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	05/21/2026

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This Citation pertains to Intake Number 2997914.Based on observation, interview and record review, the facility failed to ensure appropriate interventions were in place to provide a safe and monitored environment to prevent falls with injuries for 3 residents (Resident #1, Resident #4, Resident #5) of 3 resident reviewed for falls, resulting in Residents #1, #4 and #5 repeatedly falling, hitting their heads and sustaining injuries. Findings Include: FallsResident #1:A record review of the Face sheet and Minimum Data Set/MDS indicated Resident #1 was admitted to the facility on [DATE] with diagnoses: History of Traumatic Brain Injury, history of falls, dementia, diabetes, depression, and heart failure. The MDS assessment dated [DATE] revealed the resident had severe cognitive loss with a Brief Interview for Mental Status/BIMS score of 1/15 and the resident needed assistance with all care.Further review of the MDS assessment revealed Section J: Health Conditions said Resident #1 had 2 or more falls since admission to the facility.On 5/20/2026 at 2:00 PM, the Director of Nursing was asked about Resident #1's history of falls and she said he had a few falls. The Incident and Accident reports for Resident #1 were requested.During a review of the Incident and Accident reports for Resident #1 it indicated that the resident had fallen 16 times since January 2026: 1/21/2926, 2/9/2026, 2/10/2026, 2/14/2026, 2/17/2026, 2/19/2026, 2/21/2026, 2/28/2026, 3/6/2026, 3/8/2026, 3/14/2026, 3/27/2026, 4/3/2026, 4/22/2026, 5/2/2026, 5/2/2026, 5/12/2026.Of the 16 falls Resident #1 sustained, he hit his head 6 times. On 2/17/2026 at 9:50 AM the resident fell in the hallway and per a progress note . hit head hard on floor with instant large hematoma with bleeding. (ambulance) contacted, arrived and left with pt (patient) around 1020.).A progress note dated 2/17/2026 at 5:08 PM provided, Pt returned back to facility by (ambulance) around 1545 (3:45 PM) . Pt received 3 staples to back of head (at hospital) .A physician progress note dated 3/3/2026 at 7:05 AM, revealed . Resident noted to have frequent falls per staff report. Recently evaluated in emergency department following fall from standing with scalp laceration requiring three staples. Staff monitoring closely due to fall risk and cognitive impairment.Three days later, Resident #1 was transferred to the hospital on 3/6/2026 after falling and hitting his head. A progress note dated 3/6/2026 at 10:32 PM provided, Resident was found on the floor holding side of head. Resident stated he was trying to go to the bathroom and lost balance and fell.3/6/2026 at 10:57 PM, a SBAR Summary note . resident was holding side of head by right ear and holding right hip. New Testing Orders: X-ray, CT scan.3/7/2026 at 2:24 PM, a progress note, Pt arrived back from hospital around 0730, CT and x-ray were clear.3/7/2026 at 4:05 PM, Focused charting, Post fall. Pt requires supervision and redirection, consistently attempt to stand or walk from his w/c (wheelchair), pt is unstable and high fall risk.3/8/2026 at 1:31 PM Focused charting, Post fall. Resident requires supervision as he constantly tires to get up from his w/c and is a high fall risk.4/22/2026 at 7:00 PM, a progress note Patient noted lying on the floor in front of nurses station. Patient alert and not giving reason why is on the floor but stating yes did hit his head. small abrasion on left elbow.5/4/2026 at 9:41 AM, an IDT (Interdisciplinary Team) note, IDT met to review resident sliding out of wheelchair. Resident is very unpredictable and continues to attempt to self-transfer.5/13/2026 3:53 PM, IDT note, IDT met to (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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F 0689 Level of Harm - Actual harm Residents Affected - Few	review resident recent fall. Resident was sitting at the nurse's station and talking with staff. Nurse was charting at desk and was alerted by noise, and resident was observed on floor.A review of the Neurological assessments/Neuros that were completed by the nurse if it was suspected a resident may have hit their head or hit their head, identified 6 sets of Neuro checks to correspond with some of the falls Resident #1 had sustained: 2/14/2026, 2/21/2026, 3/8/2026, 4/3/2026, 4/22/2026 and 5/3/2026. Five of the Neurological assessments were incomplete. Some were missing vital signs. Some were missing the neurological testing, and some were missing all of it for several days. There was no consistent assessment and monitoring to identify a neurological change in condition for Resident #1.On 5/20/2026 at 2:26 PM, Resident #1 was observed sitting in a wheelchair near the nurses desk on the Central unit. He began to lean forward and his head was bobbing, as if he was falling asleep. Nurse D was asked if the resident layed down in the afternoon and she said he would try to get out of bed if he layed down and that was why he was sitting at the nurses station. Nurse D asked the resident if he was tired and he wanted to lay down and he said Yes. The nurse was assisted by a nurse aide to transfer the resident to his bed. He was weak and had difficulty standing and following directions to sit down on the bed. On 5/20/2026 at 3:15 PM, Nurse D said Resident #1 had his brief changed and was provided with a nutritional supplement then he went to sleep. Per a progress note dated 5/20/2026 at 6:10 PM, Resident was at the nurses station half the day, had to be redirected to sit a few times. About 1500 (3:00 PM) resident was fed, changed and helped to bed. Resident sleep until dinner.On 5/21/2026 at 10:27 AM, Confidential Person K was interviewed about Resident #1 and said Resident #1 had fallen and had a huge knot on the back of his head on the left corner. During the interview, Confidential Person K stated, There would be 15-16 residents to 1 Aide on the afternoon shift. It was too much.On 5/21/2026 at 1:23 PM, Confidential Person L was interviewed and said Resident #1 had multiple falls. The Confidential Person L said there was no clear Care Plan and the resident had declined further, They said they would keep an eye on him, but he kept falling. The Confidential Person L said the resident couldn't feed himself and was barely eating his food, I think he just got weaker and doesn't have the strength to get up.A review of the Care Plans for Resident #1 identified the following: (Resident #1) is at risk for falls or fall related injury r/t (related to) incontinence, cardiac, psychotropic, antidepressant, and anticonvulsant medication use, history of falls, date initiated 11/20/2026 and revised 4/28/2026 with Interventions including: q (every) 15 min (minute) checks, date initiated 3/9/2026 and q 15 minute checks for 24 hours, dated initiated 4/23/2026 and revised 4/23/2026. There were no additional interventions related to monitoring/supervising the resident to prevent falls.A review of the 15 minute checks documentation for Resident #1 identified three documents titled 15 Minute Check and Chart and none were dated: One document indicated the resident was at the Nurses Station/NS from 6:30 AM until 11:30 AM. There was no documentation that the resident ate between 6:00 AM- 6:00 PM. There was one entry, Anxious: brief change. There were no additional entries that the resident was provided with assistance with toileting.Another document indicated that the resident was in the hallway from 6:45 AM until 9:15 AM and then was in bed from 9:15 AM until 6:00 PM. There was no indication the resident ate during that timeframe. There was documentation that the resident's brief was changed twice from 6:45 AM until 6:00 PM.The last document was from 6:00 AM until 10:15 AM and indicated the resident was at the nurse's station from 6:15 AM until 10:15 AM and was assisted with toileting at 8:15 AM. The remainder of the document was blank.Resident #4:A record review of the Face sheet and MDS assessment indicated Resident #4 was readmitted to the facility on [DATE] and on 1/6/2026 with diagnoses: Alzheimer's Dementia, depression, anxiety, psychosis, heart failure, epilepsy, COPD, and Pulmonary fibrosis. The MDS assessment dated [DATE] revealed the resident had cognitive decline, needed assistance with care and had experienced two or more falls with injury since admission. The resident was discharge to the hospital on 4/24/2026 with a change of condition.A record review of the Incident and Accident reports for Resident #4 identified the resident had fallen 6 times from January 2026 through April 25, 2026: 1/2/2026, 1/3/2026, 1/4/2026, (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	1/12/2026, 1/22/2026, and 2/28/2026.On 1/2/2026 the Incident Report for Resident #4 revealed that she was sedated and had attempted to get up multiple times during the night. The resident was confused, and her left hand was slightly reddened.On 1/3/2026 the resident's roommate alerted the staff that Resident #4 had fallen. She sustained an abrasion to her right cheek and a golf ball sized hematoma on her right forehead.On 1/4/2026 Resident #4 was tried to stand in the hallway and fell. She obtained a hematoma on the left side of her forehead.On 1/12/2026 the resident's roommate used the call light to let the staff know Resident #4 was in the bathroom by herself. She was found on the floor and she said she hit her head.On 1/22/2026, Resident #4 was found on the floor beside her bed. 15 minute checks were implemented.On 2/28/2026 Resident #4 was found on the floor by her bed.Resident #4 was transferred to the hospital from the facility on 1/5/2026 after falling on 1/4/2026 at the facility. She was treated for a head injury and contusion/bruise to the left knee per the Hospital discharge instructions. A history of X-rays in the hospital notes indicated on 12/25/2025 the resident had sustained a right wrist fracture.Resident #4 hit her head during a fall 3 times: 1/3/2026, 1/4/2026 and 1/12/2026. A review of the Neuro checks for the resident indicated Neuro assessments for 1/12/2026 and 1/22/2026. Both sets of Neuro assessments were incomplete.A 15 Minute Check and Chart document for Resident #4 was undated. It was timed 12:30 PM until 6:00 PM. The document indicated she was in her room in bed sleeping for part of the time and at the nurses desk awake for the rest of the time. No further information. There were no additional 15 minute check documents.A review of the Care Plans for Resident #4 identified the following: (Resident #4) is at risk for falls or fall related injury r/t (related to) impaired balance, impaired cognition, poor safety awareness, vision problems, epilepsy, anxiety, psychotropic medication use, incontinence, history of falls including recent fall which resulted in right wrist fracture, date initiated 12/3/2025 and revised 1/7/2026 with Interventions including: Room move for increased supervision for safety, date initiated 1/13/2026. The resident had already fallen 4 times and sustained 2 head injuries. There were no additional interventions for monitoring and supervision. Her Care Plans were not reviewed after she fell on 1/2/2026 and 1/3/2026. After she fell on 1/4/2026 the Care Plans were reviewed and updated with a perimeter mattress. Resident #5:A record review of the Face sheet and MDS assessment indicated Resident #5 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses: Alzheimer's Dementia, history of a stroke, heart disease, depression, anxiety, epilepsy, and arthritis. The MDS assessment dated [DATE] revealed the resident had severe cognitive loss with a BIMS score of 6/15, needed assistance with care and had at least 2 falls since admission, including a fall with injury.A review of the Incident and Accident Reports for Resident #5 indicated the resident had 3 falls from January 2026 through April 2026: 1/25/2026, 2/3/2026 and 4/24/2026.On 1/25/2026 the resident was found on the floor in her room.On 2/3/2026 the resident was found in the bathroom trying to sit back into her wheelchair. She said she fell and hit her face on the sink. There was redness and a skin tear to the right side of her face. Neuro checks and 15 minute checks were initiated.On 4/24/2026 the resident fell while trying to sit in her wheelchair.A review of the Neuro checks identified a document for 4/24/2026 with incomplete assessment.An X-ray of the sacrum and coccyx was completed for Resident #5 on 4/25/2026 due to complaints of pain after falling.A review of the Care Plans for Resident #5 revealed the following: (Resident #5) is at risk for falls or fall related injury r/t decreased mobility/weakness, impaired cognition, unsteady gait, incontinence, psychotropic & opioid medication use, epilepsy, poor safety awareness. She has a history of falls including a fall that resulted in a clavicle fracture, date initiated 9/12/2025 and revised 10/22/2025 with Interventions including: Increase frequency of rounding, date initiated 11/21/2025.On 5/21/2026 at 9:30 AM, the Director of Nursing/DON was interviewed about the falls with injury that Residents' #1, #4 and #5 sustained. She said the staff were performing 15 minute checks at times, because each resident had repeated falls. Reviewed that Resident #1 had 16 falls with multiple instances of hitting his head and sustaining injuries while at the facility, as well as Residents #4 and #5. Reviewed with the DON that 15 minute checks were not consistently implemented and Neuro checks were (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	incomplete. The DON said she thought everything had been tried to prevent the residents falls. The DON was asked about closer monitoring, staffing or 1:1 monitoring and she said sometimes a Respite care outside person would come in and spend time with the residents, but it was not on a regular basis. Reviewed staffing on the Central hall where Residents #1, #4 and #5 resided and the DON said there were usually 3 or 4 nurse aides on the hall. On 5/20/2026 the first day of survey there were 3 nurse aides and on 5/21/2026 the 2nd day of survey there were 4 nurse aides; she said there were usually 2 nurses on the hall also. The DON was asked if the residents were more closely monitored when there were 4 nurse aides, as some staff indicated one staff member could more closely monitor and work with the residents who were prone to falls when there were 4 nurse aides. The DON said they did sometimes do that.A review of the facility policy titled, Fall Prevention dated approved 12/12/2023 provided, Each Person will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. High Risk Protocols: a. The resident will be placed on the facility's Fall Prevention Program. Increased frequency of rounds. Sitter, if indicated. Interventions will be monitored for effectiveness.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This Citation pertains to Intake Number 2997914. Based on observation, interview and record review the facility failed to ensure that interventions were enacted to promote nutrition and prevent weight loss for one resident (Resident #1) of 1 resident reviewed for food or nutrition, resulting in Resident #1 experiencing significant weight loss without identification and access to favored foods. Findings Include: Resident #1:A record review of the Face sheet and Minimum Data Set/MDS indicated Resident #1 was admitted to the facility on [DATE] with diagnoses: History of Traumatic Brain Injury, history of falls, dementia, diabetes, depression, and heart failure. The MDS assessment dated [DATE] revealed the resident had severe cognitive loss with a Brief Interview for Mental Status (BIMS) score of 1/15 and the resident needed assistance with all care.On 5/20/2026 at 2:26 PM, Resident #1 was observed sitting in a wheelchair near the nurses' desk on the Central Unit. He began to lean forward and his head was bobbing, as if he was falling asleep. Nurse D was asked if the resident layed down in the afternoon and she said he would try to get out of bed if he layed down and that was why he was sitting at the nurses' station. Nurse D asked the resident if he was tired and if he wanted to lay down and he said Yes. The nurse was assisted by a nurse aide to transfer the resident to his bed. He was weak and had difficulty standing and following directions to sit down on the bed. The resident appeared very thin.On 5/20/2026 at 3:15 PM, Nurse D said Resident #1 had his brief changed and was provided with a nutritional supplement then he went to sleep. Per a progress note dated 5/20/2026 at 6:10 PM, Resident was at the nurses' station half the day, had to be redirected to sit a few times. About 1500 (3:00 PM) resident was fed, changed and helped to bed. Resident (slept) until dinner.A review of the Weight Summary for Resident #1 from January 15, 2026, to May 19, 2026 revealed Resident #1 had lost 14.2 lbs. He weighed 108.6 lbs. on January 15, 2026, and 94.4 lbs. on May 19, 2026. For 3 months from February 24, 2026, to May 19, 2026, the resident lost 13.1 lbs. 12.2% weight. For 30 days from April 15, 2026, to May 19, 2026, the resident lost 6.6 lbs./6.5%.A review of the documentation in the electronic medical record (EMR) Task: Nutrition-Amount Eaten from April 22, 2026, to May 20, 2026, identified the following:6 meals the resident ate 26-50%.3 meals the resident ate 0-25%.35 meals were 51-75%41 meals were 76-100%More recently since May 2026 the resident began eating less. On 5/21/2026 at 1:23 PM, during an interview, Confidential Person L stated that they said the resident couldn't feed himself and was barely eating his food, I think he just got weaker and doesn't have the strength to get up. The Confidential Person L said he used to bring the resident food and he really liked it. The Confidential Person said the resident ate the food, but a staff member told the Confidential Person the outside food wasn't good for the resident, and they no longer brought him in food. He said they would bring food the resident liked, such as burritos, because he wasn't eating the food at the facility as well. The Confidential Person said the resident had lost more weight. He said the resident lost his dentures at the facility and they had not been replaced. He was not sure what the facilities plan for replacing the dentures was.A review of the Resident Care Team Review, dated 5/6/2026, identified Weight Loss: Weight Change: a. Significant. There was no mention that the resident's dentures were missing.On 5/21/2026 at 2:00 PM, during an interview Registered Dietitian/RD M stated that she had been monitoring Resident #1 for weight loss. She said he had diabetes and sometimes his blood sugars were high, but he needed to eat more so she had added extra protein to his meals, in addition to other interventions. She said he ate better with finger foods. Reviewed with the RD M that the resident no longer had food that he enjoyed brought in from outside the facility, because someone told the family not to bring it in. The RD said she was not aware of that and asked how long it had been since he had the extra food; reviewed with her it had been greater than a month. The RD said she would check with the family to see what else the resident preferred and what he could have brought in that he would like to eat.A review of the Care Plans for Resident #1 identified the following: (Resident #1) presents with potential for (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	nutritional risk related to recent bilateral subdural hematomas/brain bleed. (Diagnoses: diabetes, hypertension, high cholesterol, Traumatic brain injury). Therapeutic diet liberalized r/t weight loss. Supplements ordered for weight increase. Appetite stimulant. Good oral intake/appetite now but continued weight loss, date initiated 11/26/2026 and revised 4/29/2026 with Interventions including: Honor food/fluid preferences as possible, date initiated 11/26/2025. The Care Plan did not mention that the resident ate better with finger foods.A review of the facility policy titled, Nutrition Assessment, date effective 8/1/2025, stated, Purpose: To identify and accommodate the individual dietary needs and preferences of each resident/patient.