

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235578	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/23/2024
NAME OF PROVIDER OR SUPPLIER Four Seasons Nursing Center of Westland		STREET ADDRESS, CITY, STATE, ZIP CODE 8365 Newburgh 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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44750</p> <p>This citation pertains to Intakes MI00147560 and MI00147466.</p> <p>Based on observation, interview, and record review, the facility failed to prevent resident to resident abuse, between two residents (R700 and R701) out of three reviewed for abuse. Findings Include:</p> <p>A review of an Incident and Accident (I/A) report for R700 dated 10/10/2024 at 5:19 AM revealed the following,</p> <p>Nursing Description: CNA (Certified Nursing Assistant) reported that resident was wet, and the resident stated that R701 poured water on [them]. Writer asked R701 did [they] pour water on R701, [they] stated, I've been asking (R700) for months to shut the f*** up.</p> <p>Resident Description: Resident stated, R701 poured water on me repeatedly and stated, what are you going to do about this.</p> <p>A review of the medical record revealed R700 admitted into the facility on [DATE] with the following diagnoses, Functional Quadriplegia, Depression, and Anxiety. A review of the Minimum Data Set assessment revealed a Brief Interview for Mental Status score of 13/15 indicating an intact cognition. R700 also required staff assistance with bed mobility and transfers.</p> <p>A review of an Incident and Accident (I/A) for R701 dated 10/10/2024 at 4:45 AM revealed the following,</p> <p>Nursing Description: CNA (Certified Nursing Assistant) reported that resident was wet, and the resident stated that R701 poured water on [them]. Writer asked R701 did [they] pour water on R701, [they] stated, I've been asking (R700) for months to shut the f*** up.</p> <p>Resident Description: I've been asking R700 for months to shut the f*** up. No one has done anything about it, no one cares about my mental health.</p> <p>A review of the medical record revealed that R701 was admitted into the facility on [DATE] with the following diagnoses, Schizophrenia and Muscle Weakness. A review of the Minimum Data Set assessment revealed a Brief Interview for Mental Status score of 14/15 indicating an intact cognition. R701 also required assistance with bed mobility and transfers.</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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/23/2024 at 10:01 AM, an interview was conducted with R700. R700 stated they currently feel safe in the facility and has not seen R701. R700 stated they had just eaten breakfast and did not feel like discussing the incident any further.</p> <p>On 10/23/2024 at 10:07 AM, an interview was conducted with R701. R701 stated they told numerous staff they wanted a new roommate, and no one did anything about it for months. R701 stated after a month of no sleeping because of R700's screaming constantly they went a little wild and poured the water on R700 so they would shut up. R700 stated they are comfortable in their new room and get along with their new roommates.</p> <p>On 10/23/2024 at 1:25 PM, an interview was conducted with the Nursing Home Administrator (NHA). The NHA stated they were notified and R701 was moved to another room immediately. The NHA stated they were unaware of R701 making a complaint regarding R700, only against R701's brother being in the room and being disruptive.</p> <p>A review of a facility policy titled, Abuse revealed the following, Resident's have the right to be free from abuse, neglect, exploitation, mistreatment, and misappropriation of resident property.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44750</p> <p>This citation pertains to Intake MI00147570.</p> <p>Based on observation, interview and record review, the facility failed to implement a nutritional care plan intervention for one resident (R702) out of one reviewed for nutrition. Findings Include:</p> <p>On 10/23/2024 at 12:48 PM, R702 was observed eating lunch in their room. R702 stated they were making a mess and said they had a method for how to eat their food, which included trying to scoop the food together and take a bite. R702 was observed to have food on their (bib like) towel and the bedside table.</p> <p>Observation of the diet ticket on R702's meal tray stated they were supposed to have a divided plate. R702's food was observed to be on a regular plate.</p> <p>On 10/23/2024 at 12:50 PM, Certified Nursing Assistant (CNA) E was observed removing R702's meal tray. CNA E was asked to observe the meal ticket, as well as the plate R702 was eating off. CNA E stated R702 should have a divided plate, and they were unsure why they did not have one.</p> <p>A review of the medical record revealed R702 admitted into the facility on [DATE] with the following diagnoses, Dysphagia and Multiple Sclerosis. A review of the Minimum Data Set assessment revealed a Brief Interview for Mental status score of 15/15 indicating an intact cognition. R702 also required assistance with bed mobility and transfers.</p> <p>Further review of the nutritional care plan revealed the following intervention, Provide Divided Plate to Help with Self Feeding.</p> <p>On 10/23/2024 at 1:05 PM, an interview was conducted with the Director of Nursing (DON). The DON stated they know R702 was recently seen by speech and had their diet upgraded and they believe the scoop plate was to assist with food being pushed against the side.</p> <p>On 10/23/2024 at 1:43 PM, an interview was conducted with Dietary Manager (DM) F. DM F stated they are unsure how the plate made it out the kitchen and the food should have been on a divided plate. DM F stated it was an oversight.</p> <p>A review of a facility policy titled, Care Plan Comprehensive and Revision revealed the following, Care Plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making.</p>		

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<p>F 0691</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44750</p> <p>This citation pertains to Intake MI00147570.</p> <p>Based on observation, interview, and record review, the facility failed to provide and/or document colostomy care for one resident (R702) out of one reviewed for ostomy care. Findings Include:</p> <p>A review of Intake MI00147570 noted the following, Complainant states that there has been skin breakdown around R702's ostomy because they sit in their own waste for extended periods of time.</p> <p>A review of the medical record revealed that R702 admitted into the facility on [DATE] with the following diagnoses, Dysphagia and Multiple Sclerosis. A review of the Minimum Data Set assessment revealed a Brief Interview for Mental status score of 15/15 indicating an intact cognition.</p> <p>On 10/23/2024 at 9:33 AM, an interview was conducted with R702. R702 stated the facility staff do not empty their colostomy as often as they should. R702 stated because the colostomy is not emptied as it should be then it fills and burst and has to be changed frequently.</p> <p>A review of the Treatment Administration Record (TAR) for the month of September revealed the following, Colostomy Care Q (Every) shift and as needed every shift for Colostomy Care Q Shift (Every Shift). Further review showed blank spaces indicating no care was documented on the following days during the AM shift, 9/3, 9/6, 9/12, 9/14, 9/15, 9/17, 9/18, 9/22, 9/25, 9/26, and 9/30/24.</p> <p>A review of the Treatment Administration Record (TAR) for the month of October revealed the following, Colostomy Care Q (Every) shift and as needed every shift for Colostomy Care Q Shift (Every Shift). Further review showed blank spaces indicating no care was documented on the following days during the AM shift, 10/1, 10/5, 10/9, and 10/13/24.</p> <p>On 10/23/2024 at 1:05 PM, an interview was conducted with the Director of Nursing (DON). The DON stated there has been many complaints from R702 regarding their colostomy and emptying it and changing it. The DON stated they have actively been working with R702 to ensure there have been no more problems. The DON stated they also have been working on the documentation as well.</p> <p>A review of a facility policy titled, Ostomy Care-Colostomy and Ileostomy noted the following, Document procedure in the resident's electronic health record.</p>		