STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235467	A. Building B. Wing	02/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Four Chaplains Nursing Care Center	28349 Joy Rd Westland, MI 48185

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure accurate diagnoses in comprehensive assessments for one (R14) of 18 sampled residents reviewed for accurate Minimum Data Set (MDS) assessments. Findings include:Review of an admission Record revealed, R14 admitted to the facility on [DATE] with pertinent diagnoses which included bipolar disorder and Post-Traumatic Stress Disorder (PTSD). Review of a MDS assessment, with a reference date of 5/6/25 revealed R14 had active diagnosis of PTSD. The Bipolar Disorder was marked no. Review of a MDS assessment, with a reference date of 11/6/25 revealed R14 had active diagnosis of bipolar disorder and Schizophrenia. The PTSD was marked no. Review of a PASSAR (Pre-admission Screening and Resident Review) dated 4/15/25 revealed, R14 had a diagnosis of Schizophrenia and PTSD. In an interview on 2/13/26 at 10:58 a.m., Regional Clinical Registered Nurse (RN) E confirmed the MDS assessments dated 5/6/25 and 11/6/25 were not accurate. RN E reported they were uncertain as to why the former MDS nurse manually changed the bipolar and schizophrenia diagnosis in November (2025). RN E then reported they would chalk that up to a coding error.At 2:27 p.m., RN E reported the MDS nurse is to follow the RAI (Resident Assessment Instrument) manual for completing MDS assessments accurately.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure timely repositioning for two residents, (R11, R78) of three reviewed for services to prevent pressure ulcer development. Findings include: R11On 02/11/2026 at 3:24 PM, R11 was observed, down in bed about a foot from the top of the mattress, leaning toward the left. R11 had multiple food items on a meal tray without much eaten for breakfast and lunch. A review of the record indicated a sacral wound; pressure related and a history of deterioration. On 02/12/2026 at 9:13 AM, R11 was observed hunched down, on their backside in bed. No devices were observed to be at the sides or under the legs to offload pressure. R11 was eating from the meal on the over bed tray table. At 11:02 AM, 12:30 PM, and 2:50 PM, R11 was observed to be on their back in bed, with the head of the bed almost flat. At 2:50 PM, the right hip was tilted up slightly, with heels, and backside on the bed without positioning devices. At 2:29 PM, the Therapy Manager reported R11 had been picked up for therapy after a hospitalization in late November (2025) post a lower leg amputation. A review of the current therapy notes documented bed mobility was max too dependent on staff, transfers were dependent on staff, and activities of daily were max assist too dependent on staff. This included upper body dressing and sitting balance and dependence for moving the wheelchair. At 4:28 PM, R11 was observed seated in a wheelchair in the dining room.On 02/13/2026 at 8:13 AM, R11 was on their backside in bed, with the head up 60-90 degrees eating breakfast. At 9:55 AM, R11 continued on their backside in bed and declined an observation of their wounds. A review of the record for R11 revealed R11 was admitted in the facility on 08/27/25. Diagnoses included Respiratory Failure, Heart Failure, and Above to Knee Leg Amputation. The Care plan initiated, 08/27/25 and revised 02/12/26 documented, .ADL deficit . Bed mobility 1PA (one person assist) . The Minimum Data Set (MDS) dated [DATE] documented moderately impaired cognition and dependence on staff to roll left and right in bed, sitting to the side of the bed and transfers. A review of the skin and wound note dated 02/11/2026 at 9:42 AM, documented, Skin Issues: Skin Issue: #001: Location: Sacrum. Issue type: Pressure ulcer / injury. Progress: Stable: previously deteriorating wound characteristics plateaued. Pressure ulcer staging: Unstageable pressure ulcer / injury. Unstageable ulcer due to slough and / or eschar. Wound was present on admission. Length centimeters (cm): 2.67 Width (cm): 1.98 Depth (cm): 0.5 Area (cm2): 3.24 Undermining: No. Tunneling: No. Granulation: 20%. Slough {non-viable tissue}: 80%. Exudate (drainage) amount: Light. Exudate {drainage) type: Serosanguineous: mixture of serous and sanguineous fluid, typically pale, red, and watery .R78On 02/11/2026 at 10:30 AM, R78, was observed to be on their back in bed, dressed in a hospital style gown. No devices were observed to offload pressure from the back and buttocks. The tubing for the wound vac (device which assists with wound closure/healing) extended from behind the left shoulder to the motor and canister on the nightstand. The heels rested on the bed surface. A low air loss mattress was in place. R78 provided nonsensical answers to questions regarding the wounds and urinary catheter. On 02/12/2026 8:21 AM, 9:59 AM, 10:57 AM, 3:03 PM and 4:28 PM, R78 was observed to on their back dressed in a hospital style gown. The head of the bed up around 30 to 45 degrees. No devices were observed to alleviate pressure from the back, tailbone and buttocks. The heels rested on the bed surface. R78 was not observed to have purposeful movements of the extremities other than to feed themself meals.On 02/12/2026 at 2:42 PM, the therapy history for R78 was reviewed with the Therapy Manager. R78 was reported to be on the current therapy caseload. Upon review of the therapy notes the current ability of R78 was reported as maximal assistance to dependent on staff for all dressing, toileting, bathing and grooming. R78 was moderate assist for bed mobility and still need one person. R78 was dependent on staff for transfer and could not maintain a sitting position at the side of the bed. On 02/13/2026 at 8:22 AM, certified nursing assistant (CNA) A reported R11 and R78 required staff assistance for repositioning.On 02/13/2026 at 8:25 AM until 9:45, R78 was on their back in bed with the head of the (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bed up around 45 degrees their gown off the shoulders. At 12:27 PM, R78 was seated on their backside in a recliner at the right side of the bed, dressed, and with their head down toward the left shoulder as if asleep. Lunch had been served and did not appear eaten. On 02/13/2026 at 12:43 PM, R78 was observed to be in the recliner, asleep. Licensed Practical Nurse (LPN) F reported concerns with R78's ability to move independently and generally needs assist to reposition.A review of the record for R78 revealed R78 was admitted into the facility on [DATE] with a readmission from after a five-day hospital stay on 01/19/26. Diagnoses included Pressure Ulcer of the Sacral (lower back/tailbone) Region, Cervical (neck) Spinal Cord Injury and Dehydration. The care plan initiated 01/06/26 documented, .admitted with stage four to sacrum, stage three pressure ulcer to bilateral buttocks . Wound vac in place . Encourage me to make small frequent shifts in my position . The care plan further documented, I have a potential/actual (Activities of Daily Living) ADL deficit . Bed Mobility (one person assist) 1PA . The Minimum Data Set assessment dated [DATE] documented R78 to dependent on staff for rolling left and right in bed, toileting, dressing, sitting, bathing and transfers. Substantial/maximal assistance was required for eating and personal hygiene. A review of the wound noted dated 02/10/26 by wound nurse C documented, .sacral wound: Pressure ulcer / Injury Length centimeters (cm) 3.81, Width (cm), 6.3 Depth (cm) 2cm Area (cm^2) 20.13 .On 02/13/2026 at 1:35 PM, Wound care nurse C reported the intervention requirements for a resident with pressure sore such as R11 and R78 include timely repositioning, cushions in the wheelchairs, treatments as ordered and collaboration with physician.A review of the facility policy titled, Wound Management Program revised 08/17/17 revealed, Purpose: To eliminate, modify or minimize factors that place residents at risk for skin breakdown. Policy: To assure that residents who are admitted with, or acquire, wounds receive treatment and services to promote healing, prevent complications and prevent new skin conditions from developing.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review, the facility failed to ensure a medication error rate below 5% in three (R79, R14, R23) of six residents reviewed for medication administration. Findings include: R79In an observation and interview on 2/12/26 at 11:33a.m., Registered Nurse (RN) I prepared medications for R79. RN I removed R79's medication pack that read 7am-10am and included duloxentine (used for depression). RN I confirmed duloxentine was scheduled at 12:00 p.m. and was given at 10:00 a.m. RN I then reported she is sure she gave it because it was in the pack with the other meds scheduled for that time (7am -10am). RN I was asked within what timeframe a medication could be given, RN I confirmed if a medication is scheduled at 12 pm it should be given between 11 a.m. to 1p.m. Review of R79's medical record revealed admission into the facility on 3/14/23 with pertinent diagnosis which included Depression. Additional review revealed a current physician's order for duloxetine 60mg, give 1 capsule by mouth in the morning, with a start date of 11/16/24 and pass time of 1200 (12:00 pm). Review of a Medication Administration Record (MAR) for February 2026 for R79 revealed, Duloxetine documented as given on 2/12/26 at 1200 (not the observed 10:00 am time) by RN I. R14In an observation and interview on 2/12/26 at 12:03 p.m., RN H took a medication pack out of the cart. Isosorbide (used to prevent chest pain) was packaged with morning meds scheduled at 6:00 a.m. RN H reported Isosorbide had not been given yet and is being held to confirm with the doctor if it should be given at that time (12:03 PM).In an interview on 2/12/26 at 12:17 p.m., Regional Clinical RN E confirmed all new medication orders processed in the afternoon are given on the afternoon shift even when the medication is ordered to be administered as morning medication. This process has caused an issue where the order gets submitted as an afternoon or morning medication administration.Review of R14's medical record revealed a physician's order for, Isosorbide 60mg (milligram) give 1 tablet by mouth in the morning for HTN (hypertension) hold for SBP (systolic blood pressure) less than 110, with a start date of 9/18/25. Additional review revealed Isosorbide documented as not given on 2/12/26 at 1200 on the February 2026 MAR.Review of a progress note at 2/12/26 at 4:02 p.m., revealed documentation the physician was contacted about Isosorbide being held (4 hours after it was due to be administered). R23In an observation on 2/13/26 at 8:23 a.m., RN G entered R23's room with 10 medications including Lokelma (used to lower potassium levels) and Furosemide (water pill). R23 asked the nurse about the Lokelma, RN G explained all medications to R23 except the Lokelma. Review of the current physician's orders revealed R23 had an order for Lokelma 10gm (gram) give 1 packet by mouth in the morning, with a start date of 1/23/26 and Furosemide 80mg given by mouth in the morning every Mon, Wed, Fri. Review of a Lokelma information document revised 2/2024 revealed, . Lokelma can change the absorption of co-administered drugs. potentially leading to altered efficacy or safety of these drugs when taken close to the time LOKELMA is administered. In general, other oral medications should be administered at least 2 hours before or 2 hours after LOKELMA. The document further revealed that testing showed Furosemide systemic exposure (rapid absorption causing water depletion and dehydration) increases when co-administered with Lokelma. Review of a Medication Administration Record (MAR) for February 2026 for R23 revealed, Lokelma and Furosemide was documented as given on 2/13/26. In an interview on 2/13/26 at 12:55 p.m., RN G was asked if she was familiar with the medication Lokelma and reported not being familiar with it. RN G then reported if they aren't familiar with a medication, they should ask the pharmacist or doctor.In an interview on 2/13/26 at 1:20 p.m., Licensed Practical Nurse (LPN) F reported if they were unfamiliar with a medication they were ordered to give, they would find out more about it before giving, like looking it up or calling the doctor.Neither RN G or LPN F were able to confirm researching the medication Lokelma it's indications and usage.In an interview on 2/13/26 at 1:24 p.m., the Director of Nursing (DON) reported medications can be administered 1 hour before or after the scheduled time. DON reported medications packaged for the wrong time should not be given and the doctor should be called if the timing is in (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	question. The DON was asked what a nurse should do if they are not familiar with medication. The DON reported that if a nurse is not familiar with a medication, they should look it up. Review of a Medication Administration policy with a date of 01/21 revealed, Medications are administered as prescribed in accordance with manufacturers' specifications, good nursing principles. Personnel authorized to administer medications do so only after they have familiarized themselves with the medication. 13. Explain to resident the type of medication being administered and the procedure. 14. Medications are administered within 60 minutes of scheduled time .