on abx for wound infection. Pressure Ulcer Weekly Observation Assessment: 2/22/2024: Unstageable coccyx wound with 100% yellow adherent slough and small serous drainage. The peri wound tissue was fragile wit deep purple discoloration and wound edges attached. Current treatment was Traid This was the first observation of the wound completed by the wound NP. 2/29/2024: Worsening unstageable coccyx wound with 100% yellow adherent slough and small serosanguineous drainage. The wound had eschar forming and a strong malodorous odor. The peri-wound tissue was fragile with wound edges attached. Continue treatment of triad. 3/7/2024: Worsening stage 4 pressure ulcer with slough and neurotic tissue present. Moderate amount of pale yellow seropurulent drainage with slight malodorous smell with macerated wound edges. Treatment orders were changed. 3/14/2024: Worsening unstageable coccyx wound with 20% slough and 80% necrotic tissue. Moderate seropurulent drainage with slight malodorous smell. 12-12 undermining 2.4 cm at 11 and depth was unknown. The wound edges were attached, and infections was suspected. Wound progress was evaluated at poor. Nurse Practitioner Wound Care notes: 2/22/2024 at 00:00: .Will initiate a treatment plan to coccyx to be that of triad cream to promote autolytic debridement and to protect area from further moisture related breakdown . Coccyx, unstageable- This wound measures 2.5 x 1.6 centimeters with unknown depth. This wound is an assumed full thickness. There is a light amount of serous drainage from this area. Wound bed consists of 100% pale yellow adherent slough. Edges are attached and there is no eschar, tunneling, undermining, or odor. The surrounding tissue is fragile with a deep purple discoloration but without redness, warmth, swelling, pain, induration, or sign of infection. Treatment: Cleanse site with saline or wound wash. Gently pat dry. Apply dime size amount of triad cream and spread in thin layer. May leave in place and reapply in thin layers for 3 days. Remove with A & D ointment on day 4 and reapply triad as per previous instructions . (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	2/29/2024 at 00:00: .Will continue treatment plan for sacral unstageable to be that of triad cream to promote autolytic debridement and to protect area from further moisture related breakdown . Sacrum, unstageable- This wound measures 4.0 x 1.4 centimeters with unknown depth. This wound is an assumed full thickness. There is a light amount of serous drainage from this area. Wound bed consists of 100% pale yellow adherent slough with eschar formation. Slight malodorous smell. Edges are attached and there is no eschar, tunneling, or undermining. The surrounding tissue is fragile with a deep purple discoloration but without redness, warmth, swelling, pain, induration, or sign of infection. Treatment: Cleanse site with saline or wound wash. Gently pat dry. Apply dime size amount of triad cream and spread in thin layer. May leave in place and reapply in thin layers for 3 days. Remove with A & D ointment on day 4 and reapply triad as per previous instructions . 3/7/2024 at 00:00: Sacral site now stageable as there is noted granulation tissue. Bone is palpable with noted facia making this a stage IV. Will adjust treatment plan for sacral to be that hydrogel impregnated gauze to promote autolytic debridement . declining sacral wound . Sacrum, stage 4- This wound measures 4. 5 x 5.0 centimeters with a depth of 1.1 centimeters. This wound is full thickness. There is a moderate amount of serosanguanious and yellow seropurlent drainage from this area. Wound bed consists of 40% pale yellow adherent slough, 30% necrotic tissue, and 30% intermittent granulation tissue. Slight malodorous smell. Edges are not attached as there is noted undermining from 9 to 11 o'clock with max depth of 1.1 centimeters and again from 12 to 2 o'clock with a max depth of 0.6 centimeters .surrounding tissue is fragile with a deep purple discoloration but without redness, warmth, swelling, pain, induration, or sign of infection. Treatment: Cleanse site with normal saline or wound wash. Pat dry. Apply hydrogel impregnated gauze (autolytic debridement) to site and gently pack with undermining areas. Apply barrier cream to periwound. Cover with gently bordered gauze. Perform daily and as needed if soiled or dislodged . 3/14/2024 at 00:00: .Sacral site unstageable as there is noted 80% necrotic tissue with a malodorous smell. Will adjust treatment plan for sacrum to be that of 1/2 percent dakins soaked gauze (wet-to-dry) dressing. This is to be performed BID and as needed if soiled or dislodged x 7 days. Will start patient on antibiotics, keflex 500 mg BID x 7 days for wound infection . declining sacral wound .Sacrum, stage 4- This wound measures 4.7 x 5.5 centimeters with an unknown depth. This wound is full thickness. There is a moderate amount of light brown seropurlent drainage from this area. Wound bed consists of 20% yellow-brown adherent slough, and 80% necrotic tissue. Noted malodorous smell. Edges are not attached as there is noted 360% undermining with a max depth at 11 o?clock of 2.4 cm. The surrounding tissue is fragile with a deep purple discoloration but without redness, warmth, swelling, pain, induration, or sign of infection . IDT (interdisciplinary Team) Risk Review Notes: IDT met .Wound note 3/7 reviewed. Wound care orders reviewed . The IDT reviewed Resident #74's wound care notes and orders from 3/7/2024 and overlooked the change in the wound care treatment order. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	It can be noted that after Resident #74 was assessed by the practitioner on 3/7/2024 the wound care treatment order was not changed from Triad to hydrogel impregnated gauze until 3/14/2024 at 6:00 AM. Resident #74 did not receive the appropriate wound care treatment for seven days. On 3/14/2024, Resident #74 was assessed by the practitioner and found with 80% necrotic tissue, malodorous smell, and signs of infections. Resident #74 was sent to the emergency room for probable sepsis. The hospital admission record stated the following, XXX[AGE] year old female with history of CVA and left sided hemiparesis who is bed-bound and PEG tube dependent for feeding with chronic kidney disease and hypertension .patient with infected sacral decubitus ulcer as well as foul smelling urine .CBC with WBC of 22.9, hgb 8.4 .placed on IV antibiotics .Principal problem: Sepsis Leukocytosis/Sepsis/ Infected Sacral Decubitus . Resident #74 admitted with a wound but during her course of stay at the facility it worsened and became infected. The facility did not implement the wound treatment timely nor were there any physician notes that indicated the wound worsening was unavoidable. On 5/22/2024 at 10:00 AM, a discussion was held with DON (Director of Nursing), ADON (Assistant Director of Nursing) and Corporate Consultant P, regarding the deterioration and infection of Resident #74's coccyx wound. They reported the wound began to worsen when she completed her course of antibiotics that she was admitted on . They explained they were packing her wound with hydrogel as the wound was deep and full of slough. This writer, Consultant P and DON reviewed Resident #74's wound treatment orders against the wound practitioner notes and found on 3/7/24 the practitioner changed the wound care order from Triad to Hydrogel Impregnated gauze, but this order was never inputted into the resident's chart. Resident #74 was not receiving the appropriate wound care treatment for seven days; her wound worsened and became infected. The DON and Consultant P were not able to provide rationale as to why the appropriate treatment intervention was not implemented timely. Resident #290: During initial tour on 5/20/2024, Resident #290 was observed resting in bed and was in good spirits. The resident was observed to have a dressing on her right foot that was not dated nor initialed. On 5/21/2024 at approximately 8:45 AM, Resident #290's right foot was dressing was observed to still not dated nor initialed. The ADON (Assistant Director of Nursing) was shown the dressing and reported it should be dated and initialed by the nurses who completed wound care. On 5/21/2024 at 9:39 AM, Resident #290's right foot wound dressing change was completed by the ADON. The dressing was not dated nor initialed. The dressing was dried onto the wound and wound wash had to be utilized to remove the stuck-on dressing. On 5/21/2024 at approximately 10:30 AM, a review was completed of Resident #290's medical records and it indicated the resident admitted to facility on 5/10/2024 with diagnoses that included, Sepsis, Bacteremia, Urinary Tract Infection, Anxiety, Depression, Paroxysmal Atrial Fibrillation and Heart Disease. Resident #292: (continued on next page)

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Majestic Care of Flushing	540 Sunnyside Dr Flushing, MI 48433

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During initial tour on 5/20/2024, Resident #292 was resting in bed watching television. She was in good spirits and spoke about her reasoning for entering the facility. Resident #292 had bilateral dressings to her feet that were not dated or initialed. The residents' feet were not floated nor were heel protector boots on. On 5/21/2024 at approximately 9:00 AM, this writer and the ADON observed Resident #292's bilateral dressings to her feet and they again were not dated nor initialed. The dressings were observed to have drainage seeping through that was yellow in color. The ADON was asked regarding the blank dressing and stated upon dressing changes being completed nurses should initial and date the dressings. On 5/21/2024 at approximately 10:45 AM, a review was completed of Resident #292's medical record and it indicated the resident admitted to the facility on [DATE] with diagnosis that included, Chronic Osteomyelitis with draining, Methicillin Resistant Staphylococcus Aureus (MRSA), Diabetes, Peripheral Vascular Disease (PVD) and Chronic Kidney Disease. Further review of Resident #292's medical records revealed the following: Physician Orders: - Resident to wear heel protectant boots while in bed every shift. Care Plan: (Resident #292) was admitted with right heel ischemia area d/t (due to) PVD . (Resident #292) was admitted with left heel ischemia area d/t (due to) PVD .elevate heels when in bed as allows .wound treatment as ordered . While the care plan indicated to elevate heels the resident had an order for heel protectant boots that did not carry over to care plan and Kardex. On 5/21/2024 at approximately 4:20 PM, this writer and Nurse B observed Resident #292 lying in bed and did not have on her heel protectant boots. Nurse B searched for the boots and were not able to locate them in the resident's room. We reviewed the orders and saw the resident was ordered to wear heel protectant boots while in bed. Review was completed of the facility policy entitled, Pressure Injury Prevention and Management. The policy stated, This facility is committed to .provide treatment and services to heal the pressure ulcer/injury, prevent infection and the development of additional pressure ulcers/injuries .Any changed to the facility's pressure injury prevention and management processes will be communicated to relevant staff in a timely manner . The policy was not dated with a reviewed or revised by date.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22927 This Citation pertains Intake Number MI00143956 Based on observation, interview and record review, the facility failed to provide supervision to prevent injuries for 2 residents (Resident #17, Resident #84) of 4 residents reviewed, resulting in Resident #17 sustaining a fracture of the 3rd and 4th metacarpal on the right hand, and no complete comprehensive post fall assessments for Resident #84, who sustained a fall with head injury, laceration, and required emergency medical treatment. Findings include: Record review of facility 'Fall management' policy dated 6/2023 revealed the purpose to prevent injuries related to falls. Post-Fall: (1.) Any resident experiencing a fall will be assessed immediately by the charge nurse for possible injuries and necessary treatment will be provided. A neurological assessment will be initiated on all residents with a suspected head injury based upon the fall; every 15 minutes for 1 hour then every 30 minutes for 1 hour then every 1 hour for four hours, then every 4 hours for 24 hours, then every 8 hours until 72 hours. (4.) The family will be notified immediately by the charge nurse of falls with injury. Record review of facility 'Documentation in Medical Record' policy undated with reference date of February 2023 Appendix PP guidance material, revealed each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation. (4.) Principles of Documentation: (b.) Documentation shall be accurate, relevant, and complete, containing sufficient details about the residents' care and/or responses to care. Resident #84: Record review of Resident #84's electronic medical record revealed an admitted [DATE]. Record review of Resident #84's progress notes dated 4/12/2024 at 6:15 PM noted resident arrival to facility via EMS from hospital. Resident noted as alert and oriented to self only. Head to toe assessment completed. Record review of Resident #84's fall/accident report, dated 4/14/2024, revealed the resident was trying to leave the building unauthorized and when he pushed through the door a staff was standing there and startled him and he tripped and fell and hit his head on the floor. Resident #84 was noted to be unable to give a description of what he was doing. The nurse helped the resident back to his room and gave first aid, called another nurse to help facilitate the paperwork to send resident to the emergency room for the big knot that formed on the right side of his forehead and the bleeding from the abrasion on the side of the face. Resident's mental status was noted to be oriented to self and there were alarms sounding at the time. Resident #84 was noted to be an active exit seeker. Resident #84 was resistive with redirection. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Record review of resident #84's progress note, dated 4/14/2024 at 00:12 AM, revealed the resident was trying to leave the building unauthorized and when he pushed through the door a staff (member) was standing there and startled resident and he tripped and fell and hit his head on the door. Record review of progress note dated 4/14/2024 at 00:13 AM noted resident sent to the emergency room for further evaluation. Record review of the Resident #84's progress note, dated 4/14/2024 3:12 AM, the resident returned from the hospital at 3:30 AM. Resident received 2 stitches on forehead and basic first aid treatments to other abrasions. EMT reported that he fell at hospital and was in restraints upon pick up. Cannot assess pain at time due to resident not being able to verbalize. Record review of the Resident #84's progress note, dated 4/14/2024 4:18 AM, revealed follow up and care instructions are on the discharge papers. Resident needs to be seen to get stitches out in 5 days. Record review of Resident #84's progress notes, dated 4/13/2024 through 4/15/2024, revealed there was no neurological evaluations documented post-fall with head injury that required emergency room treatment and sutures to the head. An interview on 05/20/24 at 11:20 AM with Resident #84, while he was lying in bed, revealed that he did try to go home, and that he got hit in the face with the door. Resident #84 stated he was going. When asked where Resident #84 was going to, the resident did not respond to the question. An interview and record review was conducted on 05/21/24 at 12:19 PM with the Director of Nursing (DON) regarding Resident #84's falls, dated: 4/14/2024, 5/15/2024, and 5/19/24. The state surveyor had the DON review the electronic medical record of Resident #84 who sustained a fall with head injury, went to the emergency room for evaluation and stitches to the head and the surveyor was requesting 'Neurological Evaluation Flow Sheet' dated 4/14/2024 once the Resident #84 returned to the facility. The DON stated that the North Hall Unit manager would have the fall packet. The DON reviewed the yellow folder post fall packets note to a shelf on the bookcase in his office. No post fall packet was found for Resident #84 in the DON's office. The DON stated that on April 14, 2024, the facility placed Resident #84 on 1 to 1 supervision while awake. An interview and observation was conducted on 05/21/24 at 12:29 PM with Licensed Practical Nurse (LPN) North Hall Unit Manager E regarding Resident #84's fall packets and a check off list that is part of the post-fall investigation. LPN E stated that the post-fall packet has everything that needs to be done post fall. Observation of a blank post fall packet revealed a 'Neurological Evaluation Flow Sheet', Incident/Fall Checklist, Incident & Accident Investigation Form, Resident #84 has had three falls since being admitted . LPN E stated that she did not do or have any post-fall packets for Resident #84. Record review of Resident #84's fall report, dated 4/14/2024, noted resident received a head injury. LPN E stated that the fall packets are filled out by the nurse at the time incident, then it goes to the Director of Nursing (DON), with the previous DON, the fall packet and neurological checks were to be scanned into electronic medical record system. LPN E stated that she had not seen or received a post-fall packet for the falls of Resident #84. LPN E stated that the facility had process that was working, and the facility got new management and the process stopped, if The DON does not have them then the there is none. 34568 (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Resident #17 (R17): Review of R17's Electronic Medical Record (EMR) revealed admission to the facility on [DATE] with diagnoses including dementia with other behavioral disturbances. According to the 3/1/24 Quarterly Minimum Data Set (MDS) assessment, R17 received a 4/15 on the Brief Interview for Mental Status (BIMS) score indicating severely impaired cognition. Review of R17's Progress Notes read, in part, 5/5/24 Resident was assisted to Central unit by another nurse who said resident was visiting another resident and fell . Resident was sitting in his wheelchair with his right hand wrapped in ice. Resident tip of right finger was ben upward .resident to be transferred to ER (emergency room) .5/6/24 patient transferred back to facility via w/c (wheelchair) .X-ray results to right hand indicating has fractures to the third and fourth metacarpals. Cast noted to right hand up to arm is intact . On 5/20/24 at 11:52 a.m. R17 was observed in the hallway with his right arm noted to be in a cast wrapped with an ACE bandage. An interview with the Director of Nursing (DON on 5/21/24 at approximately 4:30 p.m. confirmed R17's injury of unknown source did not include witness statements from staff. The DON stated that R17 and the other resident involved were able to tell you what happened despite being cognitively impaired, and that staff were able to see R17 exit the room. The DON stated that R17 was asked to visit this specific resident in more public areas instead of her private room, and that was not followed and the time of the incident. During this interview with the DON, R17 was observed to be wheeling by the office. R17 was asked if he could recall the incident that took place on 5/5/24. R17 stated, Fall down, go boom! and pointed to the sidewalk outside. The DON stated that R17 knows that he should not have been visiting the female resident (later identified as R66) and is changing his story. On 5/22/24 at 9:05 a.m. an interview was attempted with R66. R66 recalled that R17 was in her room. When asked what happened, R66 stated, Well he (R66) likes to cuddle on the bed and likes to hum-hum with his hands. R66 could not recall when or how R17 fractured his hand and continued to attempt to fold towels on her bed. On 5/22/24 at 9:19 a.m. a follow up interview was conducted with the DON. When told what R66 had stated earlier, the DON confirmed that R66's cognition changes from day to day. The DON stated that they saw R17 come out of R66's room and did not suspect abuse. Review of R17's care plan read, in part, (R17) is at risk for falls or fall related injury r/t (related to), poor safety awareness, confusion, incontinence, gait/balance problems .he has a hx (history) of falls including recent fall with metacarpal fractures . It was noted that the interventions listed for R17 did not include increase in supervision or to attempt to keep R17 out of other resident rooms.