

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 06/05/2025
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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure dignity by, Residents #23, #40 and #76, -not having call lights accessible and extended call light response times, Resident #43- not assisting with toileting and Resident #42- not toileting prior to meals and residents' verbal complaints from the confidential Resident Council group meeting (held on 6/23/25 at 1:19 PM), regarding call light response times, resulting in, fear of abandonment, anger, skin irritation (from having urine and feces on skin for an extended time), and embarrassment.</p> <p>Findings Include:</p> <p>Review of Resident Council anonymous meeting notes done by State Social Worker dated 6/3/25 at 1:19 p. m., stated they (call lights) are not being answered in timely manner they (staff) say they answer it timely and don't meet their needs; taking an hour to answer to come or more; the nurses will not answer the call lights.</p> <p>Resident #23:</p> <p>Review of the Face Sheet, care plans dated 3/23 through 5/25, and cognitive assessment dated [DATE], revealed Resident #23 was [AGE] years old, alert, cooperative, admitted to the facility on [DATE], had a guardian in place due and was dependent on staff for all Activities of Daily Living/ADL's. The resident's diagnosis included, convulsions, tremors, opioid pain medication use, diabetes, attention-deficit, depression, chronic kidney disease, intellectual disabilities, adult failure to thrive, and stroke.</p> <p>Review of the resident's facility at risk for falls care plan dated 3/20/23, stated Keep call light and frequently used personal items within reach.</p> <p>Observation and interview done on 6/4/25 at 9:39 a.m., revealed the resident was in her bed, she was unable to reach her call light and stated, staff don't care about me.</p> <p>Resident #40:</p> <p>Review of the Face Sheet, care plans dated 8/23 to 3/25, and cognitive assessment dated [DATE], revealed Resident #40 was [AGE] years old, alert and able to make own decisions regarding health, bed bound and dependent on staff for all ADL's. Resident #40's diagnosis included heart disease with heart failure, Atrial Fibrillation, morbid obesity, chronic respiratory failure with oxygen decency.</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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the resident's facility Fall, Skin, and ADL care plans dated 8/1/23, revealed she had a flat round call light, was incontinent, and preferred bed baths 2 times weekly. The resident had refusals of medications and care; staff were to re-approach and encourage resident to accept care and medications and honor decisions and preferences.</p> <p>Observation was done on 6/3/25 at 12:11 p.m., the resident was in bed and Family member was sitting in the chair next to the bed. The resident had a flat call light hooked to the right upper side of her pillow. The residents Family member #1 had just finished changing the resident after an incontinence episode. When this surveyor asked him why he was changing the resident he said, no one comes. When asked if she was able to reach the call light, the resident said she had a hard time getting it and no one cares.</p> <p>A second observation was made on 6/3 25 at 1:35 p.m., the resident was in her bed with Family member still sitting in the chair next to her bed. When this surveyor asked the resident if staff answered her call light timely, she stated They (staff) don't come when I put my call light on; on the weekends and on nights. One time, I had a bowel movement and put my light on; they shut it off and did not come back for 5 hours; it was dried on and my butt was red and sore. Family member agreed with what the resident said and said he changes her when she is wet but can't when she has a bowel movement.</p> <p>Resident #76:</p> <p>Review of the Face Sheet, care plans dated 5/25, and cognitive assessment dated [DATE], revealed Resident #76 was [AGE] years old, alert able to be interviewed, admitted to the facility on [DATE], and dependent on staff for ADL's. The resident's diagnosis included, heart disease, stage 3 kidney disease and mild cognitive impairment and dependent on staff for ADL's.</p> <p>Review of the resident's Fall care plan dated 1/24/24, stated Keep call light and frequently used personal items within reach.</p> <p>During an interview done on 6/3/25 at 11:26 a.m., the resident said he does not have a call light, and he can't find it when it's clipped to the top of his bed. At the time the resident's call light was clipped to the very top of his pillow on the right side. When asked if he knew if he had a call light, he was not aware of the location of his light.</p> <p>Review of the facility Call Light policy (un-dated), stated Staff will ensure the call light is within reach of reach.</p> <p>Review of the facility Resident's Rights policy dated 10/2019, stated All care team members recognize the rights of residents at all times and residents assume their responsibilities to enable dignity, respect, and proper delivery of care.</p> <p>Resident #42:</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review revealed Resident #42 was originally admitted to the facility on [DATE] with diagnoses which included Parkinson's disease, dementia, cerebral infarction (stroke), depression, and anxiety. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was cognitively intact, was dependent upon staff for toileting and personal hygiene and required supervision or touching assistance with eating.</p> <p>An interview was completed with Licensed Practical Nurse (LPN) P on 06/04/25 12:22 PM. When queried what Residents required assistance to eat on their unit, LPN P responded that Resident #42 required staff assistance.</p> <p>On 6/4/25 at 12:27 PM, Resident #42 was observed in their room. The Resident was in bed with the head of the bed elevated with a food tray in front of them. There were no staff present in the room and no adaptive eating equipment was present on the tray. The Resident was attempting to eat by themselves, and the front of their shirt was covered in spilled food. The Resident did not have a clothing protector in place. A foul bowel movement odor was present in the room and stronger near Resident #42. An interview was completed at this time. When queried regarding the care at the facility, Resident #42 stated, They told me I have to wait. Resident #42 was asked what they meant and stated, They told me I had to wait to get cleaned up when brought the tray. When asked if they had been incontinent and soiled themselves, Resident #42 replied, Yes. When asked if they had urinated or had a Bowel Movement (BM), Resident #42 stated, Both. With further inquiry, Resident #42 verbalized they asked the staff for assistance in getting cleaned up due to being incontinent when they brought the food tray into the room and were told they would have to wait until after they ate. Resident #42 was asked how that made them feel and looked away but did not provide a verbal response.</p> <p>On 6/4/25 at 12:56 PM, Certified Nursing Assistant (CNA) X and CNA Y were observed in Resident #42's room. The Resident's food tray had been removed from the room and the staff were preparing to provide incontinence care. CNA X and CNA Y were asked if either of them brought Resident #42 their food tray and both responded they did not. When asked who delivered the Resident's food tray, neither staff member were able to provide a response.</p> <p>Review of Resident #42's Electronic Medical Record (EMR) revealed a care plan entitled, (Resident #42) needs assistance with activities of daily living r/t (related to) Parkinson's disease, dementia . is a Hospice patient . The care plan included the following current and recently changed interventions:</p> <ul style="list-style-type: none"> - Toilet Use: dependent on staff for toilet use. Check routinely for incontinence and provide incontinent care as needed (Initiated and Revised: 3/25/25) - Resolved: Eating: 1:1 Supervision (Initiated: 3/25/25; Resolved: 6/4/25) - Eating: Set up, provide cueing and assist prn (as needed) (Initiated: 6/4/25) <p>Resident #43:</p> <p>On 6/03/25, at 1:52 PM, A record review of Resident #30's electronic medical record revealed an admission on [DATE] with diagnoses that included Obstructive sleep apnea, Heart Failure and Chronic Obstructive Pulmonary Disease. Resident required extensive assistance with all Activities of Daily Living and had severely impaired cognition</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 6/03/25, at 4:01 PM, Resident #43 was sitting in their wheelchair in their room with their pants down passed their bottom. Resident #43 quickly stood up and walked towards their bathroom. Resident #43 opened the bathroom door and turned to enter. At that time, Resident #43's unclothed backside was exposed to the hallway as the room door was wide open. Resident #43 entered the bathroom and closed the door.</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>Based on observation, interview and record review, the facility failed to follow and/or revise care plans for Activities of Daily Living (ADL) for three (#35, #50, #85) residents, resulting in residents who verbalized concerns with missed bathing/showers, and with unkept appearances with body odor.</p> <p>Findings include:</p> <p>Record review of the facility 'Resident Rights' policy dated 10/2019 revealed that all residents will be treated with dignity and respect and resident rights will be followed. All care team members recognize the rights of residents at all times to enable dignity, respect, and proper delivery of care.</p> <p>Record review of the facility 'Comprehensive Care Plan' policy revision date of 5/16/2025 revealed the purpose was to develop and implement a comprehensive person-centered care plan for each resident Definition: Person-Centered care means to focus on the resident as the locus of control and support the resident in making their own choices and having control over their daily lives.</p> <p>Resident #35:</p> <p>Observation on 06/03/25 at 12:33 PM of Resident #35 to be in need of shower, body odor noted when interviewing the resident. Resident state that they don't give showers regularly around here.</p> <p>Record review of Resident #35's 'Activity of Daily Living' care plan revised 4/9/2025 revealed: staff assistance for sponge bath 2 x/weekly & PRN (as needed). There were no specific individualized days noted and whether a sponge bath was resident preference of bathing.</p> <p>Record review of Resident #35's shower/bathing tasks 30-day look back from 5/5/25 through 6/2/25 revealed 4 showers (5/8/25, 5/15/25, 5/26/25, 5/27/25). Bathing task was noted as total dependence or staff to assist.</p> <p>Record review of Resident #35's progress notes dated 5/5/25 through 6/4/25 revealed that there were no documented refusals of showers noted.</p> <p>Observation on 06/04/25 at 01:20 PM with Licensed Practical Nurse (LPN) P of Resident #35's for nephrostomy tube site dressing, body odor still there, he stated that no shower given today.</p> <p>Resident #50:</p> <p>In an interview on 06/03/25 at 09:36 AM with Resident #50 during the screen process at the beginning of the survey revealed there is no service, they tell us no or wait till next shift to go to the bathroom. The staff have attitudes. I do get cleaned up; I can do most of it myself. Some staff are great, and others are terrible. Third shift, there's just not enough helpers, they call in and then the staff that shows up has to do 30 people.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #50's 'Activity of Daily Living' care plan revised 5/9/2025 revealed: staff assistance for showers 2 x/weekly & PRN (as needed). There were no specific individualized days noted and whether a sponge bath was resident preference of bathing.</p> <p>Record review of resident #50's shower/bathing tasks from 5/6/25 through 6/3/25 revealed no showers were given on 5/30/25 and 6/3/25.</p> <p>Record review of Resident #50's progress notes dated 5/30/2025 through 6/4/2025 revealed that there were no documented refusal of showers noted.</p> <p>Observation on 06/05/25 at 09:06 AM of Resident #50 with Certified Nurse Assistant Q was observed to be getting beard trim. Resident #50 was asked about Showers given yesterday. No, they just give you a washcloth. Hair not washed. no they don't know how to give a shower. Do you refuse showers? No, why would I.</p> <p>Resident #85:</p> <p>In an interview on 06/03/25 at 08:58 AM with Resident #85 during the screen process at the beginning of the survey revealed the resident stated there were no showers given here, they give him a fast wash with a wet cloth in his bed, and he doesn't like it.</p> <p>Record review of Resident #85's 'Activity of Daily Living' care plan revised 1/16/2025 revealed: staff assistance for showers 2 x/weekly & PRN (as needed). reapproach as needed when resident refuses showers. Document and notify nurse of continued refusals. There were no specific individualized days noted and whether a sponge bath was resident preference of bathing.</p> <p>Record review of resident #50's shower/bathing tasks 30-day look-back from 5/5/25 through 6/1/25 revealed only 2 showers were given on 5/15/25 and 5/26/25.</p> <p>Record review of Resident #85's progress notes dated 5/1/2025 through 6/4/2025 revealed that there were no documented refusal of showers noted.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure resident showers were given and Activities of Daily Living (ADL) were given for 8 resident's (Resident's #23, #30, #35, #40, #50, #65 and #85, and per interviews done during the anonymous Resident Council (done on 6/3/25), resulting in verbalizations of anger, disappointment, unfair treatment, and embarrassment.</p> <p>Findings Include:</p> <p>Resident #23:</p> <p>Review of the Face Sheet, care plans dated 3/23 through 5/25, and cognitive assessment dated [DATE], revealed Resident #23 was [AGE] years old, alert, cooperative, admitted to the facility on [DATE], had a guardian in place due and was dependent on staff for all Activities of Daily Living/ADL's. The resident's diagnosis included, convulsions, tremors, opioid pain medication use, diabetes, attention-deficit, depression, chronic kidney disease, intellectual disabilities, adult failure to thrive, and stroke.</p> <p>Review of the resident's facility ADL care plan dated 3/23, revealed staff were to ensure ADL's were done daily (including hygiene and clean clothing).</p> <p>Review of the residents facility ADL task sheet dated 5/7/25 through 5/31/25, revealed a total of 3 showers that had not been done: on 5/14/25, on 5/17/25, and on 5/30/25.</p> <p>During an interview done on 6/3/25 at 11:52 a.m., Resident #23 stated, I wish I could get a shower this week, I wish I could get one.</p> <p>During an interview done on 6/3/25 at 11:54 a.m., Nurse, LPN F stated They are short on second shift and she gets her showers on second. Nurse F said she tries to assist the Nursing Assistants when they are short, but she can't always help.</p> <p>Observation made on 6/3/25 at 2:16 p.m., revealed the resident sitting in their wheelchair in the hallway, with dried on food and wet spots on her teeshirt.</p> <p>Resident #40:</p> <p>Review of the Face Sheet, care plans dated 8/23 to 3/25, and cognitive assessment dated [DATE], revealed Resident #40 was [AGE] years old, alert and able to make own decisions regarding health, bed bound and dependent on staff for all ADL's. resident #40's diagnosis included heart disease with heart failure, Atrial Fibrillation, morbid obesity, chronic respiratory failure with oxygen decency.</p> <p>Review of the resident's facility ADL care plan dated 8/23, revealed the resident was to receive 3 showers per week; staff were to give the showers.</p> <p>Review of the resident's facility ADL sheet dated 5/7/25 through 5/31/25, revealed a total of 3 showers that had not been done: on 5/14/25, 5/17/25, and on 5/24/25.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview done on 6/3/25 at 1:50 PM, Resident #40 stated, It's (bed bath, does not get showers) supposed to be twice a week, they may do it once a week if I ask only</p> <p>06/04/25 12:32 PM I want my bed bath, I am supposed to get it tomorrow.</p> <p>During an interview done on 6/3/25 at 1:52 p.m., Nurse LPN, E stated on 6/3/25 at 1:52 PM Sometimes the Aides come to me and say they didn't get showers done, they are busy.</p> <p>During an interview done on 6/4/25 at 1:15 PM, the Director of Nursing stated I have done education regarding showers (and ADL's) with staff.</p> <p>Review of the facility Activities of Daily Living (ADL's) policy dated 12/12/23, stated A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Care and services will be provided for the following activities of daily living: Bathing, dressing, grooming and oral care.</p> <p>Resident #35:</p> <p>Observation on 06/03/25 at 12:33 PM of Resident #35 to be in need of shower, body odor noted when interviewing the resident. Resident state that they don't give showers regularly around here.</p> <p>Record review of Resident #35's 'Activity of Daily Living' care plan revised 4/9/2025 revealed: staff assistance for sponge bath 2 x/weekly & PRN (as needed). There were no specific individualized days noted and whether a sponge bath was resident preference of bathing.</p> <p>Record review of Resident #35's Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview of Mental status (BIMS) of 14 out of 15, cognitively intact.</p> <p>Record review of Resident #35's shower/bathing tasks 30-day look back from 5/5/25 through 6/2/25 revealed 4 showers (5/8/25, 5/15/25, 5/26/25, 5/27/25). Bathing task was noted as total dependence or staff to assist.</p> <p>Record review of Resident #35's progress notes dated 5/5/25 through 6/4/25 revealed that there were no documented refusals of showers noted.</p> <p>Observation on 06/04/25 at 01:20 PM with Licensed Practical Nurse (LPN) P of Resident #35's for nephrostomy tube site dressing, body odor still there, he stated that no shower given today.</p> <p>Resident #50:</p> <p>In an interview on 06/03/25 at 09:36 AM with Resident #50 during the screen process at the beginning of the survey revealed there is no service, they tell us no or wait till next shift to go to the bathroom. The staff have attitudes. I do get cleaned up; I can do most of it myself. Some staff are great, and others are terrible. Third shift, there's just not enough helpers, they call in and then the staff that shows up to work has to do 30 people.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #50's 'Activity of Daily Living' care plan revised 5/9/2025 revealed: staff assistance for showers 2 x/weekly & PRN (as needed). There were no specific individualized days noted and whether a sponge bath was resident preference of bathing.</p> <p>Record review of Resident #50's Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview of Mental status (BIMS) of 9 out of 15, moderately impaired.</p> <p>Record review of resident #50's shower/bathing tasks from 5/6/25 through 6/3/25 revealed no showers were given on 5/30/25 and 6/3/25.</p> <p>Record review of Resident #50's progress notes dated 5/30/2025 through 6/4/2025 revealed that there was no documented refusal of showers noted.</p> <p>Observation on 06/05/25 at 09:06 AM of Resident #50 with Certified Nurse Assistant Q was observed to be getting beard trim. Resident #50 was asked about Showers given yesterday. No, they just give you a washcloth. Hair not washed. No, they don't know how to give a shower. Do you refuse showers? No, why would I.</p> <p>Resident #85:</p> <p>In an interview on 06/03/25 at 08:58 AM with Resident #85 during the screen process at the beginning of the survey revealed the resident stated there were no showers given here, they give him a fast wash with a wet cloth in his bed, and he doesn't like it.</p> <p>Record review of Resident #85's 'Activity of Daily Living' care plan revised 1/16/2025 revealed: staff assistance for showers 2 x/weekly & PRN (as needed). reapproach as needed when resident refuses showers. Document and notify nurse of continued refusals. There were no specific individualized days noted and whether a sponge bath was resident preference of bathing.</p> <p>Record review of Resident #85's Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview of Mental status (BIMS) of 6 out of 15, severe impairment.</p> <p>Record review of resident #85's shower/bathing tasks 30-day look-back from 5/5/25 through 6/1/25 revealed only 2 showers were given on 5/15/25 and 5/26/25.</p> <p>Record review of Resident #85's progress notes dated 5/1/2025 through 6/4/2025 revealed that there was no documented refusal of showers noted.</p> <p>Resident #30:</p> <p>On 6/03/25, at 9:20 AM, Resident #30 was resting in bed. Resident #30 had a moderate amount of facial hair/whiskers. Resident #30 complained that it made them feel lousy.</p> <p>On 6/03/25, at 1:52 PM, A record review of Resident #30's electronic medical record revealed an admission on [DATE] with diagnoses that included Obstructive sleep apnea, Heart Failure and Chronic Obstructive Pulmonary Disease. Resident required extensive assistance with all Activities of Daily Living and had severely impaired cognition.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of the . needs assistance with activities of daily living . Interventions . PERSONAL HYGIENE: Staff assistance 1 p a Date Initiated: 04/11/2023 Revision on: 04/11/2023 .</p> <p>On 6/04/25, at 11:05 AM, Resident #30 was sitting in their room with occupational therapy treatment. Their facial hair remained unshaven. Resident #30 had received a shower with the assist of the occupational therapist.</p> <p>On 6/05/25 11:25 AM, an observation along with Nurse T of Resident #30's facial hair that remained unshaven. Nurse T offered, they would assist with shaving the long facial hair. Moments later, Scheduler was observed shaving Resident #30's facial hair/whiskers.</p> <p>Resident #65:</p> <p>On 6/03/25, at 10:47 AM, Resident #65 was resting in their bed and complained their nails were dirty. Some of their fingernails were nearly a centimeter long. There was brown buildup under their nails.</p> <p>On 6/04/25, at 9:24 AM, Resident #65 was in their bed. Their nails remained long and dirty.</p> <p>On 6/04/25, at 10:47 AM, An observation along with the Director of Nursing (DON) of Resident #65's long and dirty nails was conducted. The DON offered, I see they soaked them yesterday. Resident #65 turned their hands around and dirty buildup was still noted under their nails. The DON was asked who is responsible for cutting nails and the DON offered, The CNA's and offered the nurse would clip them.</p> <p>On 6/04/25, at 1:01 PM, a record review of Resident #65's electronic medical record revealed an admission on [DATE] with diagnoses that included Aphasia, Stroke and Cognitive communication Deficit. Resident #65 required assistance with all Activities of Daily Living and had impaired cognition.</p> <p>A review of the . needs assistance with activities of daily living r/t hx of stroke which resulted in aphasia and L Hemiparesis . Goal . will have care needs met daily with assistance with staff . Interventions . PERSONAL HYGIENE: staff assistance Date Initiated: 03/20/2025 Revision on: 04/01/2025 .</p> <p>A review of the Task: ADL-Personal Hygiene . 6/4/2025 12:53 . The box for TOTAL DEPENDENCE - Full staff performance was check marked.</p> <p>Resident #43:</p> <p>On 6/03/25, at 1:11 PM, Resident #43 was sitting in their wheelchair. Their hair was messy and appeared uncombed. They had on black sweat pants, slippers and a green sweatshirt over top of a darker green silky night shirt.</p> <p>On 6/04/25, at 9:22 AM, Resident #43 was in their wheelchair with the same clothing they had on the day prior. Their hair remained uncombed.</p> <p>(continued on next page)</p>		

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

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 6/04/25, at 10:00 AM, a record review of Resident #43's electronic medical record revealed an admission [DATE] with diagnoses that included visual loss right eye, Dementia and history of falling. Resident #43 required extensive assistance with all activities of daily living and had severely impaired cognition.</p> <p>A review of the . needs assistance with activities of daily living . Goal . will have care needs met daily with assistance of staff to promote comfort and dignity . Interventions . Prefers to wear pajamas and a gown during the day at times. Offer to get her in her clothes daily Date Initiated: 04/25/2025 . DRESSING: Self assistance Date Initiated: 04/10/2025 Revision on: 04/10/2025 .</p> <p>On 6/04/25, at 2:57 PM, Resident #43 was in their wheelchair and remained in the same clothing. Their sweatshirt was soiled with food debris.</p> <p>On 6/05/2025, at 10:30 AM, Resident #43 was sitting in their wheelchair. They had on blue jean shorts and a green sweatshirt. The sweatshirt was on backwards.</p>

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide activities to meet all resident's needs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to offer meaningful activities for one resident (Resident #37) of two residents reviewed for activities, resulting in complaints of nothing to do and being bored.</p> <p>Findings include:</p> <p>Resident #37:</p> <p>On 06/03/25, at 10:10 AM, Resident #37 was resting in their bed. Their television was on, the volume was off and the remote was out of reach. Resident #37 was asked what they do for activities and Resident #37 complained there was nothing to do. Resident #37 was asked if they were bored and Resident #37 complained, Yes, very much.</p> <p>On 06/04/25, at 2:14 PM, an interview with Activity Director I was conducted regarding the activities that was provided for Resident #37. AD I offered they do have one on one activities and offer hydration cart/popcorn for the resident and food club. AD I was asked what the food club was and AD I offered the group makes fresh cookies and popcorn and take them to the residents room. AD I was asked if they have an activity cart they can take to residents rooms with activity choices they offer and AD I stated, they do not have an activity cart. A record review of the Resident #37's care plan with AD I was conducted which revealed (the resident) prefers self-directed and independent activities at this time. While also welcoming 1:1 visits at his leisure. (the resident) activities like Board Games and listening to country music. Date Initiated:12/27/2024 . Interventions Provide materials of interest for independent leisure activity . discuss past interests with resident . provide assistance/escort to activity functions . provide monthly calendar . AD I was asked what at his leisure meant and AD I offered, the activities department would offer one on one activities. AD I was asked to provide the activity documentation for Resident #37.</p> <p>On 06/04/25, at 2:20 PM, a record review of Resident #37's electronic medical record revealed an admission on [DATE] with diagnoses that included Dementia, Dysphagia and Depression. Resident #37 required assistance with activities of daily living and had impaired cognition.</p> <p>A record review of Activities - Initial Review . Date: 12/23/2024 . What were your past activity interests and hobbies? . Cards/other games Reading/writing TV/Radio were all check marked.</p> <p>A record review of the Task: Activities for the Look Back: 30 days revealed only four activities were provided of club Food/Cooking Group Hydration Cart.</p> <p>On 06/04/25, at 2:37 PM, an observation along with the Director of Nursing (DON) of Resident #37 who was resting in their bed awake was conducted. Resident #37's glasses were out of reach on their nightstand. The TV remained on with the volume off. The DON was alerted the TV was off for both days and the DON turned the TV volume up to 96 and there was still no sound coming from the TV.</p> <p>On 06/05/25, at 1:45 PM, Resident #37 was resting in bed awake. The TV was on. The volume remained off.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to follow care-planned interventions, provide supervision and provide assistance with toileting for one resident (Resident #43) of three residents reviewed for supervision, resulting in unassisted toileting and unassisted ambulation.</p> <p>Findings include:</p> <p>Resident #43:</p> <p>On 6/03/25, at 1:27 PM, Resident #43 was sitting in their wheelchair in their room. Resident #43 stood up out of their wheelchair without locking the wheelchair and walked to their closet. CNA AA entered the room and assisted the resident to a seated position. Once CNA AA left out of the room, the resident removed their socks donned a new pair and then their slippers. Resident #43 propelled in their wheelchair towards the hallway.</p> <p>On 6/03/25, at 4:01 PM, Resident #43 was sitting in their wheelchair in their room with their black pants down below their bottom. Resident #43 stood up while holding their pants up and ambulated without assistance to their bathroom. The breaks to the wheelchair were not locked. Resident #43 opened the bathroom door, turned to enter while exposing their entire unclothed backside to the open door into the hallway. While Resident #43 was in the bathroom, the wheelchair rolled towards the closed bathroom door hitting it. Resident #43 attempted to open the bathroom door to exit and hit their wheelchair with the door. Resident #43 quickly closed the bathroom door and complained oh my. Shortly later, the resident pushed open the door into their wheelchair and exited the bathroom. Once out of the bathroom, Resident #43 pushed their wheelchair around and sat down without locking the brakes.</p> <p>On 6/04/25, at 9:38 AM, a review of the electronic medical record revealed an admission on [DATE] with diagnoses that included visual loss of right eye, Dementia and history of falling. Resident #43 required assistance with activities of daily living and was severely cognitively impaired.</p> <p>A review of Resident #43's incident reports revealed the following unwitnessed falls:</p> <p>4/5/25 unwitnessed fall</p> <p>4/17/25 unwitnessed fall</p> <p>4/22/25 unwitnessed fall</p> <p>5/9/25 unwitnessed fall</p> <p>6/1/25 unwitnessed fall</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the . at risk for falls or fall related injury r/t impaired balance, impaired cognition, poor safety awareness, psychotropic & opioid medication use, wandering behaviors, incontinence, She has a hx of falls . Date Initiated: 04/01/2025 . Goal . will have reduced risk for falls and fall related injuries . Interventions Encourage and assist to wear appropriate non skid footwear Date Initiated: 04/01/2025 . Offer to ambulate (the resident) when she is restless Date Initiated: 04/07/2025 offer toileting assistance after breakfast Date Initiated: 06/01/2025 Assist with toileting Date Initiated: 04/01/2025 Assist with transfers Date Initiated: 04/01/2025</p> <p>A review of the . needs assistance with activities of daily living r/t CKD (kidney disease), malnutrition, visual deficits, hearing deficit. She is a Hospice patient and a decline is expected Date Initiated: 04/01/2025 Goal (the resident) will have care needs met daily with assistance of staff to promote comfort and dignity . Interventions Continence - assist with incontinent care . DRESSING: Staff assistance . AMBULATION: requires staff assistance x 1 Assistive Devise used: rolling walker with seat Date Initiated: 04/01/2025 TOILET USE: Staff assistance Date Initiated: 04/01/2025 TRANSFER: Staff assistance x 1 Date Initiated: 04/01/2025 .</p> <p>On 6/05/25, at 8:39 AM, Hospice Nurse Z was interviewed regarding Resident #43's falls and cognition. Hospice Nurse Z offered, regarding the falls, I think it's more of her poor safety awareness, her stage of dementia and is unsafe to walk on her own.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure clean Continuous Positive Air Pressure(CPAP) equipment for one resident (Resident #30) of one resident reviewed for respiratory equipment, resulting in visibly soiled respiratory equipment.</p> <p>Findings include:</p> <p>Resident #30:</p> <p>On 6/03/25, at 10:37 AM, Resident #30 was resting in bed. Their CPAP nasal mask was lying on their bed. The nasal piece had gross amount of dirty buildup. The coiled tubing had brown residue on the outside and on the inside of the tubing approximately 12 inches from the nasal mask into the tubing. The head strap was soiled with brown buildup. The resident complained nobody cleans it.</p> <p>On 6/03/25, at 1:52 PM, A record review of Resident #30's electronic medical record revealed an admission on [DATE] with diagnoses that included Obstructive sleep apnea, Heart Failure and Chronic Obstructive Pulmonary Disease. Resident #30 required assistance with Activities of Daily Living (ADL)'s and had impaired cognition.</p> <p>A review of the physician orders revealed CPAP: Corrugated Tubing Cleaning: Cleanse corrugated tubing for CPAP weekly by placing in warm soapy water, rinse with water and allow to air dry on towel .</p> <p>A review of the TREATMENT ADMINISTRATION RECORD 6/1/2025 - 6/30/2025 revealed . CPAP: Corrugated Tubing Cleaning: Cleanse corrugated tubing for CPAP weekly by placing in warm soapy water, rinse with water and allow to air dry on towel. at bedtime every Sun . Sun 1 . box was check marked which revealed the treatment was completed despite the brown buildup noted on the tubing and mask.</p> <p>On 6/04/25, at 9:20 AM, Resident #30 was resting in bed. Their nasal CPAP mask was resting on the bedding. The tubing, mask and strap remain with brown buildup.</p> <p>On 6/05/25, at 11:31 AM, Resident #30 was sitting in their wheelchair. An observation along with Nurse T was conducted of the CPAP mask and tubing. The CPAP mask and tubing was coiled up resting directly on the floor. Nurse T was asked what they saw on the nasal mask and tubing and Nurse T offered, its brown buildup of something and planned to get the resident new equipment. Nurse T was asked if they though it had been cleaned lately and Nurse T offered, it is dirty.</p> <p>On 6/05/25, at 1:00 PM, an observation of Nurse T in Resident #30's room was conducted. Nurse T had cleaned the nasal mask and strap for the resident. The respiratory equipment was clean of all brown buildup. Resident #30 offered they were happy with the new equipment.</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This Citation pertains, in part, to Intake Number MI00153038.</p> <p>Based on observation, interview and record review, the facility failed to ensure that adequate staffing to meet residents' needs for Activities of Daily Living (ADL) was performed and respond to and provide care to meet the needs, resulting in complaints about showers not being provided, and frustration of residents' unmet needs.</p> <p>Findings include:</p> <p>During Resident Council held on 6/3/2025 at 1:15 PM, the residents were queried regarding staffing at the facility. The sixteen residents in attendance unanimously stated there was a shortage of staff at the facility and shared the following:</p> <p>Many times, there is only one aide working the floor and that makes it difficult to meet their needs.</p> <p>They take an extended amount of time to answer their call lights and once they arrive, they say it's because they are short staffed.</p> <p>If staff know someone is going to call-in, they are not going to pick up the shift as they don't want to work short.</p> <p>Many aides have a set pattern during their shift that they will not adjust it, so residents have to wait until the aide is ready to assist them with their needs.</p> <p>Due to the staffing their call light response times are extended, they are not consistently receiving their showers and incontinence care is not being completed in a timely manner.</p> <p>Interviewed residents did not want to be identified:</p> <p>In an interview on 06/03/25 at 09:28 AM with male resident when queried about staffing and call light response replied: No. Not enough people to help us, and they have attitudes too. I'm old and I feel like I am being treated poor. They just don't care.</p> <p>In an interview on 06/03/25 at 09:32 AM with a male resident when queried about staffing and call light response replied: They need more aides, the call lights on 30 minutes to 2 hours. They need more staff, and I would think that 30 minutes is reasonable for them to get there. They will come in and shut my call light off and not come back and not do anything.</p> <p>In an interview on 06/03/25 at 09:36 AM with a male resident when queried about staffing and call light response replied: There is no service, they tell us no or wait till next shift to go to the bathroom. The staff have attitudes, I do get cleaned up, I can do most of it myself. Some staff are great, and others are terrible. Third shift, there's just not enough helpers, they call in and then the staff that shows up has to do 30 people.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 06/03/25 at 10:59 AM with a male resident when queried about staffing and call light response replied: No, there is not enough staff here. I call out all night just to get someone to help me. I can hear them in the hallway, and they don't come in here. It takes a long while to get someone in here. I yell out when I hear them.</p> <p>In an interview on 06/03/25 at 11:19 AM with a female resident when queried about staffing and call light response replied: The staff lack empathy to us residents. I tell the aides that I have pain, and they tell me to wait my turn. The third shift is the worst, we don't even see them, they will turn off the call light and not come back. I had to get up and go to the nurse station, to get help. I wait so long I have wet my pants waiting for help to go to the bathroom. They say give me a second and an hour later they come back.</p> <p>In an interview on 06/04/25 at 12:40 PM with a male resident when queried about staffing and call light response replied: There seems to not be enough staffing. An aide will come in that is not my aide and say what do you need? and then say I'm not your aide but I will tell them know and shuts off the call lights and no one comes. They will run in and shut the light off and say I all be back. They may say wait till next shift to get cleaned up. Call lights can take up to 20 minutes to over an hour. There used to be shower aide and they got rid of her and now the floor aides have to do the showers. Showers are not as often and it depends on who the aide is, and usually no I don't get the shower. There is so much turnover in staff that they can't keep the staff here. They will walk by my room and not even ask if there was something I need. There are staff that will hide and not do the work or just walk up and down the hallways. Night shift doesn't bring the waters in the evenings, and I can go all night and not see a soul. I can hear them way down the hall laughing.</p> <p>In an interview on 06/03/25 at 10:37 AM with a male resident when queried about staffing and call light response replied: I did put in a complaint about staffing- it's been a while ago, there is not enough aides at night after 9-10 PM. I can ask for water, and no one will bring me any water. I have to ask 3-4 times to get water. They tell me I'll be right back and then I wouldn't see them again. Call lights are slow they take a long time, or they don't come at all. My roommate turned his call light on and waited 2 hours just to get dressed, I finally went out into the hallway to get someone to help him put on his pants. When I bitch, I get a shower. They will tell me that I get a shower at PM and they say they are waiting for the afternoon shift to give the shower. The aide will put me in the shower room and leave to go make the bed or just to go somewhere. They leave me in the shower room [ROOM NUMBER] minutes, just sitting. The aides are not trained to give a shower, they just get us wet.</p> <p>In an interview on 06/03/25 at 09:43 AM with a male resident when queried about staffing and call light response replied: There are a couple of sore spots (employees) that work here. Most of the time there are people that call in, and management can't get staff to work. Call light response, I have waited 1 to 1.5 hours before, I don't want to name any names, but they are lazy. I eat in my room, most of the time it is warm when I get it. It depends on how many (employees) are here to pass the trays and how long it sits in the hallway before I get it. There are a couple of staff that just walk the halls and look busy, but they don't want to be here at all.</p> <p>Observation on 06/04/25 at 09:15 AM by the surveyor while standing at the nursing station 4 staff members to be complaining about being short staffed.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 06/04/25 at 09:27 AM with Certified Nurse Assistant (CNA)/Clinical staff scheduler O Nurses clinical staff discussion of staffing levels revealed: Honestly, they do work short. I cannot get staff in on some days and the CNA's do work short. I can come in if I can and work. I can't be here all the time. If know ahead I can plan to work, short call-ins, sometimes I can get coverage, sometimes I cannot. Unfortunately, with the current staff we have short staff because of call-ins. My burned-out staff are the ones that come in pick up the extra shift. It's just daily with the call-ins, I have been in this position and there have been few days that there has not been a call-in. The Call-in process, employee calls in to phone number for the on-call nurse, The on-call nurse lets me know and I go to work to find the coverage. We do not use agency; we are not allowed too. Coverage comes from within the building staff. Scheduler O was asked if she was aware of Call lights not being answered- not to my knowledge, I have had a resident yesterday tell me that staff come in and shut off the call light and do not provide the service and don't come back. We had a drastic resident move in rooms to the north unit and the staff have had a bad attitude, some have quit, some have been termed, and some don't do their job and hide instead of doing the work.</p> <p>Record review of the facility 'Certified Nursing Assistant' job description dated 3/2025, position summary the Certified Nurse Assistant (CNA) is a member of the community nursing team whose responsibility is to assist professional nursing personnel by delivering direct hands-on nursing care to ambulatory and non-ambulatory residents on a daily basis . To perform or assist the resident with completing Activities of Daily Living (ADL).</p> <p>Record review and interview on 06/05/25 at 10:03 AM Human resource (HR) staff R stated that bathing and showers is on the annual competency and orientation forms, both the employee and manger sign off on the competency forms annually. Record review of the competency form identified that Activities of Daily Living/Showers was listed as a skill for competency review yearly.</p> <p>In an interview on 06/05/25 at 12:14 PM with the Nursing Home Administrator (NHA) in discussion of Staffing and staff turnover, replied: The facility is weeding out some people. We educate and re-educate, but they (employees) do not want to perform the job. The state surveyor inquired about the Cameras in the hallways and if they were ever reviewed for resident care/response times. The NHA replied that the cameras are not functional. NHA was Notified of One star rating for staffing for weekends. The Nursing Home Administrator was notified that the surveyor received Call light complaints from residents for lack of water pass on third shift, call light shut offs and call light waits times of 30 minutes to an hour for the staff to come back but they don't come back. The Nursing Home Administrator (NHA) stated that the facility did have call light audits on the time of response, but no audit on the actual service being provided to the residents. Residents complaining that the service is not provided.</p> <p>Record review of facility 'Staffing' policy revision date 9/19/2024 revealed the purpose is to provide sufficient care team members with appropriate competencies and skill sets to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident . (E.) Providing care includes but is not limited to. assessing, evaluating, planning and implementing resident care plans and responding to resident's needs.</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Resident #40:</p> <p>Review of the Face Sheet, care plans dated 8/23 to 3/25, and cognitive assessment dated [DATE], revealed Resident #40 was [AGE] years old, alert and able to make own decisions regarding health, bed bound and dependent on staff for all ADL's. resident #40's diagnosis included heart disease with heart failure, Atrial Fibrillation, morbid obesity, chronic respiratory failure with oxygen decency.</p> <p>Review of the resident's facility Fall, Skin, and ADL care plans dated 8/1/23, revealed she had a flat round call light, was incontinent, and preferred bed baths 2 times weekly. The resident had refusals of medications and care; staff were to re-approach and encourage resident to accept care and medications and honor decisions and preferences.</p> <p>During an interview done on 6/3/25 at 11:45 a.m., Resident #40 stated It's (food on meal tray) is cold, it's bad; they have an issue here, I am allergic to caffeine, so they don't give me coffee. The other night they served egg salad and I got egg shells in mine, they were crunchy. You may get your tray (noon) meal at 1:00 p.m., or later in the day, as late as 6:00 p.m.</p> <p>Observation was done on 6/3/25 at 1:30 p.m., revealed the resident was delivered her meal in her room and this surveyor present. The resident's tray did not have 1/2 cup of mashed potatoes and 1/2 cup of green beans on it, however it was on the dietary slip dated 6/3/25 for the noon meal. The facility did not honor the residents preference.</p> <p>During an interview done on 6/4/25 at 11:47 a.m., the resident stated she did not receive her oatmeal this morning.</p> <p>During an interview done on 6/4/25 at 1:55 p.m., Director of Activities U stated Their (residents who attend the council meeting monthly) main complaint is they don't get what they are supposed to get on their trays.</p> <p>Based on observation, interview and record review, the facility failed to ensure palatable and per preference meals for 2 residents (Residents #35 and Resident #40) of 19 sampled residents and the Resident Council, resulting in resident dissatisfaction with food and the meal experience.</p> <p>Findings include:</p> <p>During Resident Council held on 6/3/2025 at 1:15 PM, the residents were queried regarding the food and meals at the facility. The sixteen residents in attendance unanimously stated there was food issues and shared the following:</p> <ul style="list-style-type: none"> - not good. - not enough food. - eggs with bread every day want something else. - taste rotten - certain meals the lasagna- the sausage. <p>(continued on next page)</p>

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

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- said they are doing too much with the food and tossing it over the food.</p> <p>- it takes too long for them to get to you, and it comes from the kitchen hot but by the time it delivered to the residents it cold- it's a 15-20 minutes later than his roommate.</p> <p>- oatmeal lumpy or watery- not consistently.</p> <p>13-14 Residents responded and all meals are not timely- 30 minutes or more late and every week get the menu and go through it and put the residents name and what he would like and tell them choices and still don't get preferences.</p> <p>- allergic to tomatoes and still get them.</p> <p>- does not get meal preferences.</p> <p>-dietary staff was leaving at 7 PM and not supposed to leave until 8 PM. kitchen staff does what they want to do when they want to do it.</p> <p>-her workers don't respect her and when they give her instructions, and they do the opposite, and they are fearful in speaking up.</p> <p>Resident #35:</p> <p>In an observation and interview on 06/03/25 at 12:34 PM with Resident #35 is thin in appearance and has missing teeth in front. Resident #35 stated that he eats his meals in the room and that its usually cold and tasteless. He does eat the food and stated he doesn't like to complain about it. Observed Resident #35 to have a case of bottled water in his room at bedside with 6 bottles left in a 12 pack of bottles. Resident #35 stated that because he doesn't get fresh water regularly and so he keeps water bottles in his room.</p> <p>In an observation and interview on 06/04/25 at 01:14 PM the surveyor observed Resident #35's noon meal tray, and he had eaten everything on the plate and drank all 4 glasses of fluids on the tray. Resident #35 stated that the food is flavorless and that its cold when he gets it.</p> <p>In an observation and interview and 06/05/25 at 08:50 AM with Resident #35 stated I keep the water pack in here because I can reach it when I want water, I got fresh water today this morning, usually it takes a while. The surveyor observed that there were less than 6 bottles left in the water package at bedside.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to 1) Maintain a clean, sanitary kitchen and 2) Ensure that kitchen equipment (dishwasher), walk-in cooler fan covers and kitchen sink were in good working condition, resulting in the potential for cross contamination, residents, visitors and staff illnesses.</p> <p>Findings Include:</p> <p>Review of the Public Health Service 2009 Food Code, adopted by the Michigan Food Law, effective October 1, 2012, Chapter 4-501.14 directs that equipment cleaning frequency is to be throughout the day at frequency necessary to prevent recontamination of equipment and utensils.</p> <p>During the initial tour of the facility kitchen, done on 6/3/25 starting at 9:30 a.m., accompanied by [NAME] A #1 ([NAME]), the following was observed:</p> <p>-At 9:30 a.m., 2 clean and ready for use kitchen food knives were observed in the knife rack with dried on food on the blades.</p> <p>-At 9:35 a.m., the clean and ready for use large can opener was found to have a black piece of dried oil-like substance on the blade.</p> <p>During an interview done on 6/3/25 at 9:32 a.m., [NAME] A #1 stated I have no idea what that is, I will wash it.</p> <p>-At 9:36 a.m., 2 plate warmers were observed to have 3 clean and ready for use white plates with dried on food particles on the top of them; the bottom of the plate warmers had pieces of food and crumbs in them.</p> <p>-At 9:37 a.m., the steam table had 4 tops covering each water compartment, and all of them had crumbs and dried on food on them. All the food had been taken out by this time.</p> <p>During an interview done on 6/3/25 at 9:38 a.m., cook A #1 stated The cooks are supposed to clean them (steam table and lids).</p> <p>-At 9:40 a.m., the professional oven was found to have dried drips and food on the front, sides, and the handles.</p> <p>-During an interview done on 6/3/25 at 9:41 a.m., [NAME] A #1 said it (the professional oven) should be wiped down after each use.</p> <p>-At 9:42 a.m., the microwave was found to have dried on food on and inside the white vents in the back.</p> <p>During the interview done on 6/3/25 at 9:42 a.m., [NAME] A #1 stated cooks clean it (microwave)out.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Review of the facility kitchen job duties/tasks (un-dated) revealed Cooks had the jobs of cleaning food equipment and weekly cleanings of equipment (including the refrigerators/freezers).</p> <p>-At 9:45 a.m., the working large dishwasher was observed spraying hot water (strip tested at 160 degrees) onto the silver water shield that was loose, moving around with the vibration of the dishwasher, and dripping water on the floor and spraying staff. There was a substantial amount of water on the floor with no safety mats on the floor for staff. Staff members (x 3) were walking in the puddles of water caused by the dishwasher. The back of the dishwasher was also spraying water on the floor and on staff, so the floor at the back of the dishwasher was also wet with no mats down. The blue plastic curtains connected to the back of the dishwasher were bent and did not prevent the water from coming out of the machine.</p> <p>During an interview done on 6/3/25 at 9:46 a.m., Dietary Aide C stated yes, it's hot (the water, strip tested at 160 degrees) when it sprays out, both sides spray out.</p> <p>During an interview done on 6/3/25 at 9:46 a.m., [NAME] A #1 stated They did not put the mats down. The 2 black mats were observed to be rolled up under the sink counter at the time.</p> <p>During an interview done on 6/3/25 at 10:10 a.m., Director of Maintenance D stated That's the way it is, there is nothing we can do about it. This surveyor requested the dishwasher manual and the companies phone number to follow-up.</p> <p>During a phone interview done on 6/3/25 at 3:35 p.m., regarding the dishwasher model CL44e, the company that made and installed the dishwasher was contacted by this surveyor. Company Representative J said it was not normal for water to spray out of both sides of the dishwasher and the curtains need to be replaced; it's not normal for the shield to be loose.</p> <p>-At 9:47 a.m., 2 clean and ready for use soft plastic specula's were found in the utensil drawer; both had pieces broken off of them and had dried food (batter-like substance) on them. In the same drawer a silver metal large specula was found with dried on food.</p> <p>-At 9:48 a.m., the three compartment sink in the dish room was turned on and water sprayed out the side of the faucet, all over the wall.</p> <p>During an interview done on 6/3/25 at 9:48 a.m., [NAME] A #1 stated the company (facility maintenance) put that (sink faucet) on about 2 to 3 weeks ago.</p> <p>During a interview done on 6/3/25 at 10:10 a.m., Director of Maintenance D stated We didn't know about the sink spraying.</p> <p>-At 9:52 a.m., Dried coffee was noted inside the drawer under the coffee pot makers.</p> <p>-At 9:53 a.m., the walk-in cooler fans (x 2 fans) was observed to have black dust/dirt on the top outside of the covers.</p> <p>During an interview done on 6/3/25 at 3:30 p.m., Director of Maintenance D stated I have no documentation of cleaning the covers (of the walk-in cooler), we don't have a specific time for fan covers; we wait for Dietary to let us know.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Review of the Service Report dated 4/25/25, given to this surveyor by Director of Maintenance D, revealed ice from the walk-in cooler had been removed on 4/25/25 (deiced the fans in the cooler).</p> <p>-At 9:50 a.m., the floor drain under the cook's sink had an excessive amount of dirt, dust and 2 packs of butter inside of it.</p> <p>During an interview done on 6/3/25 at 9:50 a.m., [NAME] A #1 stated It (the floor and floor drains) should be cleaned weekly.</p> <p>-At 9:55 a.m., the milk cooler was found to have dried milk dripping on the floor, and dried milk was noted on the inside bottom of the cooler.</p> <p>-At 10:00 a.m., 3 metal pans were found on the clean pan rack with no less than 50% of the non-stick coating wore off.</p> <p>During an interview done on 6/3/25 at 10:00 a.m., [NAME] A #1 stated they (kitchen staff) are supposed to replace them when they are warn; she promptly threw them away.</p> <p>During a follow-up interview done on 6/5/25 at approximately 10:13 am, the Director of Maintenance said the kitchen walk-in fan covers had not been clean from the first observation done on 6/3/25; however they were cleaning them now. The walk-in fan covers went for 3 days including day of observation, without staff cleaning them.</p> <p>Review of the facility kitchen weekly cleaning schedule, revealed on Tuesdays drains were to be cleaned out, on Wednesdays utensil drawers were to be cleaned, and on Saturday, the steam table lids were to be cleaned.</p> <p>Review of the facility kitchen daily cleaning schedule revealed the microwave and can opener were to be cleaned daily.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** During an observation done on 6/3/25 at 12:16 PM, no hand sanitizer was in the in container of Resident #40's room.</p> <p>Throughout the survey (from 6/3/25 to 6/5/25), at random times during first shift, food delivery with set-up, Dietary staff and Nursing Assistant's/CNA's were observed in the residents room touching the residents food tray, bedding and environment with no hand washing or hand sanitizer used prior to leaving the residents room.</p> <p>Based on observation, interview and record review, the facility failed to implement and operationalize a comprehensive infection control program including outcome and process surveillance resulting in 1) Inaccurate and incomplete outcome surveillance; 2) A lack of documentation of process surveillance; 3) A lack of surveillance to identify potential infections; 4) A lack of analysis of infection data; 5) A lack of appropriate response to staff report of potential bed bugs; and 6) A lack of easily accessible hand hygiene equipment and appropriate hand hygiene by staff.</p> <p>Findings include:</p> <p>On 6/3/25 at 10:49 AM, an interview was completed with Infection Control (IC) Registered Nurse (RN) K. When asked how long they had been working at the facility, IC RN K stated, I hired into (sister facility in different city). With further inquiry IC RN K stated, They had issues with having an IC person here, so I started coming here 2 days a week to assist with vaccines then the IC (nurse) here recently left their position, so I come here Tuesday and Friday now because still working (at sister facility in different city). IC RN K was asked when the full time IC nurse at the facility left their position and replied, They left last week I think. IC RN K was queried regarding the facility process/process for IC surveillance at the facility and stated, The computer does it and then I print it and put it in the book. IC RN K revealed they did were not sure how the prior IC nurse completed surveillance including line listings. When queried regarding the facility water management plan, IC RN K stated, I know nothing about it. I have not looked at it. When asked if any residents were on Transmission Based Isolation Precautions (TBP), IC RN K replied, No. With further inquiry regarding the facility IC program, IC RN K indicated there were Very few (residents) on antibiotics as well. The facility IC data including surveillance and line listings for the past six months were requested at this time.</p> <p>The facility provided a binder containing infection surveillance data and surveillance documentation for January 2025 to May 2025. A brief review of months provided revealed a summary and analysis of the monthly infections were not included.</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Review of Resident #28's Electronic Medical Record (EMR) revealed a General Progress Note dated 6/2/25 at 12:42 AM which detailed, While cleaning my cart, I was approached by both second-shift aides (Certified Nursing Assistant [CNA]) who reported a concern regarding a possible bed bug infestation involving the resident. The aides stated that during routine care-while changing and cleaning the resident-they observed dark brown specks on the resident's blankets and sheets. When one of the aides attempted to touch one of the specks, it reportedly began moving on its own. The aides completed care before bringing this to my attention. Upon being informed, I contacted the on-call supervisor to report the situation. I was instructed to double bag any items used in the resident's room or on the resident until Pest control is able to inspect and treat the area. These instructions were communicated to both second-shift aides as well as the third-shift aide. The situation will continue to be monitored until resolved.</p> <p>No further progress note documentation was present in Resident #28's EMR.</p> <p>A skin assessment was not present in Resident #28's EMR.</p> <p>Record review revealed Resident #28 was admitted to the facility on [DATE] with diagnoses which included heart disease, dementia, dysphagia (difficulty swallowing), and psychotic disturbance. A review of Resident #28's Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was rarely/never understood and required maximum to total assistance to complete all Activities of Daily Living (ADLs).</p> <p>On 6/3/25 at 3:46 PM, Resident #28 was observed in their room from the hallway of the facility. The Resident was in bed and yelling out non-sensical words.</p> <p>At 3:48 PM on 6/3/25, three staff members were observed sitting and talking at the nurses' station. The staff included CNA L, CNA M, and Licensed Practical Nurse (LPN) N. When queried regarding documentation in Resident #28's EMR indicating staff observed bed bugs in the room, the staff indicated they were aware. CNA L then stated they never saw no bugs. CNA M then stated, It actually happened Saturday or Sunday. I know for sure it wasn't yesterday (Monday). LPN N confirmed the bed bugs were reported over the weekend but were unsure of the day and stated, This is East (unit) and I am usually on North (unit). When queried, all three staff relayed they were not working when the bugs were observed in the Resident's room. When asked if they were informed during Report, all staff verbalized they were not informed in report. CNA M then stated, (Staff O) told us about it. When asked if the Resident had any alterations in skin integrity, LPN N and CNA L indicated the Resident was getting a preventive cream on their buttock. When asked if they had observed any bites, such as bed bug bites on Resident #28, the staff responded they had not. When asked if they knew what bed bug bites looked like on an African American individual, all three staff revealed they did not.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>An interview was completed with IC RN K on 6/3/25 at 4:15 PM. IC RN K was shown the progress note related to bed bugs dated 6/2/25 in Resident #28's EMR. When asked if they were notified staff found insects, identified as possible bed bugs, in the Resident's bed/bedding, IC RN K stated, I was not aware of that. The Director of Nursing (DON) entered the room at this time. When asked, the DON stated, I was aware. When asked what happened, the DON stated, Maintenance was notified and the Administrator. (Maintenance Director D) notified pest control (company) and checked in the meantime. When queried if a nursing skin assessment should have been completed after bugs were discovered in the Resident's bed/bedding, the DON replied, I would assume and IC RN K verbalized a skin assessment should be completed from an IC perspective. When asked if a skin assessment had been completed, IC RN K reviewed Resident #28's EMR and confirmed a skin assessment had not been completed. When asked if any additional actions and/or precautions should have been implemented/taken, no further explanation was provided. When queried regarding documentation of actions, including from the pest control company, the DON indicated that would need to get the documentation from Maintenance Director D.</p> <p>An interview was completed with Maintenance Director D and IC RN K on 6/3/25 at 4:25 PM. When queried regarding documentation related to the report of potential bed bugs in Resident #28's room, Maintenance Director D responded that they did not have any documentation. Maintenance Director D was asked what happened and revealed the Administrator called them on Sunday to inform them of the concern. When asked what time the Administrator contacted them, Maintenance Director D responded that it was around 5:00 PM. Maintenance Director D indicated they came to the facility and stated, I called pest control on my way. When queried what time they arrived at the facility, a response was not provided. When asked what happened when they arrived at the facility, Maintenance Director D stated, I did a complete investigation of the room and looked at the sheets on the bed and did not find any tracks, etc. When asked if they looked at the sheets that were in place on the Resident's bed at that time, Maintenance Director D confirmed that was what they were saying. Maintenance Director D did not state where the removed sheets/bedding were when they arrived at the facility. Maintenance Director D then stated, I went in and looked at the Resident and did a skin assessment. Director D indicated a Therapy Staff was in the room and verbalized they did not see any evidence of bed bugs and/or bed bug bites on the Resident's skin.</p> <p>When asked what their professional ability and/or credentials are to be able to assess a Resident's skin, Maintenance Director D responded that they have been in a Maintenance for 20 years and know what they are doing. Maintenance Director D was asked again what professional licensure and/or certification they have to look at and assess a Resident's skin, Director D stated, I have no professional experience. When asked what a bed bug bite looks like, Maintenance Director D stated, A red spot with a dot of blood in the center. When asked if there is a difference in appearance of bed bug bites in Caucasian and African American skin tones, Maintenance Director D replied, I don't know. When asked how they assessed Resident #28's skin for potential bed bug bites when they did not know what a bed bug bite looks like, Director D did not provide a constructive response. When queried regarding the pest control company response, Maintenance Director D stated, On my way home, I called and canceled pest control. When queried, Maintenance Director D indicated they cancelled the pest control company because they did not observe any bed bugs. After Maintenance Director D exited the room, IC RN K was asked what their thoughts were regarding what Maintenance Director D had verbalized and stated, How do I rectify this? IC RN K confirmed Maintenance Director D should not have assessed the Resident's skin and they were unsure why therapy staff were involved. IC RN K indicated an assessment should have been completed by nursing and verbalized they would complete a skin assessment for Resident #28.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>An interview was conducted with the Administrator and DON on 6/3/25 at 5:15 PM. The Administrator and DON were informed of the interview with and statements made by Maintenance Director D. When asked if Maintenance Director D is able to complete a skin assessment, the DON replied, No. The Administrator then stated, I'm sure (Maintenance Director D) didn't mean it that way. When asked why they clearly stated that, even when asked to clarify, the Administrator replied, Probably mean something else. When queried why a nursing assessment, including skin assessment, was not completed, the DON replied, Well (the nurse) did it but just forgot to document it. When queried regarding accurate and timely documentation, further explanation was not provided. When queried regarding facility policy/procedure related to suspected and/or potential bed bug identification in the facility and infection control, the Administrator revealed they did not believe there was a specific policy. A policy/procedure was requested.</p> <p>An interview was completed with the DON at 5:30 PM on 6/3/25. When queried if they were aware that Maintenance Director D canceled the pest control company, the DON replied, No. The DON stated, I was informed that maintenance came in and that pest control was called. When asked if the pest control company should have been cancelled, the DON did not respond. When queried who was responsible for IC in the facility when RN IC K was not in the facility, the DON revealed they were and indicated RN IC K was transitioning to work in the building full time. The DON was then asked who the facility IC data and program should be reviewed with and responded IC RN K.</p> <p>A review of facility provided infection control documentation for January 2025 was completed. The provided documentation did not include a summary and/or analysis of the infections for the month.</p> <p>The provided information included a mapping tool, a written Monthly Infection Surveillance Report line list, three Documentation of Infection Signs/Symptoms Communicable Disease . Employee forms, staff education, and laboratory testing reports for Resident #30 and Resident #348.</p> <p>Review of the number of infections on the mapping tool and the Monthly Infection Surveillance Report line list did not match.</p> <p>Additionally, the line list detailed five Residents had Covid-19 infections but there was no documentation of Health Department notification, outbreak investigation/testing, and/or implementation of measures to prevent transmission of Covid-19 including in the provided IC information.</p> <p>The Monthly Infection Surveillance Report line list included the headings: Resident, Room #, admit date , Date of Onset of Symptoms, Type of Infection, Signs & Symptoms of Infection, Specific Diagnostics/lab testing, Causative Organism, Treatment, Date Initiated, Date Discontinued, Meets McGeers Criteria . Transmission-Based Precautions . Repeat Diagnostic Testing if any/Date, Nosocomial (Facility acquired) or Community Acquired .</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>The line listing detailed Resident #30 had a Urinary Tract Infection (UTI). Resident #30 was included on the line list two separate times for a UTI with different admission dates but with the same organism and treatment information. One of the listings indicating the Resident was on Standard precautions and the other indicated the Resident had EBP (Enhanced Barrier Precautions) in place but no date was specified. Per the line list, signs and symptoms of infection included foul odor in one line and overall decline in another. Both lines listed the infection was nosocomial and date of symptom onset was 1/6/25. A UA (urinalysis) with Culture and Sensitivity (C&S) was completed and the Resident was treated with Augmentin (antibiotic) 500/125 milligrams (mg) for seven days from 1/16/25 to 1/23/25. The line listing surveillance form did not indicate if the infection met McGeers criteria nor did it specify the date the UA with C & S was completed. However, a copy of the laboratory testing results for the Resident was included in the infection control documentation for the month. Per the laboratory testing information, the UA was completed on 1/6/25 and the C&S results were reported to the facility on 1/13/25 and showed Proteus mirabilis (bacteria found in the GI tract and often in feces) in Resident #30's urine. The line list did not specify if the Resident had an indwelling urinary catheter.</p> <p>A wound C&S for Resident #348 dated as completed on 1/8/25 and reported on 1/13/25 was present in the provided IC documentation for January 2025. The C&S detailed, Heavy Growth Proteus Mirabilis and Heavy Growth Streptococcus (Group B) Agalactiae (bacteria often found in the intestines and lower genital tract). Resident #348 was not included on the line listing for the month. A review of the Resident's Electronic Medical Record (EMR) revealed the Resident did not receive antibiotic treatment and no documentation addressing the culture results was noted.</p> <p>On 6/4/25 at 12:56 PM, an observation of ADL care completion for Resident #42 was completed with Certified Nursing Assistant (CNA) X and CNA Y. The Resident was wearing a brief and had been incontinent of both bowel and bladder. The staff donned gloves, cleaned the Resident, and applied a new brief. During care, a moderate amount of bright red blood was observed on Resident #42's left ear and pillow. CNA Y pointed the area out to CNA X and CNA Y touched the open, bleeding wound on the Resident's ear while wearing the same gloves they wore while cleaning the Resident's peri area and bowel movement. CNA Y then touched the room divider curtain with their visibly soiled gloves. CNA Y removed their gloves and exited the room without performing hand hygiene. When CNA Y left the room, CNA X entered the restroom in the room without removing their gloves or performing hand hygiene to assist Resident #38 (Resident #42's roommate). The bathroom door was open, and the sink was not heard. CNA X assisted Resident #38 out of the bathroom into the shared room. After positioning Resident #38 in their wheelchair, CNA X removed their gloves and exited the room without performing hand hygiene. An observation of the room revealed there was not a hand sanitizer dispenser in the room or bathroom. A closer observation of the room divider curtain revealed the curtain was visibly soiled with multiple areas of different colored and unknown substances on various areas of the curtain.</p> <p>An interview and review of facility provided infection control documentation was completed on 6/4/25 at 1:56 PM with IC RN K. When queried, IC RN K stated, McGeer is criteria used for infections.</p> <p>IC RN K was asked to review the Infection Control documentation for January 2025 at this time. When queried if the number of infections on the line listing should correlate with the number of infections indicated on the mapping tool, IC RN K verbalized they should. IC RN K was asked why the number of infections did not match and indicated they would need to review and count. After counting, IC RN K confirmed the number of infections listed did not match. When queried regarding the discrepancy, IC RN K reiterated they had not completed the IC data for the month and were not sure.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Upon request, IC RN K reviewed the C&S report for Resident #348 included in the IC documentation for January 2025. When asked if the C&S indicated Resident #348 had an active infection, IC RN K confirmed they did. IC RN K was then asked why Resident #348 was not included on the IC line list for the month and indicated they should be. After reviewing the line list form, IC RN K verified Resident #348 was not on the line list. When asked if Resident #348 received treatment for the infection, IC RN K reviewed the Resident's EMR and replied, No treatment. When asked why the wound infection was not treated, IC RN K reviewed the Resident's EMR including progress note documentation as well as the IC surveillance and listing documentation for the month. IC RN K verbalized there was no documentation in the EMR, and they were unable to provide an explanation. When queried regarding the location of the wound, IC RN K replied, Heel. IC RN K was then asked how two bacteria, commonly found in the intestines and fecal matter had caused an infection in the Resident's heel and stated, I have no words. With further inquiry, IC RN K indicated the infection provided multiple opportunities for further analysis and staff education.</p> <p>IC RN K was then queried regarding Resident #30's UTI. When queried if the two separate listings for Resident #30's UTI was the same infection, IC RN K reviewed the documentation and indicated they would assume it was same infection as the dates, infection type, and causative microorganism were the same. When asked why the infection was listed twice with two different signs and symptoms of infection indicated, IC RN K was unable to provide an explanation. IC RN K was asked if the infection should be on the line listing form twice and replied, No. When asked if Resident #30 has an indwelling urinary catheter, IC RN K verbalized the information was not included on the line list. When asked if it should be, for infection surveillance and tracking, IC RN K indicated it should. When asked if the infection met McGeer Criteria for treatment, IC RN K confirmed the line list did not specify and there was no documentation included in the provided IC information for January 2025. IC RN K revealed they complete an Infection Screening Evaluation in the resident's EMR at the facility they primarily work at which includes McGeer criteria. A review of Resident #30's EMR revealed an Infection Screening Evaluation dated 1/6/25 had been completed and specified the Resident had urinary frequency and urinary urgency. IC RN K was then asked when the signs and symptoms of urinary frequency and urgency began, IC RN K verbalized the line list indicated 1/6/25. When queried if testing and treatment are typically initiated the same day symptoms of infection start, IC RN K replied, No, not typically and began reviewing Resident #30's EMR. IC RN K revealed they did not see documentation of frequency and urgency in the Resident's EMR but stated, They had a fall on 1/5/25 and indicated the UA and symptoms may have been identified at that time, but they were unable to say for sure.</p> <p>Resident #349's infection information on the line list was reviewed with IC RN K at this time. The Resident was listed as having a nosocomial UTI. Per the line list, the signs and symptoms of infection began on 1/20/25 and included dysuria (painful urination), urgency, and another illegible symptom. The line list detailed a UA with C&S was completed (no date) which showed the Resident had E-coli (Escherichia coli-bacteria found in GI tract and oftentimes feces)/ESBL (Extended-spectrum beta-lactamases- group of bacteria which are antibiotic resistant) and was treated with antibiotics from 1/21/25 to 1/28/25. Laboratory testing for Resident #349 was not included in the IC documentation for January 2025. When queried regarding the Resident's symptoms, IC RN K reviewed the Resident's EMR and revealed an Infection Screening Evaluation was completed on 1/22/25. When asked why the evaluation was not completed until 1/22/25 when the line listing specified symptoms and treatment started on 1/20/25, IC RN K revealed they were unsure. A review of Resident #349's EMR revealed a General Progress Note dated 1/20/25 at 8:00 AM which specified, Late Entry . patient was sent out (to hospital Emergency Department) due to being unresponsive. patient was sent back with order of amoxicillin (antibiotic) due to (UTI).</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During review of Resident #349's EMR, it was noted that the Resident tested positive for Covid-19 on 1/29/25 and was started on Paxlovid (anti-viral medication used as a treatment for Covid-19) on 1/31/25. Resident #349 was not included on the January 2025 line listing for Covid-19 infection. When queried why Resident #349's Covid infection was not included on the infection surveillance line list for January 2025, IC RN K was unable to provide an explanation but confirmed the infection should have been included. When asked why the Resident was not started on Paxlovid until 1/31/25 when they tested positive for Covid-19 on 1/29/25, IC RN K revealed they did not have an explanation. No progress note documentation providing additional explanation was present in the Resident's EMR.</p> <p>Review of the January 2025 line listing details for Resident #35 revealed the Resident was treated for a UTI. The signs/symptoms of infection included nephrostomy (surgical procedure where a catheter is surgically placed through the back, directly to the kidneys to allow for the drainage of urine) tube placement and began on 1/6/25. Per the line listing, the causative organism of the infection was Pseudomonas aeruginosa (bacteria which commonly causes infections with some strains being resistant to nearly all antibiotics). The line listing did not include the date antibiotic treatment was started but specified Cipro (antibiotic) was discontinued on 1/11/25 and detailed n/a for McGeers criteria and did not specify if the infection was facility or community acquired. The facility IC documentation for January 2025 did not include laboratory testing results including C&S for Resident #35.</p> <p>Resident #81 was included on the January 2025 as having a UTI. Per the line list, the Resident was admitted to the facility on [DATE] and the signs/symptoms of infection began on 1/6/25. The signs/symptoms of infection were listed as back. The line listing detailed a UA with C&S was completed (no date) which showed pseudomonas (bacteria)/candida parap. (candida parapsilosis - fungal organism commonly found on the skin and in the GI tract which can lead to serious infection). The line list specified the infection was community acquired, and Resident #81 received Bactrim DS (antibiotic) from 1/14/25 to 1/17/25 as well as 1/6/25 to 1/17/25. A review of Resident #81's EMR revealed the Resident was originally admitted to the facility on [DATE] and their most recent discharge to the hospital, prior to 1/6/25 had been on 12/13/24.</p> <p>At this time, IC RN K was asked to review the infection information for Resident #35, Resident #81, and Resident #351.</p> <p>A follow-up interview was completed with IC RN K on 6/4/25 at 3:39 PM. When queried regarding Resident #35, IC RN K provided hospital medical record documentation of the Resident's urine culture dated 1/8/25. The culture detailed Pseudomonas aeruginosa and Enterococcus faecalis (bacteria normally found in the GI tract and feces) were identified in Resident #35's urine. When asked why Enterococcus faecalis was not included on the line list, IC RN K was unable to provide an explanation as they had not completed the IC surveillance data. When asked how they knew that Cipro was the appropriate treatment for the infection, IC RN K reviewed the documentation and confirmed a C&S was not present. IC RN K indicated the information may not have been sent with the Resident when they returned to the facility.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>When queried regarding Resident #81, IC RN K revealed they did not have a C & S for the UTI with symptom onset of 1/6/25. IC RN K verbalized the Resident was transferred to the hospital on 1/6/25 due to complaints of not feeling well and were diagnosed with a UTI at the hospital. IC RN K revealed the Resident returned to the facility on 1/13/25 which would explain why the line listing indicated that date as their admission date. When asked if 1/6/25 was first date of sign/symptom of infection, a review of Resident #81's EMR was completed with IC RN K. Review revealed a General Progress Note dated 1/5/25 at 5:18 PM which included documentation of the Resident stating they did not feel well. When asked if they were able to locate any other information pertaining to the UTI on 1/6/25, IC RN K revealed they did not and stated an Infection Screening Evaluation had not been completed. IC RN K revealed Resident #81 returned to the hospital on 1/18/25, diagnosed with a UTI, and admitted . Resident #81 returned to the facility on 2/1/25. When asked how the infection on 1/6/25 was community acquired when the Resident had been in the facility for three weeks prior to development/diagnosis, IC RN K confirmed the UTI was a facility acquired infection.</p> <p>IC RN K was then queried regarding the five Residents identified as having Covid-19 on the line list form for January 2025. Resident # 351 was identified as a carry over infection from December 2024. When asked if other facility residents had Covid-19 in December, IC RN K revealed they did not know. The line list detailed Resident #351 was in room [ROOM NUMBER]B and then moved to room [ROOM NUMBER] but did not specify the date moved. Per the line list, the infection was community acquired, and Resident did not receive any treatment (N/A), but treatment dates were documented as initiated 12/28/24 and discontinued 1/6/25.</p> <p>A review of Resident #351's EMR was completed with IC RN K. Review of Resident #351's hospital documentation revealed the Resident had been admitted to the hospital on [DATE] and diagnosed with Covid-19. The Resident was discharged from the hospital and admitted to the facility on [DATE]. Upon admission to the facility, Resident #351 was placed in room [ROOM NUMBER]B, a semiprivate, shared room, and then moved to room [ROOM NUMBER]A on 1/2/25. Review of Resident #351's facility EMR revealed a Covid test was completed on 1/2/25 with a negative result. On 1/3/25 at 6:00 PM, an order for Droplet isolation . until 1/6/25 . was implemented. IC RN K was asked to clarify if the Resident was admitted to the facility while being Covid positive and confirmed they were from what they read in the Resident's EMR. When asked if the Resident should have been placed in transmission-based isolation precautions for Covid-19 per Centers for Disease Control (CDC) recommendations upon admission, IC RN K stated, Yes. When asked if the Resident was placed in transmission-based isolation precautions for Covid-19 when they were admitted , IC RN K replied, No. IC RN K was asked the reason and was unable to provide an explanation. When queried why Resident #351 was tested for Covid-19 at the facility after having tested positive at the hospital, IC RN K revealed they were unaware of reason the Resident would have been tested on [DATE] due to already having a positive diagnosis.</p> <p>IC RN K was then queried regarding hand hygiene performance by staff and verbalized it is one of the most important things staff can do to prevent the spread of infection. When asked what staff are supposed to do before and after donning gloves, IC RN K stated, Hand Hygiene. When asked what should occur, in regard to gloves and hand hygiene when caring for different Residents, IC RN K replied, Should remove gloves and perform hand hygiene. IC RN K was then informed of observations of lack of hand hygiene during care of Resident #42 and Resident #38.</p> <p>When queried how employee, including contracted employee, call ins and illnesses are monitored and tracked, IC RN K stated, I don't know how they monitor employee call ins.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>IC RN K was then asked how the facility monitors residents with potential infections, as each resident infection on the line list was receiving antimicrobial treatment and did not include any residents with signs and symptoms of infection who did not receive treatment. IC RN K stated they did not know. With further inquiry, IC RN K confirmed they did not see any documentation of potential infections on any of the facility IC documentation.</p> <p>An interview was completed with the Director of Nursing (DON) and IC RN K on 6/5/25 at 9:00 AM. When asked how the facility monitors and tracks employee call ins and illnesses from an IC perspective, the DON stated, It's in the book. A review of the facility provided three ringer binder book cont[TRUNCATED]</p>

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<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Implement a program that monitors antibiotic use.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review the facility failed to implement and operationalize a comprehensive Antibiotic Stewardship Program including documentation and treatment for four residents (#7, #35, #81, and #82) of four residents reviewed for antimicrobial treatment.</p> <p>Findings include:</p> <p>A review of facility provided infection control documentation for January 2025 was completed. The provided documentation did not include a summary and/or analysis of the infections for the month. The provided Monthly Infection Surveillance Report line list included multiple headings including one for Meets McGeers Criteria . A review of the line listing for January 2025 revealed the Meets McGeers Criteria section was blank for 15 of the 31 resident infections with treatment listed.</p> <p>An interview and review of facility provided infection control documentation was completed on 6/4/25 at 1:56 PM with IC RN K. When queried, IC RN K stated, McGeer is criteria used for infections. When queried if the infection on the line list did not meet McGeer criteria if Meet McGeers Criteria was not checked, IC RN K revealed they did not know as they had not completed the infection surveillance.</p> <p>Resident #35:</p> <p>Review of the January 2025 line listing details for Resident #35 revealed the Resident was treated for a UTI. The signs/symptoms of infection included nephrostomy (surgical procedure where a catheter is surgically placed through the back, directly to the kidneys to allow for the drainage of urine) tube placement and began on 1/6/25. Per the line listing, the causative organism of the infection was Pseudomonas aeruginosa (bacteria which commonly causes infections with some strains being resistant to nearly all antibiotics). The line listing did not include the date antibiotic treatment was started but specified Cipro (antibiotic) was discontinued on 1/11/25 and detailed n/a for McGeers criteria and did not specify if the infection was facility or community acquired. The facility IC documentation for January 2025 did not include laboratory testing results including C&S for Resident #35.</p> <p>An interview was completed with IC RN K on 6/4/25 at 3:39 PM. When queried regarding Resident #35, IC RN K provided hospital medical record documentation of the Resident's urine culture dated 1/8/25. The culture detailed Pseudomonas aeruginosa and Enterococcus faecalis (bacteria normally found in the GI tract and feces) were identified in Resident #35's urine. When asked why Enterococcus faecalis was not included on the line list, IC RN K was unable to provide an explanation. When asked how they knew that Cipro was the appropriate treatment for the infection, IC RN K reviewed the documentation and confirmed sensitivity for the organism was not present. IC RN K indicated the information may not have been sent with the Resident when they returned to the facility, and they were unable to say if the antibiotic was appropriate to treat the infection. Review of the Resident's antibiotic medication administration documentation revealed there was a delay in initiation of antibiotic treatment. When asked the reason, IC RN K revealed they did not know.</p> <p>Resident #81:</p> <p>(continued on next page)</p>		

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<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Resident #81 was included on the January 2025 as having a UTI. Per the line list, the Resident was admitted to the facility on [DATE] and the signs/symptoms of infection began on 1/6/25. The signs/symptoms of infection were listed as back. The line listing detailed a UA with C&S was completed (no date) which showed pseudomonas (bacteria)/candida parap. (candida parapsilosis - fungal organism commonly found on the skin and in the GI tract which can lead to serious infection). The line list specified the infection was community acquired, and Resident #81 received Bactrim DS (antibiotic) from 1/14/25 to 1/17/25 as well as 1/6/25 to 1/17/25. A review of Resident #81's EMR revealed the Resident was originally admitted to the facility on [DATE] and their most recent discharge to the hospital, prior to 1/6/25 had been on 12/13/24.</p> <p>On 6/4/25 at 3:29 PM, a follow up interview was completed with IC RN K. When queried regarding Resident #81, IC RN K revealed they did not have a C & S for the UTI with symptom onset of 1/6/25. IC RN K verbalized the Resident was transferred to the hospital on 1/6/25 due to complaints of not feeling well and were diagnosed with a UTI at the hospital. IC RN K revealed the Resident returned to the facility on 1/13/25 which would explain why the line listing indicated that date as their admission date. When asked if 1/6/25 was first date of sign/symptom of infection, a review of Resident #81's EMR was completed with IC RN K. Review revealed a General Progress Note dated 1/5/25 at 5:18 PM which included documentation of the Resident stating they did not feel well. When asked if they were able to locate any other information pertaining to the UTI on 1/6/25, IC RN K revealed they did not and stated an Infection Screening Evaluation had not been completed. IC RN K revealed Resident #81 returned to the hospital on 1/18/25 and was admitted with a diagnosis of a UTI. Resident #81 returned to the facility on 2/1/25. When asked how the infection on 1/6/25 was community acquired as indicated on the line list when the Resident had been in the facility for three weeks prior to development/diagnosis, IC RN K confirmed the UTI was a facility acquired infection. When queried how they evaluated and determined the antibiotic treatment was appropriate without the C&S, IC RN K verbalized they could not.</p> <p>When queried regarding the antibiotic stewardship program, IC RN K stated, I don't know what the system failure is.</p> <p>Review of facility policy/procedure entitled, Antibiotic Stewardship (Revised: 12/16/24) revealed, Purpose: To prescribed and administered antibiotics to resident/patients under the guidance of (facility) Antibiotic Stewardship Program . The purpose . is to monitor the use of antibiotics . When a culture and sensitivity (C&S) is ordered lab results and the current clinical situation will be communicated to the prescriber in a timely manner to determine if antibiotic therapy should be started, continued, modified, or discontinued .</p> <p>Resident #7:</p> <p>06/03/25 at 12:41 PM, Resident #7 was observed resting in bed and appeared to be in good spirits. She was asked if she currently on an antibiotic and she reported she was as the podiatrist had cut her toenail off recently.</p> <p>On 6/3/2025 at approximately 3:15 PM, a review was conducted of Resident #7's medical records and it indicated she admitted to the facility on [DATE] with diagnoses that included Cerebral Infarction, Diabetes, Dementia, Adjustment Disorder and Chronic Kidney Disease. Further review of her records yielded the following:</p> <p>(continued on next page)</p>		

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<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Physician Orders:</p> <p>Bacitracin Ointment 500 Unit/GM (gram)- apply to per additional directions topically every day shift for treat bacterial skin infection initiated on 5/31/2025.</p> <p>Cephalexin Oral Capsule 500 MG (milligrams)- give 1 capsule by mouth three times a day for bacterial infection until 6/9/2025. Initiated on 5/31/2025.</p> <p>Progress Notes:</p> <p>There were no progress notes related to the podiatry visit, assessment of the area nor signs and symptoms documented of the skin infection when the two antibiotics were started.</p> <p>On 6/4/2025 at 12:50 PM, an interview was conducted with Infection Control Nurse K regarding Resident #7's antibiotic administration. Nurse K reported she had a great right toe skin infection and was started on Keflex and Bacitracin by the Podiatrist. Nurse K was asked if she had any additional documentation from the podiatrist that detailed his reasoning and provided the assessment of Resident #7's toe. Nurse K stated she did not have any notes from the Podiatrist and is unsure why she was started on the antibiotics.</p> <p>On 6/4/2025 at 1:20 PM, the DON (Director of Nursing) reported they are waiting on a callback from the Podiatrist as he was prescribing the antibiotics prophylactically to residents.</p> <p>Resident #82:</p> <p>On 6/3/2025 at approximately 3:30 PM, a review was conducted of Resident #82's records and it indicated he admitted to the facility on [DATE] with diagnoses that included Pneumonia, Abscess of the lung, Lymphoma, Adjustment Disorder and Chronic Obstructive Pulmonary Disorder. Further review of Resident #82's records yielded the following:</p> <p>Physician Orders:</p> <p>Bactrim Oral Tablet 400-80-MG- Give 1 tablet by mouth one time a day for bacterial infection for 171 days. Initiated on 4/18/2025.</p> <p>Progress Notes:</p> <p>4/18/2025 09:37: Spoke with the nurse . from specialty (facility) she informed me that the infectious disease dr had d/c (discontinue) the unsyn and the vanco. That he is to be on the oral Bactrim for 171 doses.</p> <p>Review was completed of the last three months of Infection Control Line listing and Resident #82 was not listed on their spreadsheet. It can be noted it is unknown what specific infection and the location of said infection the Bactrim was treating. Furthermore, the facility was not monitoring his continued usage of the antibiotic.</p> <p>Hospital Records:</p> <p>(continued on next page)</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Review was completed of hospital records and there was nothing found regarding the 171 doses of Bactrim ordered for the resident.</p> <p>On 6/4/2025 at 1:00 PM, Infection Control Nurse K was asked the reasoning behind Resident #82's extended use antibiotic, what was being treated and if they knew the organism. She reported she recently took over the position and has not completed her facility audit but did inquire regarding the reasoning behind his order as well. She was asked why he was not on their infection control line listing, and she just recently noticed he was not listed. Nurse K was asked for clarity regarding the resident's antibiotic order and supporting documentation.</p> <p>Follow up was completed multiple times throughout the course of the survey with the DON and Infection Control Nurse K requesting the reasoning and subsequent documentation for Resident #82's antibiotic usage but it was not provided.</p>

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 06/05/2025
NAME OF PROVIDER OR SUPPLIER Majestic Care of Flushing		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide a safe, functional, sanitary, and comfortable environment for one resident (Resident #58) and the facility's census of 91 residents and its staff resulting in an increased chance of harm.</p> <p>Findings include:</p> <p>Resident #58:</p> <p>On 6/3/2025 at 12:25 PM, Resident #58 was self-propelling around his room and in decent sprits. As the conversation continued, he asked this writer to look at this bathroom. Upon entering the bathroom, the left side corner of the baseboard was pushed inside the wall. The cement and debris were exposed, and it appears a baseball could fit within the hole. The right-side base of the toilet was cracked directly across the bolt that secured it to the floor. The crack extended transversely the length of the toilet base. The circumference of the toilet was riddled with a unknown brown substance. Resident #58 reported he is careful when using the bathroom as if he shifts his weight, he is nervous he could fall.</p> <p>On 6/3/2025 at 12:40 PM, the bathroom in room [ROOM NUMBER] was observed and the right corner underneath the sink the baseboard was missing, and the cement debris was exposed. Right above the hand sanitizer dispenser the cement block was exposed.</p> <p>On 6/5/2025 at 9:40 AM, Maintenance Director D reported he was informed about the crack at the base of the toilet yesterday by Resident #58 and he already ordered a new toilet for his room. Director D and this writer observed Resident #58's bathroom and he explained the walls are cement block with dry wall mud over it. We observed room [ROOM NUMBER]'s bathroom and he stated he was not aware of the cement block being exposed behind the hand sanitizer and the broken away baseboard.</p> <p>On 6/5/2025 at 10:13 AM, an environmental tour was completed of the facility with the Administrator and Maintenance Director D. The following concerns were observed:</p> <p>North Clean Linen Closet:</p> <p>2- gowns on the floor</p> <p>Soiled vent blowing onto clean linen (the cart was not covered)</p> <p>Briefs on the floor</p> <p>Clean Utility Room:</p> <p>Sink drains are corroded - Maintenance Director D stated they do not use that sink.</p> <p>Room next Central Bath:</p> <p>(continued on next page)</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Suction equipment on counter that was not covered and 6 + dead sewer flies behind it.</p> <p>5- oxygen concentrators sitting in front of hopper that were not covered.</p> <p>Sink drains had rubber bands, black object or insect observed and were corroded.</p> <p>There were 3-4 sewer flies were flying around in the room.</p> <p>Upon opening the undercounter dishwasher there was a rack inside piled with towels and other linen. Director D stated there was not a water supply to it but and when closing the dishwasher it turned on.</p> <p>Shower Room:</p> <p>Soiled gloves on the floor</p> <p>The emergency pull cord light was missing.</p> <p>Shampoo dispenser handle was missing</p> <p>Vent above the shower was [NAME] with dust and debris</p> <p>Bottle of body wash with no resident name on the shower bed</p> <p>Old Eagle Room:</p> <p>Both drains of the sink are corroded</p> <p>Central Short Hall</p> <p>Electrical Room:</p> <p>At the back right corner of the room the ceiling tiles are stained brown, with one of the ceiling tiles bowing. Director D reported its from an old water leak and stated there are no current water leaks in the facility.</p> <p>Air vent grate between 57-59 had a hole in the corner of the grate.</p> <p>At the bedside of 57 A there was a bottle of vinegar, liquid tide fabric softener and 32 oz bottle of rubbing alcohol that was &frac12; full.</p> <p>In room [ROOM NUMBER], the privacy curtain for Bed 1 had two holes in the upper netting, was extremely crinkly and had a stain. The privacy curtain for Bed 2 had a hole in the netting and a black stain.</p> <p>Central Nurse Station:</p> <p>(continued on next page)</p>

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>The wood on the railing was exposed and the wall (across from nurse station) to room [ROOM NUMBER] was scratched/scuffed with 2-3 inches of paint missing.</p> <p>Dirty Utility Room:</p> <p>The top for the trash can was on the floor with a soiled towel atop it.</p> <p>Sink was soiled and the drains has different miscellaneous items inside of it.</p> <p>Clean Utility Room:</p> <p>Clean linen on the floor</p> <p>Dirty broom and dustpan</p> <p>Tile missing on the floor</p> <p>In back corner there were random items stuffed in the corner on the floor.</p> <p>The [NAME] storage rack was sitting on top of a wooden board</p> <p>There was a 2 x 4 wooden board acting as baseboard or covering an opening in the wall</p> <p>Resident Activity Room:</p> <p>Four of four sliding, floor to ceiling windows are streaked with residue, the tracks are debris filled, numerous cobwebs were visible, blinds are soiled with orange, green and other unknown substances and the rubber track was not attached.</p> <p>The light in the soffit was missing outside the window.</p> <p>Wooden sliding partition was speckled with a white residue across the entire panel, spanning the width of the room.</p> <p>Activity Hall:</p> <p>Window tracks are soiled with cobwebs visible.</p> <p>Laundry Room:</p> <p>Blue bucket with standing water sitting underneath the handwashing sink.</p> <p>Industrial fan was soiled with dust/debris and was actively blowing over clean resident clothing items. The electrical cords had built up dust that led to the switch on the wall.</p> <p>Dining Room (off kitchen):</p> <p>Hole in cabinet door underneath sink</p> <p>(continued on next page)</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ceiling tile adjacent to wireless router was observed to appear wet (half-moon shaped water markings). Director D and the Administrator confirmed they were unaware of any new leaks in the facility. It was verified the tile was wet and Maintenance Director D was going to inspect the inside of the ceiling. The air condition condensation was leaking which led to the newly identified wet ceiling tile.</p> <p>East Unit</p> <p>Clean Utility Room:</p> <p>4- oxygen concentrators that were not covered</p> <p>Floor mat with gloves shoved behind the mat.</p> <p>Therapy Gym:</p> <p>There was dust on the fan blades and Therapy Manager W reported they do not store their therapy equipment in the clean utility room on east unit.</p> <p>Review was completed of the facility job description entitled, Housekeeping Supervisor. It stated, The Housekeeper Supervisor is responsible for providing a clean, orderly, safe and attractive environment for residents .inspect cleanliness, sanitation and infection control, and take corrective action .</p> <p>Review was completed of the facility job description entitled, Maintenance Director. It stated, .is responsible for the efficient function of physical plant and environmental systems as well as the appearance and upkeep of the community grounds .Daily follow up of the TELLs system for building management and tracking .</p>