

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 09/25/2024
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 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49944</p> <p>This Citation pertains to Intake Number MI00147096.</p> <p>Based on interview and record review the facility failed to assess and monitor one resident (Resident #1) with pressure ulcers upon admission of 3 residents reviewed for pressure ulcers, resulting in the facility not documenting on pressure ulcers upon admission.</p> <p>Findings Include:</p> <p>Resident #1 (R1):</p> <p>Resident #1 is a 56-yo female who was admitted to the facility on [DATE] with diagnoses that include, necrotizing fasciitis, end stage renal disease, type 2 diabetes, peripheral vascular disease, dependence on renal dialysis and bilateral above the knee amputations.</p> <p>On 09/23/24, record review of a progress note dated 09/10/24 revealed that R1 had pressure ulcers upon discharging the hospital located on the coccyx and right ischium area and was to continue receiving wound care. These pressure ulcers were not identified upon admission to the facility.</p> <p>On 09/23/24, record review of a discharge summary dated 09/13/24 revealed that R1 had an active hospital diagnosis of a stage 3 pressure injury of the buttocks.</p> <p>On 09/23/24, record review of a skin evaluation in the facilities EMR (Electronic Medical Record) dated 09/12/24 revealed that R1 had an open area on the left buttocks and a treatment was put in place.</p> <p>On 09/23/24 at 3:37 PM, an interview was conducted with UM (Unit Manager) B. UM B did the skin assessment for R1 on 09/12/24 on admission. UM B stated they observed what appeared to be a bruise on the right buttocks and that R1 had self-inflicted scratch wounds on her right and left posterior thighs. UM B was asked if they noted any other skin conditions for R1. UM B stated that no other skin conditions were present on admission.</p> <p>On 09/25/24, record review of a transfer form assessment in the EMR revealed that R1 was sent out of the facility to the ER (emergency room) on 09/17/24 at 12:33 PM for altered level of consciousness.</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 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 09/25/24, record review of progress notes from the ER dated 09/17/24 at 2:03 PM revealed that the resident had pressure ulcers noted to the right back area and extending to the right thigh. A progress note dated 09/18/24 from the wound care nurse at the hospital noted stage 3 pressure ulcers to the right ischium (back area), right upper posterior thigh, coccyx and left ischium (back area). These were noted to be present on admission to the hospital.</p> <p>On 09/25/24 at 11:25 AM an interview was conducted with NP (Nurse Practitioner) C. NP C stated that they saw the resident but did not visualize the skin, the nurse did the skin assessment, and the physician did the initial visit with R1. NP C was asked if it was possible for R1 based on her clinical conditions, to have wounds develop and worsen. NP C stated that it is possible that the wounds could have developed and/or worsened.</p> <p>Record review of the policy titled, Wound Prevention, reviewed 12/12/23 revealed:</p> <p>POLICY</p> <p>To prevent the formation of avoidable pressure injuries and to promote healing of existing pressure injuries, it is the policy of this facility to implement evidence-based interventions for all residents who are assessed at risk or who have a pressure injury present.</p> <p>PROCEDURE</p> <p>1. Individualized interventions will address specific factors identified in the resident's risk assessment, skin assessment, and any pressure injury assessment (e.g., moisture management, impaired mobility, nutritional deficit, staging, wound characteristics).</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49944</p> <p>This Citation pertains to Intake Number MI00147096.</p> <p>Based on interview and record review the facility failed to monitor one resident (Resident #1) requiring dialysis services of 3 residents reviewed, resulting in the resident being discharged to the emergency room with hallucinations and confusion.</p> <p>Findings include:</p> <p>Resident #1 (R1):</p> <p>Resident #1 is a 56-yo female and admitted to the facility on [DATE] with diagnoses that include, necrotizing fasciitis, end stage renal disease, type 2 diabetes, peripheral vascular disease, dependence on renal dialysis and bilateral above the knee amputations.</p> <p>On 09/23/24, record review of R1's physician orders in the EMR (Electronic Medical Record) revealed that R1 was to receive Hemo-Dialysis three times a week on Monday, Wednesday and Friday. R1 admitted to the facility on a Thursday 09/12/24 and R1's first dialysis treatment in the facility should have been Friday 09/13/24.</p> <p>On 09/23/24, record review of a progress note dated 09/13/24 revealed that the facility had notified the hospital that they were attempting to arrange dialysis treatment for R1, but that the dialysis facility was not accepting the resident and stated that R1 had not been at that dialysis facility since May of 2024.</p> <p>On 09/23/24 an interview was conducted with Admissions B. Admissions B stated that R1 was supposed to go to Davita [NAME] Point for dialysis but when they called there to set up the appointment on 09/13/24 they were informed that the dialysis center had no chair time for R1. Admissions B stated they then contacted the nurse navigator at the hospital and the nurse navigator said they would call them back once they had something set up for R1. Admissions B was asked if the nurse navigator called her back with a chair time for R1. Admissions B stated that the nurse navigator did not call her back and that they had to call the nurse navigator again on 09/16/24 and follow up with a chair time. Admissions B was asked if R1 received any dialysis treatments while admitted to the facility. Admissions B stated that R1 did not receive dialysis treatment during their stay from 09/12/24 to 09/17/24.</p> <p>(continued on next page)</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 09/23/24 at 1:43 PM an interview was conducted with the DON (Director of Nursing), The DON stated upon admission to the facility that none of the DaVita facilities would accept R1. The DON stated the DaVita facilities told them that R1 refused to attend dialysis in the past so they gave up her chair time. The DON was asked when R1 had their last dialysis treatment. The DON stated that they believe R1 had dialysis on 9/12/24, the day of admission and then they attempted to change R1's schedule to Tuesday, Thursday, Saturday. The DON stated that the resident had not been to Davita since around May 2024. The DON was asked why R1 was sent to the ER (emergency room) on 09/17/24. The DON stated that R1 went to the hospital with confusion and hallucinations. The DON was asked if R1 had received dialysis treatment during their stay at the facility. The DON stated they believed R1 had dialysis on September 14, 2024 while in the facility. This surveyor requested that paperwork. The DON came back after looking for the dialysis paperwork and stated that R1 did not receive dialysis while here in the facility.</p> <p>On 09/23/24 record review of a progress note dated 09/11/24 at 11:40 AM revealed that R1 was in the process of receiving dialysis that day.</p> <p>On 09/23/24 at 2:58 PM an interview was conducted with family member E of R1. Family E was asked what they knew about R1 and the dialysis treatments they were supposed to receive. Family E stated they were told by the hospital that dialysis was set up for R1 and that the facility was turned away from the dialysis center when they attempted to take R1 to dialysis. Family E stated that they had come to the facility to check on R1 and stated the nurse providing care did not know R1 needed dialysis until finding a physician's order for it. Family E was asked about R1 being sent to the ER on [DATE]. Family E stated that they initially did not know R1 was sent to the ER. Family E was unsure why the facility wouldn't send out R1 sooner to have dialysis completed in the ER until an official chair time was set up.</p> <p>On 09/25/24, record review of the EMR document eInteract Summary for Providers dated 09/17/24 at 12:33 PM revealed that R1 was being sent to the ER for hallucinations such as seeing mice on her body and because she had not been dialyzed in 5 days. The primary physician reached out to the nephrologist and the nephrologist advised to send R1 to the ER for emergency dialysis.</p> <p>On 09/25/24 at 11:25 AM an interview was conducted with the NP (nurse practitioner). NP C was asked about R1 and their dialysis. NP C said they saw R1 on admission, but the physician did the first visit. NP C assumed the resident had a nephrologist after getting their permacath (catheter for dialysis treatments) replaced in the hospital. NP C stated they called around to different dialysis centers and different nephrologists and none said they took R1 on as a patient. NP C was asked if it would have been possible to send R1 to the emergency room sooner to get dialysis completed while looking for a new center. NP C stated they did send her to the emergency room but said we could have sent her sooner after missing her first appointment. In hindsight said it could have been handled better.</p> <p>(continued on next page)</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 9/25/24 at 11:47 AM, an interview was conducted with the DON. The DON was asked if the nurses could have sent R1 out to the ER sooner since she hadn't had dialysis since 09/11/24. The DON stated that R1 was no different cognition wise from admission until the day she was sent out with her cognition becoming a problem, that is why we didn't think there was a change. The DON was asked if they could have monitored R1 better to see if they were in need of dialysis. The DON stated that on Monday afternoon 09/16/24, they wondered if the resident should have been sent out based on missing two treatments and thought about ordering labs to monitor kidney function. The DON was asked why they didn't order labs to monitor or send R1 out. The DON stated that months had gone by since she was last dialyzed, three or four months ago, so they were questioning on 09/17/24 whether R1 was hallucinating or not. That's why they didn't send R1 out earlier.</p> <p>On 9/25/24 at 12:25 PM, an interview was conducted with LPN D. LPN D was asked why R1 was transferred to the ER on [DATE]. LPN D stated they transferred R1 out because they hadn't had dialysis in a while and they were seeing mice/rats crawling on their body and around the room. LPN D believes R1 had their last dialysis treatment in the hospital, but the paperwork they received said R1 hadn't been there since May 2024.</p> <p>On 09/25/24, record review of the EMR for R1 revealed an admission weight of 167 lbs on 09/12/24, no other weights had been taken. There was no lab work ordered or completed for R1 to monitor kidney function while dialysis treatments were not being completed.</p> <p>On 09/25/24 record review of progress notes dated 09/17/24 and 09/18/24 revealed that the resident received dialysis on 09/17/24 and 09/18/24 after arriving at the ER.</p> <p>Record review of the policy titled, Dialysis, reviewed 12/12/23 revealed:</p> <p>11. If dialysis is canceled or postponed, the facility and dialysis staff will provide or obtain ongoing monitoring and medical management for changes such as fluid gain, respiratory issues, review of relevant lab results, and any other complications that occur until dialysis can be rescheduled based on resident assessment, stability and need.</p>		