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	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Majestic Care of Flushing	540 Sunnyside Drive 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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This Citation Pertains to Intake Numbers MI00152877 and MI00152910. Based on observation, interview and record review, the facility failed to ensure wounds were assessed, monitored, and that appropriate interventions were in place for 3 Residents (#1, #2, #3) of 3 residents reviewed for wounds, including Resident #1 who had a above the right knee amputation after a lack of assessment and monitoring, infection and a dehisced/opened right below the knee amputation surgical site. Findings Include: Resident #1: A record review of the Face sheet and Minimum Data Set/MDS assessment indicated Resident #1 was admitted to the facility on [DATE] with diagnoses: recent right below the knee amputation, diabetes, COPD, heart disease, atrial fibrillation, peripheral vascular disease, history of a stroke, depression and arthritis. The MDS assessment dated [DATE] revealed the resident needed assistance with care. The resident was transferred to the hospital on 5/1/2025 for additional surgery. Further review of the MDS assessment dated [DATE] for Resident #1 identified in Section M that the resident had a surgical wound and there was no treatment. A review of the admission Skin assessment for Resident #1 titled, Skin Evaluation, dated 3/31/2025 did not mention Resident #1 was admitted with a surgical wound related to a recent right below the knee amputation. On 4/3/2025 a Skin Condition Evaluation, revealed the resident had a RBKA (right below the knee amputation) surgical incision with no measurements. It did not identify if staples or sutures were present. It indicated a non-removable pressure dressing intact. There was no assessment of the surrounding skin (peri-wound). The assessment also provided, unable to see with this assessment due to dressing that stays in place until next appt. (appointment). On 4/10/2025 a Skin condition Evaluation, identified a RBKA, surgical incision, with no measurements. There was no mention of sutures or staples or what the peri-wound looked like. (continued on next page)

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

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F 0684 Level of Harm - Actual harm Residents Affected - Few	A review of the Hospital discharge instructions dated 3/31/2025 for Resident #1 identified the following: Leg Amputation, Care After . Check your residual limb, especially your incision, every day. Check for: Blisters, Scrapes, Signs of infection, such as: More redness, swelling, or pain. More fluid or blood; warmth, Pus or a bad smell. Follow instructions from your health care provider about how to take care of your incision . Change your dressing as told by your health care provider . Leave stitches (sutures), staples, skin glue, or adhesive strip in place. These skin closures may need to stay in place for 2 weeks or longer . A review of the progress notes for Resident #1 identified there was no mention of the resident's surgical incision, assessment or monitoring from 3/31/2025 the day of admission through 4/14/2025. A review of the March and April 2025 Medication Administration Records/MAR and Treatment Administration Records/TAR for Resident #1 identified there was no mention of assessment or monitoring of the Right below the knee amputation surgical site from the day of admission 3/31/2025 through 4/14/2025. A review of the Interdisciplinary Team document titled, IDT Care Plan Conference Summary, dated 4/3/2025 and locked 4/10/2025 revealed there was no mention of Resident #1's right below the knee amputation surgical site. The Nursing Goals and Summary section of the document was blank. A review of the physician orders indicated there was no mention of assessment or monitoring of the resident's RBKA surgical site until 4/15/2025: two weeks after the resident was admitted with the RBKA surgical site. A review of the Care Plans for Resident #1 revealed the following: (Resident #1) has impaired skin integrity: admitted with a R BKA surgical incision, date initiated 3/31/2025 and revised 4/18/2025 with interventions including: Assess and document skin condition, notify MD of signs of infection (redness, drainage, pain, fever), date initiated 3/31/2025; Wound treatment as ordered, date initiated 3/31/2025. Further review of the progress notes identified a Late Entry note dated 4/15/2025 at 12:30 PM, The resident returned from his appoint (ment) with a dehisced (surgical incision opened on its own) wound, to the R. BKA. Cleanse with wound cleanser, pat dry, apply iodoform packing into wound bed, apply skin prep to peri wound and allow to dry, cover with bordered dressing. Change daily and prn (as needed). The physician orders the resident to be on 1 tablet by mouth two times a day for skin infection to surgical wound until 4/25/2025. A Vascular Surgical consult note dated 4/15/2025 revealed, S/P (status post) right BKA 3/26/25 Surgical wound with dehiscence @ mid-incision. Staple removed here and there is tunneling about 1 ½ inch deep. Bloody/purulent drainage. This will need to be packed daily with packing strips. Rec. (recommend) Bactrim DS 800 mg/160 mg po BID (twice a day) x 10 days; Schedule surgical washout and debridement . Further review of the April 2025 MAR/TAR's for Resident #1 revealed a new entry dated 4/16/2025, RBKA surgical wound. Cleanse with wound cleanser, pat dry, apply iodoform packing into wound bed, apply skin prep to peri wound and allow to dry, cover with bordered dressing. Change daily and prn (as needed, every day shift for surgical wound care. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	A progress note dated 4/24/2025 at 1:28 PM revealed, Patient had pressure dressing to RBKA from admission until follow up with ortho. At that follow up appointment, incision was noted with open wound and infection. RBKA surgical incision with wound is currently treated with antibiotic therapy. Around the incision is not healing with the intention of surgeon's treatment order. Wound has slough (dead stringy tissue), copious serosanguinous drainage. Redness, swelling and warmth remains to suture line . A review of a Vascular Surgical consult dated 4/25/2025 for Resident #1 provided, Wound check of Right Below Knee amputation stump- non- healing . Debridement in hospital- please hold Apaxiban appropriately . On 5/13/2025 at 1:49 PM , Confidential Person E was interviewed about Resident #1's RBKA and said the resident was admitted to the facility on [DATE] from the hospital after having surgery: a right below the knee amputation/RBKA. She said the resident had a history of circulation issues, poor blood flow and prior wounds to his right lower leg. She said that is why he had an RBKA and needed to be monitored closely. She said the hospital discharge instructions said the surgical wound was to be inspected daily. Confidential Person E said the resident had a follow-up appointment with the Vascular Surgeon on 4/15/2025 and at that appointment the surgical wound opened up because it was infected and was not being monitored. She said the wound needed to be surgically cleaned (debrided, with removal of the dead tissue). At the resident's next appointment with the Vascular Surgeon on 4/25/2025 he was scheduled to have the debridement, but could not have it because the facility did not appropriately hold the resident's blood thinners prior to the procedure, so it could not be done. She said she was told if the wound did not heal, the resident would need another surgery: a right above the knee amputation. She said the resident went back to the hospital on 5/1/2025 to have the right above the knee amputation. During an interview with Wound Care Nurse A on 5/14/2025 at 8:50 AM, she was asked about Resident #1's RBKA and whether the surgical wound was being monitored. She said she was told by one of the medical providers that some surgeons do not want the surgical dressing to be removed prior to the scheduled post-surgical follow-up appointment, so the facility did not remove it. Nurse A was asked if the Surgeon's office was contacted to obtain information on how to care for the surgical site and she said the office was not contacted until after the first appointment on 4/15/2025. She was asked if there was documentation that the nurses were routinely assessing and monitoring the wound and she said there was a weekly skin assessment. Reviewed with Nurse A that the assessments did not describe the condition of the wound, how many staples, sutures or the surrounding skin. Nurse A was asked if it had been reviewed with the resident's physician at the facility, as there was no order not to monitor the surgical site or how to care for the wound. She said after the 4/15/2025 appointment, the nurses performed wound care daily, as the wound was infected and had opened. There was no routine documentation of assessment or monitoring to aid in identifying a change in the condition of the wound. Resident #2: A record review of the Face sheet and MDS assessment indicated Resident #2 was admitted to the facility on [DATE] with diagnoses: recent right above the knee amputation 5/2/2025, diabetes, chronic kidney disease, heart disease, and anxiety. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 5/14/2025 at 9:00 AM, Resident #2 was observed awake, alert, and sitting up in bed. Wound Nurse A was present and rolled up the resident's right pant leg to visualize his surgical site. Nurse A said there were 20 staples and 10 sutures; all were intact without redness or drainage. The resident said he had a dressing on the wound, but it was new, and he took it off because it was bulky. He said the nurses checked the incision every other day. A record review of the admission Skin assessment for Resident #2 titled, Skin Evaluation, dated 5/9/2025 and locked 5/10/2025 revealed the resident had a wound on the Right lower leg (rear) and Treatment was applied. There was no mention of the right above the knee amputation site. A review of a progress note dated 5/12/2025 at 6:19 PM revealed, Resident's right AKA (above the knee amputation) surgical site was assessed this a.m. Incision line is well approximated with staple intact. No redness. Swelling, or drainage noted. Orders to leave incision open to air for healing. Will continue to monitor . The resident had been in the facility for 3 days and this was the first note describing his right AKA surgical site. A record review of the physician orders for Resident #2 identified the following: Wound care: monitor right AKA site and sutures every shift. Notify Dr. If changes or signs and symptoms of infection (drainage, redness, swelling) may cover with dry dressing if needed, dated ordered 5/12/2025. This was the first order to monitor the resident's right AKA surgical wound. The assessment started 4 days after admission. A review of the May 2025 MAR/TAR's for Resident #2 revealed, Monitor right aka for signs/symptoms of infection q (every) shift, start date 5/12/2025 and Wound care: monitor right AKA site and sutures every shift. Notify Dr. If changes or signs and symptoms of infection (drainage, redness, swelling) may cover with dry dressing if needed, every day and night shift for wound care, start date 5/13/2025. A review of the Interdisciplinary Team (IDT) note titled, IDT Care Plan Conference Summary, dated 5/12/2025 and locked 5/13/2025 had a section titled Nursing goals and summary; this was blank. A review of the Hospital discharge instructions dated 5/9/2025 for Resident #2 included, Instructions: Wound care for right AKA: Ace wrap and elevate the R AKA to compress the stump and reduce edema until 5/9; Start wearing stump shrinker on 5/9; Sutures and staples to remain in place for 3 weeks, will be removed at outpatient follow up with (surgeon); You may shower but do not soak the wound in water or scrub at the incision line. Further review of the physician orders for Resident #2 identified an order written on 5/13/2025, Apply stump shrinker, one time a day for wound care, start date 5/14/2025. This was 5 days after admission. A review of the Care Plans for Resident #2 identified the following: (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	(Resident #2) has impaired skin integrity: Right AKA surgical site, date initiated 5/10/2025 and revised 5/12/2025 with Interventions including: Wound treatment as ordered, dated 5/10/2025. There was no mention of the Hospital discharge recommendations including an assessment of the staples/sutures, how to shower or that the resident was to wear a stump shrinker beginning on the day of admission. Resident #3: A record review of the Face sheet and MDS assessment indicated Resident #3 was admitted to the facility on [DATE] with diagnoses: acquired absence of left great toe, heart failure, diabetes, peripheral vascular disease, visual loss both eyes, anxiety, depression and history of falls. The MDS assessment dated [DATE] revealed the resident had full cognitive abilities with a Brief Interview for Mental Status score of 13/15 and the resident needed assistance with some care. On 5/14/2025 at 9:15 AM, Resident #3 was observed sitting in a chair in her room. She had two wound dressings: one on her right mid- shin and one on her left great toe amputation site. Both dressings were dated 5/13/2025. Wound Nurse A was also present and said she changed the dressings on 5/13/2025. Resident #3 said she worries about her left great toe site because the toe was already amputated and she is worried if it doesn't heal, she will lose more of her foot. She said the nurses were not always changing the dressing. Wound Nurse A removed the dressing on the left great toe area to observe the wound. The area was open approximately 1.2 cm x 1.2 cm in circumference with yellow stringy slough. The Wound Nurse said she was using Therahoney and calcium alginate over the area. The surrounding area was very red and inflamed. A review of the Nursing admission Skin Assessment titled, Skin Condition Evaluation, dated 4/28/2025 and completed 4/30/2025 (4 days after admission), identified two wounds present on admission: Right lower leg (front); laceration; length 4 cm, width 0.5 cm Left toe; surgical incision There was no measurement. Scabbed over; 100% wound covered over, surface intact Calloused-Fibrotic or Hyper-keratotic; Fragile: Skin that is at risk for breakdown; Intact: Unbroken skin No swelling or edema. A Skin Condition Evaluation, dated 5/1/2025 and locked on 5/5/2025 identified the following: Left toe; surgical incision; 1.8 cm length, 1.2 cm width and 0.1 cm depth; No closure measure present; Granulation, Slough (dead stringy tissue); 90% of wound bed filled Amount of exudate (drainage): moderate; Type of exudate: serosanguinous (fluid with blood); Peri-wound edges: Non-Attached: Edge appears as a cliff; Fragile skin that is at risk for breakdown; No swelling or edema. A Skin Condition Evaluation, dated and locked 5/8/2025 identified the following: Left toe; surgical incision; 1 cm length, 1.1 cm width, 0.1 cm depth; No closure method; Slough; 100% of wound filled; Amount of exudate: Moderate; Type of Exudate: serosanguinous; Periwound edges: Attached: Edge appears flush with wound bed or as a sloping edge; Periwound surrounding tissue: Intact: Unbroken skin; Normal in color; No swelling or edema. A review of the physician orders for Resident #3, on 5/14/2025 at 9:30 AM, identified the following: There was no order for a wound dressing/treatment for Resident #3's left great toe open wound. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	A review of the April and May 2025 Medication Administration Record/Treatment Administration Record (MAR/TAR) for Resident #3 revealed there was no documented treatment to the resident's left great toe open area. A review of an Infection screening Evaluation, dated 4/30/2025 and locked 5/6/2025 provided, Infection Analysis: . Suspected skin and soft tissue infection; McGeer's Criteria Met: Cellulitis, Soft tissue or wound infection. There was no identification of the infection location. On 5/14/2025 at 9:30 AM, Wound Nurse A was interviewed about the lack of a wound order for Resident #3's left great toe amputation site. She said she thought it was included in the order for the resident's right lower leg treatment. A review of the order revealed the left great toe was not mentioned. A review of the progress notes, MAR/TAR and nursing assessments did not identify routine assessment and monitoring of Resident #3's left great toe except for a weekly measurement by the Wound Nurse A. The wound had developed yellow stringy slough, and the peri-wound was reddened and inflamed. There was no order for the wound dressing that was observed on the left great toe area on 5/14/2025. Resident #3 had verbalized that the nurses were not consistently providing wound care to the left great toe area, but wound care was not ordered. A review of the Care Plans for Resident #3 identified the following: (Resident #3) has Skin Trauma upon admission due to post amputation to Left toe and Laceration to right lower extremity- tibial with history of Skin Infection to left toe amputation, date initiated 4/30/2025 and revised 5/7/2025 with Interventions including: Assess and document skin condition weekly and as needed, date initiated 4/30/2025; Document abnormal findings and notify MD, dated 4/30/2025; Observe for symptoms of infections (redness, drainage, warmth, increased pain), date initiated 4/30/2025; Treatment as ordered, 4/30/2025. On 5/14/2025 at 11:00 AM, Nurse C was interviewed about surgical wounds and she said assessment started on admission of the resident. She said the nurse assigned to the resident would complete the assessment and look for skin redness, breakdown, wounds, and if there were dressings. She said the nurse would document in the chart. Unit Manager B was interviewed on 5/14/2025 at 11:10 AM and asked about wound assessment of Surgical wounds. She said the wound should be assessed at least daily and documented and if there were any questions about the surgical wound, the surgeon should be called. The Director of Nursing/DON and Wound Nurse A were interviewed on 5/15/2025 at 9:30 AM, they were asked about assessment and monitoring of surgical wounds and specifically surgical amputations, as Resident's #1, #2 and #3 were not routinely monitored. Resident #1's RBKA was not monitored for 14 days after admission. There was no assessment documentation or routine monitoring to aid in identifying the wound was infected and not healing. Resident #2 did not receive a wound assessment until 3 days after admission and on the 4th day wound monitoring was initiated. Resident #3 did not have an order for treatment to her left great toe amputation site, although a treatment was being applied. The DON said the facility was reviewing their processes to ensure the resident's wounds were appropriately cared for. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Physician F was interviewed on 5/15/2025 at 9:46 AM about Residents #1, #2 and #3, as each had a surgical wound from an amputation and were lacking assessment, monitoring and a written order for wound care for Resident #3. He said the residents' skin should be looked at starting on admission and should be assessed and documented at least daily. He said he wasn't sure why the nurses were not assessing or documenting that this was done. Physician F was also asked about holding a blood thinner when a resident was to have a surgical procedure, and he said sometimes the surgeon would specify how long in advance to hold it. He said it would depend on what blood thinners the resident was taking and what the procedure was. Physician F said if the surgeon did not specify how long to hold the blood thinner, then the provider at the facility would do that. If any questions, the surgeon would be contacted. A review of the facility policy titled, Wound Management Policy, dated effective 5/30/2024 provided, It is the policy of this facility to ensure residents who do not have skin integrity impairments do not develop a new condition affecting the skin. It is also the policy of this facility that those resident with impaired skin integrity are recognized by our care team, treated timely, and interventions to heal are not exhausted until the skin is healed . Resident of this facility have their skin assessed at the time of admission/re-admission and evaluated routinely . A review of the facility policy titled, Anticoagulants, dated original 1/2/2024 did not mention management of the anticoagulant medication/blood thinner prior to a surgical procedure.