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	06/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Majestic Care of Flushing	540 Sunnyside Drive Flushing, MI 48433

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake Numbers 3074530 and 3037980. Based on observation, interview and records review, the facility failed to ensure that residents' call lights were accessible and answered in a timely manner for 10 residents (#3, #7, #10, #38, #44, #46, #50, #63, #78, #86), and a confidential group of residents, resulting in verbalizations of anger and frustration regarding not answering call lights in a timely manner. Resident 46 (R46): A review of R46's medical record revealed an admission into the facility on [DATE] and readmission on [DATE] dementia, heart disease, diabetes and history of falling. A review of the Minimum Data Set assessment revealed the Resident had a Brief Interview of Mental Status score of 09/15 that indicated moderately impaired cognition and needed supervision or touching assistance with walking. On 6/29/26 at 9:17 AM, an interview was conducted with R46 who answered questions and engaged in conversation. The Resident had a wound to the top of his head with sutures and reported he was walking and had fallen. An observation was made of the Residents call light on the floor and the bed controller on the floor with the call light. The Resident was asked if he had any concerns of the call light system, the Resident laughed and said, No Comment and shook his head back and forth in a negative response, then reported that it takes a while before it was answered. It was observed that the bed was up in a higher position. The Resident indicated he had been looking for his light for a while because he wanted to adjust the bed and didn't know where his bed controller was at and could not find the call light. At this time the Administrator (NHA) was walking in the hall and was called into the room with the concern of the Resident's call light on the floor. The NHA put the call light back on the bed and assisted the Resident with the bed controller to adjust the way he wanted to be positioned. The NHA was unsure of the correct height of the bed and indicated she would check with the staff and have staff adjust the bed height. On 6/29/26 at 9:36 AM, an interview with Unit Manager, Nurse J regarding R46 bed controller and call light not in reach and the position of the bed. The Unit Manager reported the bed was not care planned to be low and the Resident was able to adjust the bed as he wanted, but indicated the call light should be in reach. A review of R46's care plan revealed a Focus related to risk for falls that had an intervention to Keep call light and frequently used personal items within reach. Resident 50 (R50): (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of R50's medical record revealed an admission into the facility on 9/10/25 and readmission on [DATE] with diagnoses that included heart disease, obesity, diabetes, bipolar disorder, anxiety and traumatic brain injury. A review of the Minimum Data Set assessment revealed the Resident had a Brief Interview of Mental Status score of 15/15 that indicated intact cognition. On 6/28/26 at 11:06, an interview was conducted with R50 who was sitting in his wheelchair. The Resident was interviewed, answered questions and engaged in conversation. The Resident was asked about concerns he had with care received at the facility. The Resident reported long call light wait times and it was useless to use because it took too long to be answered. The Resident reported he had put it on yesterday and stated, It was on for 8 hours! An observation was made of the Resident's roommate with their call light hanging over the middle of the head of the bed with the push mechanism positioned between the wall and the head of the bed. The Resident had his head of the bed elevated and the call light was not in reach and not in sight for the Resident. Nurse Supervisor X was notified the Resident needed assistance and was unable to get to the call light. The Nurse Supervisor indicated the call light should be in reach for the resident. Resident 86 (R86): A review of R86's medical record revealed an admission into the facility on [DATE] with diagnoses that included right lower leg fracture, diabetes, heart disease, muscle weakness and difficulty in walking. A review of the Minimum Data Set assessment revealed a Brief Interview of Mental Status score of 14/15 that indicated intact cognition and the resident was dependent on a helper for toileting hygiene, bathing, personal hygiene, rolling in bed and transfers. On 6/29/26 at 8:57 AM, an interview was conducted with Resident 86 who was lying in bed. The Resident answered questions and engaged in conversation. When asked about concerns she had with the care she received at the facility, the Resident reported issues with her light not answered timely. The Resident stated, I had a bm (bowel movement), put my light on and had to wait for hours, and explained it happened last month, and stated, It takes a long time to get the light answered. An observation was made of the Resident's call not within reach for the resident. When asked about this, the Resident stated, They sometimes put the light out of reach and my roommate will get it for me. The Roommate was in the room and stated, I get her light a lot for her, it's not by her a lot of times. The Resident reported staff shutting off the light and then taking a long time to come back. On 6/29/26 at 1:05 AM, an observation was made of Resident 86 sitting up in her wheelchair. The Resident was interviewed and she explained she had gotten a shower recently and was still sitting up in her wheelchair. The Resident reported she wanted to get back to bed and stated, They (staff) have not come back to put me to bed. I had my call light on, they came in and said they would be back. I am still sitting here. My back is killing me, and reported they needed the lift to get her back into bed. The Resident had her call light in reach and was asked to put her call light on again. An observation was made from the hallway that the light was answered within a couple minutes. The staff had turned off the light and had left the room. At 1:26 PM, an observation was made of staff bringing in the lift and were going to get the Resident back to be. Resident #3: R3 admitted to the facility on [DATE] with diagnoses that include malignant neoplasm of the endometrium, heart failure, chronic kidney disease and dependence on renal dialysis. R3 has a brief interview for mental status (BIMS) score of 15, indicating they are cognitively intact. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 06/29/2026 at 9:04AM, an interview was conducted with R3, R3 was asked if the facility staff answers the call light in a timely fashion. R3 stated that it can be 30 minutes and sometimes up to 3-4 hours to get the call light answered. R3 was asked if the response time was any worse during different shifts. R3 stated that the second shift is the worst shift for answering call lights. Resident #7: R7 was admitted to the facility on [DATE] with diagnoses that include right leg above the knee amputation, hypertensive heart disease and hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side. R7 has a BIMS score of 15, indicating they are cognitively intact. On 06/28/2026 at 10:34AM, an interview was conducted with R7. R7 was asked how long it takes to get the call light answered. R7 stated it takes 30 minutes to get the light answered and that the 3rd shift staff is the worst. Resident #38: R38 admitted to the facility on [DATE] with diagnoses that include hypertensive heart disease, depression, glaucoma and unspecified asthma. R38 has a BIMS score of 15, indicating they are cognitively intact. On 06/28/2026 at10:10AM, an interview was conducted with R38. R38 was asked how long it takes the facility staff to respond to the call light. R38 stated that most times the call light gets answered in an hour or so. R38 stated that some of the nursing staff do a good job of telling us that they are short, that way we expect the long wait times R38 was asked if any of her needs haven't been met due to a long wait. R38 stated there have been times where she has had to go to the bathroom and staff didn't get here on time. Resident #63: On 06/28/2026 at 9:58AM, observation revealed the call light was out of reach. It was observed behind the bed and on the frame of the bed near the floor. On 06/29/2026 at 1:04PM, a meeting was conducted with a group of confidential residents. The confidential group was asked what the average call light time response was. The consensus of the group is that the minimum amount of time is about 30 minutes, one resident stated they were in the bathroom for 45 minutes and started yelling to get help. Other confidential residents stated that there are times it can be as long as two hours for a response. Resident #78: In an interview on 6/28/2026 at 11:07AM with Resident #78 when asked about cold food, the food taste is not good. and he has had to wait for the room trays, his roommate's tray comes and he has had to wait for 10 minutes or more, and he knows it's sitting in the hall getting cold. Resident #78 stated that the snacks are crap and cheap food snacks, off brand cracker and cheese, oatmeal cream pies, [NAME]-zits junk foods. Weekend staffing- they are short staffed all the time. They don't respond to the lights, when they do come into the room, they shut the light off and don't do anything and don't come back, the night shift is the worst. They don't answer the call lights for 30 minutes to 3 (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	hours, we wait a long time for staff, and nothing gets done about it. We can hear them in the hallway laughing and carrying on. but they don't come to help. IN an interview on 06/29/2026 at 10:58 AM with Resident #78 stated that call lights are still too long, the aides don't do sh** and the nurses don't tell them to do anything. I complain about stuff and nothing gets changed or done about it. They want my money, but don't want to do anything for me. Resident #10: In an interview on 06/29/2026 at 1:53 PM with Resident #10 stated that the call lights are not responded to it take 30 minutes or more, I could piss my pants and they don't come. Resident #44: Record review of 'Report of Concern' form for Resident #44 dated 6/30/2026 had a description of concern: Call light put on aide came in said a few people a head of him time about 3:25AM the aide didn't come back until about 4:20AM. Resident stated the aide is nice but he doesn't like to sit in poop. Record review of the Health Care Association of Michigan (HCAM) 'Rights of Residents in Michigan Nursing Facilities' dated 2024, revealed the residents are entitled to receive adequate and appropriate care, and to receive, from the appropriate individual within the health facility .,

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. The Citation pertains to Intake Number 3074530. Based on interview and record review, the facility failed to ensure that staff were utilized appropriately to sufficiently meet the needs of facility residents through multiple resident interviews and interviews with the confidential group of residents and low weekend staffing was triggered through payroll-based journal, resulting in resident increased call light complaints, unmet care needs, and a lack of resident assessment and monitoring. Findings include: On 06/29/2026 at 1:04 PM, a meeting was held with a confidential group of residents, who regularly meet once a month. The confidential group was asked what the average call light response time is. The consensus of the confidential group is that the minimum amount of time is about 30 minutes. One resident was in the bathroom for 45 minutes and started yelling to get help. The group stated sometimes it can be as long as two hours. The confidential group believes they facility needs to hire more staff and that the current staff call in too much. In an interview and records review on 06/29/2026 at 4:07 PM with Certified Nurse Assistant (CNA)/Staff scheduler L the state surveyor revealed that the survey team had heard from Resident complaints of short staffing from several residents with reported call light response times which are 30-45 minutes and up to 2 hours. Residents reported that staff sit in the lounge room and watch TV and do not respond to call lights or residents' needs. CNA L stated that as the scheduler she follows a per patient day (PPD-average number of nursing or clinical hours provided to each resident on a daily basis) of 2.85 hours/per resident. CNA L stated that the facility does not use acuity, Just the 2.85 hours/per resident guideline from corporate. 1:1 coverage- so since the census has dropped, it freed up some hours, and she was told not to include that in her PPD. Electronic Record reviews and interview with CNA L of random weekend staffing revealed: January 17th, 2026, Certified Nursing Assistants (CNA) on 2nd shift had a no show and call in from 2:00PM to 10:00PM and a second call-in 3:00PM to 7:00PM worked short that shift. Record review of the Saturday January 17, 2026, staffing sheet presented to the surveyor noted CNA names and call-ins of 4 total for the day. February 14th, 2026, Certified Nursing Assistants (CNA)CNAs on 2nd shift had two (2) call-ins or no show/no call on the 2:00PM -10:00PM shift and worked short. 3rd shift also short one CNA call-in 10:00PM -6:00AM. April 4th, 2026, - Certified Nursing Assistants (CNA) on 1st shift had four (4) CNA call offs on the 6:00AM to 2;00PM shift, they worked short, 2nd shift had 3 call offs on 2:00PM to 10:00PM shift and worked short. April 5th, 2026- Certified Nursing Assistants (CNA) on 1st shift had three (3) CNA call offs on the 6:00AM to 2;00PM shift, 2nd shift had two (2) CNA call offs on 2:00PM to 10:00PM shift and worked short. 3rd shift had two (2) CNA call offs on the 10:00PM to 6:00Am shift. May 23rd, 2026- 2nd shift had five (5) CNA call offs on 2:00PM to 10:00PM shift and staff worked (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	short. May 25th, 2026- Certified Nursing Assistants (CNA) on 1st shift had six (6) CNA call offs on the 6:00AM to 2;00PM shift, and three (3) Unit managers call off on the 8:00AM to 4:30PM shift, and three (3) licensed nurses call-off on the 10:00PM to 6:00AM shift and worked short. 3rd shift had four (4) CNA call offs on the 10:00PM to 6:00Am shift. CNA L stated that the facility will stack the weekend staffing to anticipate call offs. CNA L stated that she had heard from the residents that there is only 1 CNA on the night shift, but I compare the clock-ins against the schedule and there has not been only 1 CNA on that shift. The CNAs tell the residents stuff that's not true. 3rd shift staff are in the lounge area watching TV and do not respond to the call lights. The cameras do not work and the staff know it. The PPD that is a budget of 2.85 hours per resident, and schedule accordingly. Management does not want to go over or under, so CNA L schedules right to that, as close as she can. Corporate states that she is over the PPD, and CNA L stated that she is under the PPD. CNA L did not know why the payroll-based journal (PBJ) triggered in the first quarter. An interview and record review on 06/30/2026 at 12:03 PM with Human Resource staff K revealed that she does the payroll and assumed that corporate pulls the PBJ data from the payroll. Corporate submits the PBJ. She does not submit PBJ. That's above her pay grade. Record review of CMS PBJ report for Weekend staffing data is excessively low per the PBJ report. In an interview on 06/30/2026 at 12:21 PM with the Director of Nursing (DON) weekend staffing posted public in the hallway is to be posted by the charge nurse on duty for the weekend and that facility Payroll-Based Journal (PBJ) is submitted at the corporate level. In an interview on 06/30/2026 at 12:29 PM, Registered Nurse (RN)/Regional Clinical Consultant M revealed that the Payroll-Based Journal (PBJ) data is submitted by either corporate or the Nursing Home Administrator (NHA) and the get the assisted living facility next door and the long term care facility, which share staff sometimes. The corporate office may be getting them mixed up and they are triggering the excessively low weekend staffing. An interview on 06/30/2026 at 12:42 PM with the Nursing Home Administrator (NHA) revealed that the payroll-Based Journal (PBJ) is submitted by corporate and the NHA was aware of the excessively low weekend staffing that triggered in March 2026. Resident #78: In an interview on 6/28/2026 at 11:07 AM, Resident #78, when asked about Weekend staffing, stated they are short staffed all the time. They don't respond to the lights, when they do come into the room, they shut the light off and don't do anything and don't come back. The night shift is the worst. They don't answer the call lights for 30 minutes to 3 hours. We wait a long time for staff, and nothing gets done about it. We can hear them in the hallway laughing and carrying on. but they don't come to help. In an interview on 06/29/2026 at 10:58 AM, Resident #78 stated that call lights are still too long, the aides don't do sh** and the nurses don't tell them to do anything. I complain about staff and nothing gets changed or done about it. They want my money, but don't want to do anything for me. Resident #10: (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview on 06/29/2026 at 1:53 PM, Resident #10 stated that the call lights are not responded to it take 30 minutes or more, I could piss my pants and they don't come. Resident #44: Record review of 'Report of Concern' form for Resident #44 dated 6/30/2026 had a description of concern: Call light put on aide came in said a few people ahead of him time was documented as 3:25AM. The aide didn't come back until about 4:20AM (55-minute wait). Resident's written statement that the aide is nice, but he doesn't like to sit in poop. Record review of the Health Care Association of Michigan (HCAM) 'Rights of Residents in Michigan Nursing Facilities', dated 2024, revealed the residents are entitled to receive adequate and appropriate care, and to receive, from the appropriate individual within the health facility .,

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This Citation pertains to Intake Number 3074530. Based on interview and record review, the facility failed to ensure that orientation and annual competency skill assessments and annual performance evaluations were completed for 3 of 3 licensed staff and 5 of 5 unlicensed staff of 9 staff reviewed. Record review of the facility 'Education, Training, and Competency' policy, dated [DATE], revealed Training and competency evaluation programs ensure compliance with State and Federal regulations, support high-quality resident care, and ensure that all care team members possess and maintain the skills necessary to perform their roles safely and effectively . Competency evaluation is an integral component of the training program and is required for all care team members, including employees . Initial competency is evaluated during the orientation process. A care team member remains on orientation until all required competencies are verified. Ongoing and annual competency evaluations occur at frequency determined by: (2.) Evaluation of the training program, 3.) Job performance evaluations, 4.) Identified performance gaps or regulatory requirements. Competency checklists are used to document training and competency verification. Competency documentation is maintained in department files, the care team members personnel file for the current training year, and the care team members official human resource file An interview and records review on [DATE] at 11:10 AM with Human resource staff K revealed that she has only been at the facility for 1 month and the records were not kept up, were moved around and not filed in alphabetical order. Licensed Staff:Record review of Licensed Practical Nurse (LPN) N hire date of [DATE] employee file revealed the Cardio-Pulmonary Resuscitation (CPR) card expired: [DATE]. Record review of Licensed Practical Nurse (LPN) A hire date of [DATE] had a Skills assessment: Skills validation checklist dated [DATE] and there was no annual performance records to review noted in the file. Record review of Register Nurse (RN) O hire date of [DATE] and rehire date of [DATE] employee file revealed there was no Cardio-Pulmonary Resuscitation (CPR) card found. There was no orientation skills checklist from the rehire date of [DATE] found in the employee file. Unlicensed Certified Nursing Assistants:Certified Nurse Assistant P with hire date of [DATE] had no skills checklist or orientation form found in employee records. Certified Nurse Assistant Q with hire date of [DATE] had a skills assessment checklist dated [DATE] and no Annual Performance review by management on job performance. Certified Nurse Assistant R with hire date of [DATE] had a pre-employment Background check which was dated [DATE] for Assisted Living side of the building and not rechecked for Long Term Care/skilled care. A Skills validation checklist dated [DATE] was found int the CNA's file. There was no 2026 skills checklist located and no annual performance review by management on job performance. Certified Nurse Assistant S with hire date of [DATE] had no orientation skills checklist found within the employee file. Certified Nurse Assistant T with hire date of [DATE] had a skills validation checklist dated [DATE] and none for 2026. There was no Annual Performance review by management on job performance. In an interview on [DATE] at 12:03 PM, Human Resource Staff K was asked by the surveyor if there were any other documents she would like to submit to the surveyor regarding the employee files and missing documentations. Staff K stated that she would have to ask the Director of Nursing (DON) if any other documents were available. The surveyor would only accept documents until the end of the survey exit conference.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. This citation pertains to intake Number 3037980. Based on observation and interview the facility failed to serve food that was palatable and at an appropriate temperature and that residents were given choices of food preferences for 6 residents (R2, R3, R10, R22, R38, R78) of 10 residents reviewed for food and a confidential group of residents. Findings include:On 06/29/2026 at 12:00PM, observation of lunch meal was conducted in the Sunnyside Dining Room: This is a point of service meal for the residents that are in here, the food is served from steam wells located in the dining room. On 06/29/26 at 12:15PM, a test tray was received as requested. The meal provided is a cheeseburger on a bun and waffle fries. The waffle fries have good flavor but are a little spicy and are soggy and cold. The cheeseburger is not very warm, and no condiments were provided for the cheeseburger or fries. On 06/29/2026 at 12:26PM, an interview was conducted with R44. R44 was asked about the quality of the food at the lunch meal. R44 stated the food was ok today, but the waffle fries were a bit harsh for him (spice). Resident #38: On 06/28/2026 at 10:05AM, an interview was conducted with R38. R38 was asked about the quality of the meals. R38 stated that yesterday's lunch (6/27/26) was inedible, R38 stated she had her family grab her some fast food on the way home from work and bring it to her. R38 stated that a lot of the time the meals are cold when they get to our room. R38 stated when she received dinner yesterday (6/27/26), that she pulled the top off of it looked at it and put the top back on the plate and sent it back; R38 stated it was terrible looking. Resident #3: On 06/29/2026 at 8:54AM, R3 was interviewed about the food in the facility. R3 stated that the food is terrible. R3 was asked why they felt that the food is terrible. R3 stated, it's just not good and it seems like every meal is just thrown together. R3 stated the other day they received spaghetti noodles with no sauce on them and green beans. The meals just don't make sense; the food items don't go together. R3 stated that there are a lot of times when she will call her family and have them send her money so she can order food or have them bring me something to eat. On 6/30/26 at 12:30PM, observation revealed and empty Kentucky Fried Chicken bag in the garbage. When R3 was asked about it, she stated she had her family bring it for her so she can eat. Confidential Group of Residents: On 06/29/2026 at 1:04PM, a meeting was held with a confidential group of residents. When the group was asked about the food in the facility, the following responses were received. Three confidential residents said the hot dogs for lunch today (6/29/26) were not good. Three confidential residents stated that they regularly order food to the facility from outside restaurants. (continued on next page)

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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The group states you can't always get a hold of the always available menu. One confidential resident stated that to get anything off the always available menu, you need to have it ordered in a certain timeframe and that even if you order it in time, you still might not get it. Record review of the always available menu revealed the following alternative food options. -Hamburger (with lettuce and tomato) -Hot Dogs -Deli Sandwich -Grilled Cheese Lunch choices due by 9:30AM Dinner choices due by 1:00PM. Resident #78: In an interview on 6/28/2026 at 11:07AM, Resident #78, stated that cold food has been better lately, but taste is not good. I have to wait for the room trays, my roommates come and I have to wait for 10 minutes or more, and I know it's sitting in the hall getting cold. The snacks are crap. We get cheap food snacks, off-brand crackers and cheese, oatmeal cream pies, Cheez its, all junk foods. Weekend staffing- they are short staffed all the time. They don't respond to the call lights, when they do come in, they shut the light off and don't do anything and don't come back, the night shift is the worst. They don't answer the call lights for 30 minutes to 3 hours, we wait a long time for them, and nothing gets done about it. We can hear them in the hallway laughing and carrying on. but they don't come to help. Resident #10: In an interview on 06/28/2026 at 12:16 PM, Resident #10 stated the food 7 years ago at the facility was good and they sent a menu to the resident room and you filled it out and they brought what you ordered. Now there is only 1 entree, and you get what you get. After dinner, once the carts are out, they tear everything down in the kitchen and if you want to order a different alternative menu choice that is very limited. Residents can order an alternative but have to turn in the request slip by lunch. They only put the menus at the nursing station and do not give them to the residents in the rooms. Us bed bound residents cannot get to the nursing station to get a menu. Snacks are not good, there are no nutritious snacks like cottage cheese, fresh fruit, and healthy items. An observation and interview were conducted on 06/29/2026 at 1:01 PM of Resident #10, who was in bed with noon meal tray of chili dog, and waffle fries. Resident #10 stated that he was asleep and they didn't wake him up and now it's cold and soggy. Portions are small and there's no flavor. Record reviewed of the alternate choice menu in Resident #10's room. Resident #10 stated that the list of 4 choices shrunk from at least 10 choices which included salads, PBJs, soups, cottage cheese and other good foods. It's really sad for us residents that know what use to be offered and now they (continued on next page)

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	06/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Majestic Care of Flushing	540 Sunnyside Drive Flushing, MI 48433

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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	have cut the budget, and we are not getting the fresh vegetables and fruits, its summer and all our fruit/vegs is from a can. Resident #2: In an interview on 06/28/2026 at 12:04 PM with Resident #2 stated that most of the food s**ks, and there are very few good food items, The food taste is bad; it is salty and just is not good. Meats are dry and tough to chew. They don't bring us menus, and the alternate menu only has 4 choices, and nothing is fresh. The alternate menu residents can only order one item, you cannot order a hotdog and a hamburger or grilled cheese, just one item. Observation on 06/29/2026 at 10:40 AM at the Med-Bridge nursing station noted that menus in the culinary menu basket on the nursing station desk also had alternate choice menus. Record review of the 'Always Available Menu' (undated) noted only had 4 food choices, hotdog, hamburger, deli sandwich, grilled cheese. The form noted: Please note this is for main entree substitution only, please choose only one entree, please use separate sheets for lunch and dinner, handwritten alterations will not be accepted and please fill sheet out daily. Lunch choices were due by 9:30AM and dinner choices were due by 1:00PM. Record review of the 'Week 1' menu dated June 22-June 28th, located at the Med-Bridge nursing station for the week of survey did offer only one entree: Monday-Chili dog on a bun, waffle fries, coleslaw, cherry cobbler. Tuesday-Baked fish, rice, green beans, cornbread, lemon pie and so on . The surveyor noted that there was only one entree/choice offered per meal and only alternate menu items of hotdog, hamburger, deli sandwich or grilled cheese. In an interview on 06/29/2026 at 11:02 AM with Resident #2 stated that the food still s**ks and the other night we had a pepperoni sandwich it was nasty. They serve white macaroni with onions, it's nasty. Resident #2 stated that she usually has the aide get her a hotdog or a hamburger, we can't have both we have to choose only one, one hotdog doesn't fill you up, and sometimes you can get chips and other times they send just the hotdog and no ketchup or mustard. In an observation and interview on 06/29/2026 at 12:54 PM with Resident #2 stated that She had the chili dog. Surveyor observed the chili dog with the top scrapped off and only one to two bites. Resident #2 stated that they bring her tray in and open the milk and then they leave. Resident #2 was observed to have built-up utensils on meal tray. Resident #2 stated that she does have the fat handled utensils. The chili dog was not very good, and she took all the chili off because it did not taste good. Coleslaw does not taste good either, no, no one helps me eat, no they don't cut up my hotdog/chili dog or any of that stuff. Resident #22: In an interview on 06/28/2026 at 11:55 AM, Resident #22 stated that the food here is the same old crap, never good, the food has to get better. In an observation and interview on 06/29/2026 at 12:58 PM, Resident #22 stated that he got the chili dog with onions but it was not very good and the waffle fries are soggy, they don't bring no ketchup for the fries, it's just not good, the taste, the temperature, all of the meal was bad.