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	05/08/2025

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 39059 Based on observation, interview and record review, the facility failed to assess and monitor a percutaneous enteral tube (PEG) insertion site, provide enteral nutrition and obtain an admission weight timely for one resident (Resident #3) of three residents reviewed for enteral nutrition, resulting in a reddened area going unnoticed. Findings include: Resident #3: On 5/7/25, at 2:10 PM, Resident #3 was resting in their bed with family at their bedside. There was an enteral tube feeding pump that read clog in line down pump. The tubing was hooked to Resident #3's abdomen. Resident #3 had a slight scowl. Their family complained that the nurse had just hooked it up and now it was alarming. Resident #3's shirt was lifted slightly which exposed a white dressing at the PEG insertion site. The family member complained that they didn't feel the nurses were looking at the area. There was a split sponge on the insertion site that was undated. The family offered that they found the dressing on the nightstand and placed it to the tube site that morning as the area looked reddened and sore. The family member lifted the edges of the dressing which revealed an approximate 1 inch by 1 inch reddened area that had a slight raised appearance. Resident #3 scowled slightly and shook their head yes when asked if it was painful. On 5/7/25, at 2:20 PM, a record review of Resident #3's electronic medical record revealed an admission on 4/18/2025 with diagnoses that included Aphasia following cerebral infarction (stroke), right sided weakness (hemiplegia) and gastrostomy status. Resident #3 had intact cognition and required extensive assistance with Activities of Daily Living. A review of the physician orders revealed Enteral Feed Start Date 4/19/2025 1800 (6:00 PM) There was no order to care for the PEG site. A review of the progress notes revealed no documentation on the assessment or care of the PEG site. A review of the weights revealed the first weight was obtained on 4/23/22025 09:01 Value 193.2. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/7/25, at 2:30 PM, an interview and record review with Registered Dietician (RD) C was conducted. RD C was asked why Resident #3's admission weight was not obtained until day 5 and RD C offered that they only come to the building on Wednesday's and that they asked for it on that day. A review of the hospital discharge medication list revealed Glucerna was written down. RD C was asked what that meant and RD C offered that Glucerna is routinely Glucerna 1.5 and the facility had Glucerna 1.2 in stock so that is what Resident #3 received until the 1.5 arrived. RD C was unsure why Resident #3 did not have an enteral solution order until 24 hours after admission. On 5/7/25, at 2:50 PM, an interview and record review along with the Director of Nursing (DON) was conducted of Resident #3's electronic medical record. The DON was asked why Resident #3's admission weight was obtained on day 5 and there was no PEG site assessments documented since admission and the DON offered, they would check into it. The DON was also asked why Resident #3 didn't have an order for their enteral feed until 24 hours after admission and the DON again offered, they would check into it. The DON was asked to provide any additional documentation the facility had on Resident #3 regarding the PEG tube feeding and care. On 5/8/2025, at 10:30 AM, the DON offered that the admitting nurse called the hospital to get the tube feed orders and did provide enteral feed nutrition the day of admission. The DON was asked why there wasn't a physician order for the day of admission and not until the next day at 6:00 PM and the DON offered, the nurse forgot to put it in and that the nurse placed a late entry note. A record review revealed Late Entry Created Date 5/7/2025 19:48 Patient is a new admit, Patient is NPO and a tube feed patient, discharge summary from the hospital didn't state tube feed orders, staff had to reach out to the hospital and request tube feeding directions and instructions and rate; after receiving such information patient tube feeding was started and patient was given his feeding and flushes On 5/08/2025, at 11:15 AM, an observation of Resident #3's PEG site along with the DON was conducted. There was a split sponge that was dated 5/8. The DON pulled up the edges of the dressing to expose the insertion site which revealed a 1 inch by 1 inch bright red shiny area with noted raised pimple like areas. The DON offered, they will call the provider and get an order. On 5/08/2025, at 12:48 PM, the DON was further interviewed regarding Resident #3's PEG care and missed/late medications. The DON was asked why the electronic medical record revealed no documented assessments of the PEG insertion site and the DON offered, the nurses are reading the weekly skin evaluations as if there are new issues and he came to us with his PEG so it is not a new skin problem. A review of the Nursing admission assessment revealed no skin assessment of PEG insertion site. A review of the facility provided ENTERAL FEEDING POLICY Date 1/2/2024 revealed It is a policy of this facility to utilize feeding tubes in accordance with current clinical standards of practice, with interventions to prevent complications to the extent possible . The enteral retention device will be checked daily to assure it is properly approximated to the abdominal wall and that the surrounding skin is intact . Examination and cleaning of the insertion site in order to identify, lessen, or resolve possible skin irritation and local infection Direction for staff regarding nutritional products and meeting the resident's nutritional needs will be provided . ensuring that the administration of enteral nutrition is consistent with and follows the practitioner's orders . (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility provided policy WEIGHT MONITORING Date 1/2/2024 revealed Upon admission (or return to the facility from a hospital stay), the resident's weight and height will be taken and recorded in the EMR by the admitting nurse . During exit conference, The Administrator offered that the facility did get a weight on Resident #3. The Administrator was asked if obtaining the weight on day 5 was considered an admission weight with someone that received enteral nutrition and the Administrator responded, he was still in his assessment period. Both the DON and Administrator responded that with the lack of documentation on the PEG care that wouldn't be charted on as the facility documents on exception so that would not be a new skin area.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39059 Based on interview and record review, the facility failed to provide medications timely for one resident (Resident #3) of three residents reviewed for pharmacy services, resulting in late and missed medications. Findings include: Resident #3: On 5/7/25, at 2:20 PM, a record review of Resident #3's electronic medical record revealed an admission on 4/18/2025 with diagnoses that included Aphasia following cerebral infarction (stroke), right sided weakness (hemiplegia) and gastrostomy status. Resident #3 had intact cognition and required extensive assistance with Activities of Daily Living. On 5/7/25, at 2:50 PM, an interview and record review along with the Director of Nursing (DON) was conducted of Resident #3's electronic medical record. A record review of Resident #3's medication admission record was conducted. The DON was asked why there were numerous medications documented with a 9 or left completely blank and not signed out and the DON offered, they would check into it. On 5/8/25, at 10:35 AM, a further record review of Resident #3's Medication Administration Record 4/1/2025 - 4/30/2025 along with the DON revealed the following missed or late medications: Atorvastatin Calcium Oral Tablet 80 . 2000 Sat 19 there was 9 (see progress note) documented. Amantadine HCl Oral Solution 50 MG/5ML [NAME] Give 10 ml via G-Tube two times a day for Parkinson's -Start Date-04/19/2025 . 0800 Sat 19 there was 9 documented and for the 1600 dose the box was blank. Famotidine Tablet 20 MG Give 1 tablet via G-Tube two times a day for acid indigestion -Start Date-04/19/2025 0800 . for the dose at 2000 there was a 9 documented. Metoprolol Tartrate Oral Tablet 25 MG Give 1 tablet via G-tube two times a day for high blood pressure -Start Date- 04/19/2025 0800 . for the [NAME] at 2000 there was a 9 documented. Heparin Sodium Injection Solution 5000 UNIT/ML Inject 1 milliliter subcutaneously every 8 hours for anticoagulant blood thinners -Start Date- 04/19/2025 0000 (midnight) . for the doses on 4/19/2025 at 0800 and 4/20/2025 at 0000 there were 9 documented. For the doses ordered for 4/19/2025 1800 and 4/21/2025 1800 the boxed were left blank. The DON was asked why Resident #3 didn't receive their medications as ordered and the DON offered, if you don't get the orders in before 2:00 PM they wont be in the 2:00 AM delivery. The DON offered that the pharmacy doesn't do emergency drops for new admits and that most of the meds should be in back up. The DON was asked to provide the back up medication list and the pharmacy contract. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/08/2025, at 11:27 AM, The DON was asked if they ever obtain medications from local pharmacies until their contracted pharmacy could deliver and the DON offered no because the pharmacy does do the drop ships. The DON offered that the pharmacy is located in Indiana. On 5/08/2025, at 12:48 PM, the DON was further interviewed regarding Resident #3's missed/late medications. DON offered as to the missed Heparin injections that the nurse did get it out of back up but forgot to sign it was given. During exit conference, The DON again offered, that the Heparin was given. A review of the facility provided Pharmacy Contract revealed . 24-hour Emergency Delivery means the medication for a resident is for a new admission or a change in medication that requires a delivery prior to the next scheduled Facility Delivery per their agreed schedule . Pharmacy agrees to provide pharmaceutical services (including prescription and non-prescription medications) to Facility and its Residents as requested by Facility pursuant to an order from the Resident's attending physician of for Facility's account . New prescription orders that are requested by the prescribing practitioner to start on the day prescribed, or doses that are not available to meet the days needed will be delivered by Pharmacy, or its secondary pharmacy when applicable, on that same day. Pharmacy will also deliver new and changed prescription medications to Facility after regular business hours whenever deemed medically necessary by the practitioner . Pharmacy shall contract with a designated back up pharmacy to provide the Services after hours if appropriate .