

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 08/15/2024
NAME OF PROVIDER OR SUPPLIER Majestic Care of Flushing		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38471</p> <p>This Citation pertains to Intake Number MI00145161</p> <p>Based on interview and record review the facility failed to maintain the safety of one resident (Resident #701) of one resident reviewed for mental health procedures, resulting in Resident #701 attempting twice to commit suicide via strangulation at the facility without appropriate facility interventions.</p> <p>The facility is being cited at Past-Non-Compliance with a Compliance Date of 06/15/2024.</p> <p>Findings Include:</p> <p>Resident #701:</p> <p>On 8/13/2024 at approximately 3:30 PM, a review was conducted of Resident #701's record and it revealed he admitted to the facility on [DATE] with diagnoses that included Alcoholic Cirrhosis of Liver, Paranoid Personality Disorder and Alcohol induced persisting Dementia. Further review of Resident #701's record revealed the following:</p> <p>Care Plan:</p> <p>.resident attempting to wrap call light chord around neck .1:1 sitter .</p> <p>(Resident #701) has two blanching red areas on neck . initiated on 6/13/2024.</p> <p>Physician Orders:</p> <p>-Resident to have 1:1 sitter upon return from hospital for personal safety - inputed on 6/12/2024.</p> <p>Hospital Records:</p> <p>Pt (patient) from (long term care unit), pt was found with a phone cord wrapped around his neck. Pt arrives with bruising and bleeding around his neck. Pt gasping. Was found unresponsive for EMS .presented as Class I trauma after being found with phone cord around neck. This is a presumed suicide attempt .problems addressed: strangulation or suffocation .</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 8/14/2024 at approximately 12:45 PM, Scheduler M was asked why there was no specified 1:1 for Resident #701 on 2nd and 3rd shift on 6/14/2024. The scheduler explained CNA N was supposed to stay over on 2nd shift but was directed by CNA A to go home.</p> <p>On 8/14/2024 at 1:15 PM, an interview was conducted with CNA A regarding Resident #701's 1:1. The CNA explained their scheduler will denote on their assignment sheet if there is a 1:1. CNA M was Resident #701's sitter on 1st shift from 6:00 AM - 2:00 PM and they did not know who CNA M's relief was. CNA A directed the aide to speak to their scheduler regarding her relief and never directed her to go home.</p> <p>On 8/14/2024 at 4:00 PM, Nurse D shared the morning after Resident #701's first suicide attempt she and housekeeping completed a sweep of his room for any items he could utilize to harm himself. Nurse D reported they found multiple pill bottles in his house shoes and the sleeves of his shirts. The bottles found in the sleeves were rubber banded so they would not fall out. Nurse D stated they also found scissors and some other miscellaneous items but she did not see the cell phone charging cord or tape in the room during the sweep.</p> <p>On 8/14/2024 at 4:25 PM, an interview was conducted with CNA B regarding Resident #701 2nd suicide attempt at the facility on 6/14/2024. The CNA explained she and Nurse O took turns completing 10-20 minutes checks on Resident #701 during 3rd shift, as there was no staff designated for 1:1. CNA B stated Resident #701 was intelligent so they staggered the checks so he would not know exactly when they were coming. CNA B was unsure who was completing the checks on him prior to her arrival at 10:00 PM. During her visual checks of the resident, she did not observe a phone cord or tape in his room. Around 3:05 AM, Nurse O checked on him before going on break and he was fine. CNA B went to check on him at 3:20 AM and found him supine in the bed with the sheet covering his body, she noticed what looked like a dressing by his neck and that is what prompted her to pull the flat sheet back. CNA B Resident #701 had wrapped a phone charger around his neck, then wrapped toilet paper or Kleenex around the charger and secured it with tape. Resident #701 was breathing but would not respond verbally to CNA B. CNA B yelled for help and another aide responded and they had to cut the items around his neck in three or four places to release it.</p> <p>Further review was completed of Resident #701's record's and yielded the following:</p> <p>Progress Notes:</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>6/12/2024 at 01:00: .He was referred to (contracted psychiatric group) for cognitive assessment and mania. 6/12/24: Resident was seen in his room around lunchtime with a sitter 1:1. No acute distress noted today. He elaborated on how he was feeling by stating all of the medical issues he has including his paracentesis. He seemed to be highly manic, going from one subject to another without any flow. He started with his medical issues, and then went on how he is very particular about his medications, which according to staff, he has not been taking. He also seemed to be aloof and tangential with a mixed of flight of ideas, which sometimes alluded to SI/Hi, but made vague comments on any particular plan. His flight of ideas included his hx of being a real estate agent, which how he met his ex-girlfriend, then how his real estate partner [NAME] had made millions by having the real estate gain 64% of the profit and the duo gained the reset of the profit in AZ. He was then asked about not taking his medication and he endorsed I just want to know what they are, but I am not refusing, just cautious. Staff has indicated that he does not take his meds every day. He is not sutable to be outpatient services right now, since he has had a hx of SI, recently, and him going over with vague plans needed to be either stay on 1:1 or recommended to be petitioned .</p> <p>6/12/2024 at 01:44: .Neurological Status Evaluation:I answered his call light and found him with 2 strings tied very tightly around his neck and knotted. There were paper towels between the knotted strings and his neck. I cut the strings off .He appears of his usual cognition and is alert. He refuses to discuss why or how this happened, stating that his room mate put the call light on, not him. He has a very small reddened area in the front of his neck where strings were knotted .</p> <p>6/12/2024 at 02:49: I answered the call light for (Resident #701) room around 12:45 am. When I entered I noted his roommate was sleeping, so I pulled (Resident #701's) curtain open to see if I could assist him and I found him with 2 strings tied very tightly in knots around his neck. His bed gown tie as well as what appeared to be an overhead light pull string. There were paper towels between the strings and his neck skin. I couldn't get the strings untied so I cut them off. His eyes were moving left to right. He was not speaking, he was breathing rapidly but not gasping. He was not discolored, his facial skin and lips were of normal color. When I attempted to speak with him, his eyes moved from left to right, non-rythmically and he did not answer. I immediately took his vitals .I shook him stating, I know you are ok, why would you do this? and his eyes flinched and he opened his eyes, his breathing was normal. He refused to answer when I asked him if he is ok and began moving his eyes from left right not rythmically, but everytime I said something his movement would stop as if to listen to me then his eye movement would begin again as would his increase of respirations. When I asked him if he put the call light on he said, no, it must've been my roommate. His eyes then moved from left to right in such a way that appeared to be focused effort to do so. His roommate was sleeping. I asked him if his visitors previously in the day had anything to do with this and he said, no, I don't want to live. I asked him if I can do anything to help him and he said, no.Staff passed water and assisted this room a few minutes after 11:30pm and both residents in this room appeared to be of their usual .</p> <p>6/12/2024 at 03:43: : I received a call from (the hospital). (Resident #701) has been evaluated and appears to be of normal status, they expect to send him back to us soon. ADON and Administrator notified; orders given to assign him a 1:1 sitter upon arrival .</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>6/12/2024 at 15:53: Resident room was cleaned today during the cleaning approximately 5 pill bottles were found in his room inside of his house shoes. Inside of his shirts pills not in bottles were found in his shirt sleeve with a rubber band keeping them from falling out along with 2 pairs of scissors and a tile scrapper. Resident also two heated blankets on his bed. All items was turned into the administer.</p> <p>6/12/2024 at 22:56: .Patient was assessed in his room, resting in bed. He had a sitter at bedside, as he attempted suicide last night with a string and paper towel around his neck. He was sent to the ER for evaluation and sent back. He requires 24/7 staff at this time .</p> <p>6/14/2024 at 06:35: Resident observed in bed with a charger cord that that was reinforced with toilet paper and tape around his neck. He was unresponsive but breathing. Cord was so tight is was unable to be untangled so it had to be cut with scissors. Vitals immediately taken; all appropriate persons notified. Order to send patient out given. Spoke with Social Worker at (Hospital) and she stated she will initiate a Petition. Thorough report given.</p> <p>On 8/14/2024 at approximately 2:00 PM, an interview was conducted with the Administrator and DON (Director of Nursing) regarding Resident #701's two suicide attempts at the facility via strangulation. They explained after his first attempt they thought he would have been admitted to an inpatient psychiatric unit, but he was at the hospital for a short amount of time and returned back to the facility. Upon his return he was placed on 1:1 for continued safety and monitoring. They had a nurse complete a sweep of his room and found many items such as pill bottles and scissors that were removed to maintain his safety. The Administrator and DON were asked if he was petitioned by facility staff after his first or second attempt and they stated he was not. After further discussion it was found there were no other interventions implemented to maintain Resident #701 safety, no facility policy to address suicidality and subsequent procedures. Additionally, the facility discovered there was no specified 1:1 on the assignment sheet for 2nd and 3rd shift on 6/14/2024. The Administrator and DON reported the facility took steps after the incident to correct self-found deficiencies. They presented this writer with Past Non-Compliance.</p> <p>Facility Investigation of Suicide Attempts:</p> <p>Staff was in the room on 6/12/24 passing water and had checked on (Resident #701) and he was in bed. The nurse went down to residents' room at approximately 12:45 am on 6/12/24 to answer call light and observed resident with 2 strings tied around his neck. Nurse unable to loosen ties so cut with scissors . (Resident #701) told the nurse that he did not want to live so one on one was placed and nurse called the physician and received orders to send to ER for psychiatric evaluation . (Resident #701) returned from (emergency room) on 6/12/24 at approximately 3:40 am with no new orders and that he was fine it was just Anxiety. One to one provided to resident upon return as an immediate intervention for all day on 12th . On 6/14/24 at approximately 3 am staff completed room check and observed (Resident #701) with phone cord around his neck, the cord was cut off with scissors he was alert .The physician was called at 3:30 am and received orders to send to (emergency room) for inpatient. Social worker at hospital completed petition, and physician completed cert for involuntary placement. Facility tracked progress of resident during psychiatric placement, because of residents' acuity he was not placed at a psychiatric facility .From facility investigation we revealed that facility failed to appropriately denote 1 to 1 of staffing and maintaining safety of resident with recent active suicidal attempt as well as suicide precautions. Facility implemented suicide policy, as well as how to complete room sweeps, and how to petition residents out for active suicidal ideations .</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 8/15/2024 at 1:25 PM, an interview was conducted with Nurse C regarding Resident #701's first suicide attempt. Nurse C explained there was never any indication that he was suicidal. She recalled charting at the nurses' station and the call light sounding, Resident #701's roommate was blind and a fall risk so Nurse C immediately responded to the alarm and saw Resident #701's roommate was sleeping. She then pulled back the privacy curtain to check on Resident #701 and found the pull sting from the light above his bed and string for his gown tied tightly around his neck and knotted. Nurse C stated this was toilet paper in between the two stings. The Nurse was able to cut the strings from around his neck. Resident #701 was breathing, was not gasping for air, no skin discoloration and his vitals were stable.</p> <p>Past Non-Compliance (PNC):</p> <p>During the onsite survey, Past Non-Compliance (PNC) was cited after the facility implemented actions to correct the noncompliance which included:</p> <p>1.Systemic Changes to Prevent Recurrence:</p> <ul style="list-style-type: none"> - DON/designees started education on 6/14/24, with Licensed Nurses on the process when the schedule does not appear to be correct who to call. Suicide precautions with emphasis on making sure we sweep and remove all items including trash liners, sheets, belts phone cords, call lights, shoestrings, belts anything that resident may use to harm themselves. Education completed with scheduler on making sure sitters are identified on schedule and it is accurate. Staff members are not permitted to work a shift until education has been completed -The administrator/Designee will interview 4 staff members weekly times 4 weeks, then monthly times 1 to verify understanding of who to call when they have concerns with the schedule or schedule is not accurate with a summary of findings to QAPI for review and recommendations. -Identified residents at risk for suicidal ideations or harmful behavior will be reviewed in Behavior Management weekly time four weeks then bi-weekly times 2 weeks, and then monthly times one, with findings submitted to QAPI for review and recommendations. -The DNS/Designee will review new admissions for suicidal ideations risk and assure interventions are put in place, three times a week for 4 weeks, and then weekly times 2 weeks, and then monthly with findings submitted to QAPI for review and recommendations. <p>The facility was able to demonstrate monitoring of the corrective actions and maintained compliance.</p> <p>Compliance Date: 06/15/2024.</p>		