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	12/18/2025

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. (continued on next page)

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This Citation Pertains to Intake Number #2688386.Based on observation, interview and record review the facility failed to ensure that nail care was routinely provided for two residents (#1 and #3) of 3 residents reviewed for activities of daily living (ADL), resulting in Resident #1 and Resident #3 having long, soiled, fingernails. 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: bipolar disorder, anxiety, restlessness and agitation, contractures of left hand, left ankle and foot, heart disease, neuropathy, asthma, and recent fracture right hand 3rd finger, and urinary tract infection. The MDS assessment, dated 10/17/2025, revealed the resident had a Brief Interview for Mental Status/BIMS score of 14/15 identifying intact cognitive abilities and needed assistance with all care. The resident was dependent with bathing and needed partial/moderate assistance with hygiene.On 12/16/2025 at 3:50 PM, upon entering Resident #1's room with Nurse A. The resident was observed lying in bed. He said he was upset and verbalized a list of issues. The resident was observed to have a splint on his right hand, over his fingers and a cling wrap was over the splint. The resident had 2 fingers showing on the right hand. Nurse A asked the resident about a jagged notch on his thumbnail. She said the resident had previously scratched his wound on his coccyx when they changed the dressing and the jagged nail had made it bleed. The resident's left hand was noted to be contracted with his fingers curled towards his left-hand palm. Nurse A asked the resident if she could see his nails on the left hand and he said she could. She slowly lifted the fingers, and the nails were observed to be long, discolored, dark and jagged. The resident asked to see them and Nurse A showed them to him; the resident stated, They are starting to curl under. Nurse A asked him if he would like his nails trimmed and he said he would. A review of the Care Plan for Resident #1 identified the following: (Resident #1) is at risk for skin breakdown r/t (related to decreased mobility, long term contractures, deformities of the hands and legs and feet. chooses to keep fingernails long & scratches at his skin, date initiated 4/25/2025 and revised 8/20/2025 with Interventions: Encourage me to trim my nails when I have self-inflicted scratches, date initiated 4/26/2024. (Resident #1) needs assistance with activities of daily living due to CVA with Left hemiplegia. He has deformity of left ankle and contracture of the left hand. Frequently declines care. to have his nails trimmed . Has a right 3rd phalanx fracture., dated initiated 4/25/2025 and revised 1/25/2025. The interventions did not mention assistance with the resident's nail care or identification of an alternate plan to provide nail care.On 12/17/2025 at 10:00 AM, Nurse A Resident #1had agreed to have one hands nails trimmed and the staff assisted him.On 12/18/2025 at 11:00 AM, Nurse A said Resident #1 had both hands nails trimmed. Resident #3:A record review of the Face sheet and MDS assessment indicate Resident #3 was admitted to the facility on [DATE] with diagnoses: Dementia, arthritis, gout, heart failure, anxiety, depression, and hypothyroidism. The MDS assessment dated [DATE] revealed the resident had a BIMS score of 15/15 indicating intact cognition and the resident needed total assistance with bathing and substantial/maximal assistance with hygiene.On 12/16/2025 at 3:32 PM, Resident #3 was observed in her room, sitting in a wheelchair. The resident was noticed to have long, unclean fingernails. The resident was asked about her nails and she said she needed to have them done. Nurse A was present during the observation and asked the resident if she would like to have her nails soaked to remove the debris and then trimmed. Resident #3 asked how they would soak the nails and Nurse A said the Nurse Aide would bring in a basin of warm water to soak them and then clip them.On 12/16/2025 at 3:38 PM, Nurse A was asked when the nails were supposed to be cleaned and trimmed, and she said the task was supposed to be completed with the resident's shower.A review of the Care Plans for Resident #3 identified the following: Resident requires assistance with activities of daily living r/t (related to) RA (rheumatoid arthritis), polyneuropathy, gout, OA (osteoarthritis), history of left hip replacement, dementia; she has right hand contracture, impaired (range of motion to bilateral upper extremities), date initiated 10/21/2025 and revised 10/30/2025 with Interventions: Bathing/showering: Nail care on bath day and as necessary. Report any changes to the nurse, date initiated 10/30/2025.A review of the Tasks: Showers documentation revealed the resident's last shower was 12/9/2025. There was no documentation that nail care had been completed.A policy for Nail care/Showers was requested on 12/17/2025 at 11: 20 AM and not received prior to exit on 12/18/2025 at 2:05 PM.

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(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 - Minimal harm or potential for 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 Number 2688386. Based on observation, interview and record review, the facility failed to ensure that wound interventions were provided as ordered for 1 Resident (# 1) of 3 residents reviewed for wound care.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: bipolar disorder, anxiety, restlessness and agitation, contractures of left hand, left ankle and foot, heart disease, neuropathy, asthma, and a recent fracture right hand 3rd finger, and urinary tract infection. The MDS assessment, dated 10/17/2025, revealed the resident had a Brief Interview for Mental Status/BIMS score of 14/15 identifying intact cognitive abilities and needed assistance with all care.On 12/16/2025 at 3:50 PM, entered Resident #1's room with Nurse A. The resident was observed lying in bed. He said he was upset and verbalized a list of issues. The resident was observed to have a splint on his right hand, over his fingers and a cling wrap was over the splint. The resident had 2 fingers showing. Nurse A asked the resident about a jagged notch on his thumbnail. She said the resident had previously scratched his wound on his coccyx when they changed the dressing. A record review of the physician orders identified the following: Cleanse coccyx with na (normal saline), apply collagen wound filler, then apply comfort foam, change every day and prn (as needed), start date 11/27/2025.A review of the Care Plans for Resident #1 provided: (Resident #1) has impaired skin integrity: self-inflicted scratch to buttocks pressure ulcer to the coccyx, dated initiated 10/22/2025 and revised 11/25/2025 with Interventions, Wound treatment as ordered, date initiated 10/22/2025. On 12/17/2025 at 12:00 PM, Resident #1's coccyx wound dressing change was observed with Wound Nurse B and Nurse Manager A. Nurse A assisted the resident to roll to his left side, and a wound dressing was observed on the coccyx. It was shriveled and wrinkled and dated 12/13. Wound Nurse B was asked to hold up the dressing after it was removed to clarify the date on it and she confirmed it said 12/13. The Wound Nurse said it was supposed to be a daily dressing change. Resident #1 was asked how often his dressing was changed on his coccyx and he stated, About once a week. The resident began rapidly scratching the coccyx area with his right bandaged hand. There were several open areas, and they began to bleed. Resident #1 said the area itched a lot. Nurses' A and B encouraged the resident not to scratch, but he said he couldn't help it.A record review of the Medication Administration Record/Treatment Administration Record (MAR/TAR) for December 2025 on 12/17/2025 revealed the following: Cleanse coccyx with ns, apply collagen wound filler then apply comfort foam change every day and prn; one time a day for opening to skin, start date 11/27/2025. The wound care was initialed as completed on each day of the month including 12/13/2025 (the date on the dressing removed from the resident's wound), 12/14/2025, 12/15/2025, and 12/16/2025. The 12/17/2025 dressing change by Nurse B had not yet been recorded.The nurses had signed that they completed wound care each day, but the dressing had not been changed since 12/13/2025.On 12/17/2025 at 3:30 PM, the Director of Nursing/DON was interviewed about the outdated wound dressing on Resident #1's coccyx. Reviewed with her the dressing was dated 12/13/2025 and was shriveled and appeared it had been on the wound for several days. Reviewed with the DON that the nurses were initialing they had completed the wound care, but it was not done. She said she would look into it.On 12/18/2025 at 9:30 AM, the Director of Nursing was interviewed and said she had check into the dressing changes for Resident #1, she said she had spoken to 2 of the 3 nurses who initialed they completed the wound care and one nurse said the resident would not let her change the dressing. When the DON asked the nurse why she initialed she completed the wound care, the nurse did not have a reason for doing so. Upon review of the progress notes with the DON, it was identified there was no documentation for 12/14/2025, 12/15/2025 or 12/16/2025 that the resident had refused the dressing change. The DON said she would be working with the nurses on wound care. A wound care policy was requested at this time.A wound care policy was not received prior to exit on 12/18/2025 at 2:05 PM.