

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 08/22/2025
NAME OF PROVIDER OR SUPPLIER Majestic Care of Flushing		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</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 - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake Number 2574995. Based on observation, interview, and record review, the facility failed to provide the appropriate skin care interventions to prevent the development of pressure ulcers and promote healing consistent with professional standards for one resident (R103) of four sampled residents reviewed for pressure ulcers, resulting in a delay in treatment and healing, worsening of newly developed wounds, infection and further complications. Findings Include: Resident #103 (R103) A review of R103 Electronic Medical Record (EMR) was conducted on August 22, 2025, at 3:30 PM. According to the clinical record, R103 was [AGE] years old, admitted to the facility on [DATE], with the diagnosis of laceration of the scalp, Cerebral Palsy, Obstructive Hydrocephalus, and Epilepsy in addition to other diagnoses. R103's Brief Interview for Mental Status (BIMS) Score, assessed on June 27, 2025, was left as zero or 99, indicating that the patient was unable to complete the interview for the assessment. Minimum Data Set (MDS) section GG dated July 1, 2025, indicated that R103 is dependent on staff with all Activities of Daily Living (ADLs), including but not limited to eating, toileting, showers, and personal hygiene. R103 relied on one to two staff members for transferring to and from the chair and bed, as well as rolling in bed from side to side, and using the toilet. General Progress Notes dated 8/8/25, at 9:26 AM, was reviewed, Noted text: Resident's wound has foul odor, and had a temp of 99.1 last evening. Dr K (Last name mentioned) informed and new order received to start Bactrim DS BID (Twice a day) for 7 days. Orders Noted. A review of R103's Care Plan indicated: ADLs Care plan initiated on 6/24/25, revealing the need for assistance with incontinence care, mobility, showers, personal hygiene, toilet use, and transfers. R103 also required one-on-one assistance with feeding. R103 was assessed as a two-person assist using a Hoyer lift. A care plan for Risk of skin breakdown r/t (related to) impaired mobility, contractures, and incontinence indicated that R103 had scarring from previous pressure ulcers to the coccyx and left outer ankle. There was no active open skin breakdown noted upon admission skin assessment on 6/24/25. R103 has impaired skin integrity: Pressure ulcer to coccyx, and wounds to ischium and left heel related to mobility, contractures to lower extremity, incontinence of bowel and bladder. Initiated on 6/24/25, revision date: 8/8/25. Goal: 1.) Tissue injury will improve and be free from complications with a revised date of 8/8/2025. Note: A wound treatment intervention was initiated in R103's care plan on July 16, 2025. The following were R103's recorded Skin Assessment and Condition from admission to discharge (June 23, 2025, to discharge date on August 8, 2025: According to the Skin assessment dated [DATE], upon admission). Staff assessed by: Unknown Staples on top of R103's head from a previous history of scalp laceration Left trochanter hip (closed wound) Left outer ankle (closed wound) Coccyx-Scar tissue with surrounding dark soft tissue DTI (Deep Tissue Injury) Treatment applied: No. A review of the admission Skin Evaluation revealed that it was dated on 6/23/25, but was locked and signed until July 6, 2025. It was unknown who the nurse who did the assessments on June 23rd and who the staff member who locked the assessment in July 6th. The Director of Nursing and the wound Nurse was asked subsequently but no staff member could verify the accuracy of the findings during the surveyor's review on August 22, 2025, at 4:30 PM. The Weekly Skin Evaluation Forms were reviewed on 8/22/2025 at 4:30 PM. It indicated: 06/30/25 A. Skin Evaluation: 1. After completing a head-to-toe skin assessment, are there any new skin areas? NO 07/07/25 A. Skin Evaluation: 1. After completing a head-to-toe skin assessment, are there any new skin areas? NO 07/14/25 A. Skin Evaluation: 1. After completing a head-to-toe skin assessment, are there any new skin areas? NO 07/21/25 A. Skin Evaluation: 1. After completing a head-to-toe skin assessment, are there any new skin areas? NO 07/28/2025 A. Skin Evaluation: 1. After completing a head-to-toe skin assessment, are there any new skin areas? NO 08/04/2025 A. Skin Evaluation: 1. After completing a head-to-toe skin assessment, are there any new skin areas? NO A review of R103's Skin assessment dated [DATE], (noted: this is R103 discharged date from the facility) revealed: Coccyx (UTD)- UTD means unstageable or unknown depth. Measurement size: 7.5 X 7.0 X depth UTD with eschar 100% wound filled, heavy exudate, purulent drainage. Noted erythema described as intense bright red, dark red, or purple. 2. Left Heel-(acquired in house on 7/16/25) Measurement size: 3.5 X 3.5 X depth (UTD) unstageable or unknown depth 100% wound filled slough with a light amount of exudate described as purulent discharge 3. Left Ischium (acquired at the facility, first observed on 7/31/25, described as shearing and UTD (Unstageable Full Thickness or Tissue Loss) Measurement size: 3.0 cm (centimeters) X 3.2 cm x depth UTD, Slough 100% wound filled slough with a light amount of purulent drainage. A review of R103's skin record</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>(continued on next page)</p>

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake Number 2575492 Based on observation, interview and record review, the facility failed to ensure that a resident was appropriately assessed and provided pain relief for one resident (Resident #108), who had chronic pain out of four residents reviewed for pain. Findings include:Resident 108 (R108):R108 was [AGE] years old admitted to the facility on [DATE] with a diagnosis of Acute Pyelonephritis, Urinary Tract Infection, Type 2 Diabetes Mellitus, Gout and unspecified Osteoarthritis in addition to other diagnoses. Care Plan for Pain initiated 8/13/25 revealed: At risk for Pain due to Diabetic neuropathy, depression, gout, GERD, Osteoarthritis. Goal: R108 will verbalize adequate relief of pain. Interventions: Administer medication as ordered, Notify MD of unrelieved or worsening pain, .R108'shad an Order: Oxycodone HCl Oral Tablet 5 MG give one tablet by mouth every 6 hours for pain (start date was 8/20/25 at 20:00 (8:00 PM)).R108's Medication Administration Record (MAR) dated August 2025, showed on August 20th, 2025, R108 received the last dose of the prescribed Oxycodone 5 mg at 11:00 AM. The next Dose administered to R108 was dated 8/21/25 at 8:00 PM. There were 29 hours of no oxycodone pain medication given to R108. The Medication Administration Record (MAR) dated August 2025 noted on the following dates were:8/20/25 20:00 PM (8:00 PM) Not Administered as ordered. Nurse coded 5 which means HOLD/ See Progress Notes 8/21/25 02:00 AM, Not Administered as ordered. Nurse Coded 5 which means Hold/ See Progress Notes8/21/25 08:00 AM, Not Administered as ordered. Nurse Coded 9 which means Other/ See Progress Notes8/21/25 14:00 (2:00 PM), Not Administered as ordered. Nurse Coded 9 which means Other/See progress NotesA review of R108's Pain Record showed8/20/25: Wednesday (order: Monitor Pain assessment every 6 hours)12:17 PM 0/1017:30 (5:30 PM) 0/10 Nurse administered Tylenol22:45 (10:45 PM) 5/10 no pain medication administered8/21/25: Thursday (order: Monitor Pain every 6 hours)11:13 AM 0/10 20:28 (8:28 PM) 0/10Pain assessment was not done according to the order to monitor pain level every 6 hours and medication of oxycodone was not followed to be administered every 6 hours around the clock.On 8/21/25 at 3:30 PM, Resident 108 was restless, sitting up in bed, who appeared to have shortness of breath, sweaty and anxious. When interview, R108 stated she hasn't gotten her pain pill since yesterday afternoon. They said they were out of stock. I am hoping they will get them today. When asked how her pain level was, she replied, right now is a 9/10. When asked where the pain was that was 9/10 she said: I hurt all over but the pain is always on hip and my shoulder. I am waiting for my insurance to clear so I can have surgery to my hip. I take oxycodone. They gave me a Tylenol yesterday at 5:00 PM because I was out of Oxycodone, but it did not help a bit. I did not have any of my oxycodone since I thought around 2:00 PM yesterday. According to the Director of Nursing on 8/21/25 at 3:45 PM, She was unaware about R108's Narcotic issue but we have a backup emergency kit and if not we can have it drop shipped. The Unit Nurse G was interviewed on 8/21/25 at 4:35 PM. Nurse G revealed that he was assigned to R108 yesterday 8/20/25 and she was out of Oxycodone and admitted he was unaware it was available in the EDK. He stated, I was not sure if they have a backup for oxycodone. I was here yesterday, and I gave her the last dose yesterday (8/20/25) was recorded 11:00 AM and we are waiting for her Oxycodone. When asked if he had called or notified the doctor about the held dosages and if there were other pain management alternatives, he denied calling the physician. He did inform the oncoming nurse (night shift that told her that there was no Oxycodone in the back up box. So I have the unit manager help me to order the medication. I told the night shift nurse it was in route but never arrived. Before I left my shift on 8/20/25, Her pain level was a 6/10. I gave her Tylenol at around 5:00 PM on 8/20/25. Today I came that the drop ship did not arrive, so we are still waiting, that's why she has not received any of her oxycodone since yesterday. The Unit Manager I was interviewed on 8/21/25 at 5:00 PM and recalled that Nurse G came to his office to fax the refill order of Oxycodone. I helped him faxed it over but Nurse G never told me that R108 was out of the medication. Nurse G did not notify me that R108 was administered her last dose at 11:00 AM. We have them in Backup. The back up pharmacy was here yesterday and was filling the back-up meds. Oxycodone are available in the back up box. Nurse Manager N was interviewed on 8/21/25 at 5:15 PM. She recalled that on 8/20/25, the Oxycodone order was changed from a PRN (as needed to around the clock every 6 hours. She obtained the order from the doctor and got an order. Nurse Manager N admitted that she was not aware that R108 was out of the Oxycodone. Nurse G never told her. I just found out now. Nurse G did not check the backup box. Oxycodone is available in EDK Although there is a process to obtain the narcotic I can easily help if I was</p>		