STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235578	A. Building B. Wing	11/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Four Seasons Nursing Center of Westland	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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28776 This citation pertains to Intake: MI00147682. Based on observation, interview, and record review, the facility failed to ensure a comprehensive nursing assessment was completed and timely acute care emergent hospital transfer for one Resident (R702) of three residents reviewed for care, when R702 sustained a fall with head trauma and bleeding while taking anticoagulant medication. Findings include: Review of R702's Accident and Incident report, dated 8/19/24 at 3:00 (a.m.), revealed Licensed Practical Nurse (LPN) H was notified by staff that R702 was observed sitting on floor in their room and hit the back of their head on the wall near their bed, sustaining a head laceration. R702 stated they were trying to get up and clean and slipped and fell . The report showed LPN H assessed R 702 for pain and injuries, found R702 had 8/10 pain, and applied a cold compress to back of their head to stop the bleeding. On 11/13/24 at approximately 12:00 p.m., R702 was observed with LPN B in their room. R702's room was clean, and clear of obstacles, with the bed in the low position. R702 was observed dressed, seated in a manual wheelchair with anti-rollback devices. On 11/13/24 at approximately 12:05 p.m., LPN B reported they kept R702 by them when they were passing medications, in line of sight, due to their high fall risk and continued attempts at self-transferring, both before and after they fell on [DATE]. Review of R702's Minimum Data Set (MDS) assessment, dated 8/16/24, revealed R702 was admitted to the facility on [DATE], with diagnoses including dementia, kidney disease, diabetes, and anxiety. The pain assessment revealed no pain. The medication assessment showed R702 was on an Anti-coagulant (blood thinner) medication. The Brief Interview for Mental Status (BIMS) assessment revealed a score of 4/15, which showed R702 had severe cognitive impairment. Review of R702's progress note, dated 8/19/24 at 3:48 a.m. revealed LPN H observed R702 as alert and oriented when they fell after sustaining the head laceration which was bleeding from a fall. The note further revealed LPN H called the physician answering services and were awaiting a call back from the physician. There was no further mention in R702's progress notes if a call was returned by the physician or physician services. Review of R702's follow-up progress notes, dated 8/19/24, revealed the following: (continued on next page)

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

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/13/24 at 12:25 p.m., Unit manager LPN, C was asked about R702's fall on 8/19/24. LPN C reviewed the medical record. LPN C responded, I would have expected [LPN H] to complete a skin assessment, to describe the head laceration wound. LPN C explained if they had not received a response from the physician team for a resident with acute head trauma on a blood thinner, they would have called the Medical Director, per facility protocol. LPN C clarified it was possible R702 may have experienced a head injury with the bleeding and would have needed a head CT scan to rule this out. LPN C stated LPN H should have called the Medical Director, as R702 needed to be sent out emergently, no later than 4:30 a.m. On 11/13/24 at 1:45 p.m., LPN E was asked about R702's fall. LPN E reported when they arrived for their shift a few hours after the incident, R702's CNA (Certified Nurse Aide) reported R702's pillow was filled with blood. LPN E stated R702 had a really big cut on the back of their head. LPN E described they saw an open area on the back of R702's head, with dried blood. LPN E believed R702 needed to be transported to the hospital. LPN E explained, With an open wound to the back of the head, a resident needs to be transferred (to the hospital). LPN E reported they contacted the unit manager, who assisted R702 after the wound was discovered. LPN E clarified the nurse from the prior shift, LPN H, should have sent R702 to the hospital, and reported LPN H had not let them know about R702's head wound. On 11/13/24 at 2:12 p.m. a phone call was placed to interview LPN H. The call was not returned by the survey exit. On 11/13/24 at 2:28 p.m, Unit manager, LPN F, was asked about R702's fall on 8/19/24 during a phone interview. LPN F reported they and LPN G, another unit manager, were asked to observe R702's head wound. LPN F reported R702 was at her baseline cognitively but reported their head hurt, and put their hand on their head, and they saw the open wound. LPN F stated LPN H had been a nurse long enough to know when you can't reach the doctor, you call the Medical Director, per facility protocol, and you use your nursing clinical judgment. LPN F reported afterwards they called LPN H and asked why they had not called the Medical Director and sent R702 out emergently after the fall with an open head wound which was bleeding. LPN F stated they notified the Director of Nursing (DON) after the incident. LPN F clarified a comprehensive nursing assessment including a skin assessment should have been completed per standards of practice to explain the size and depth [of the wound]. LPN F explained, You [the nurse] are supposed to do a skin assessment ., and give a description of how the patient looks, how (R702) was acting . LPN F confirmed a resident on Eliquis, including R702, should have been sent out emergently after sustaining head trauma with an open wound, stating, It could be a slow bleed; we (nursing staff) would never know (without hospital medical diagnostic tests). On 11/13/24 at 3:30 p.m., LPN G was asked about R702's fall. LPN G clarified they recalled R702 had a laceration on top of their head, and they had to call the Medical Director to send R702 to the hospital, as the physician had not responded. LPN G confirmed the laceration appeared to be rather deep, and it looked like [R702] needed sutures, staples, or something (another acute intervention) . LPN G clarified they would have initiated an acute care hospital transfer when the incident occurred. After reviewing R702's EMR from the date and time of the incident, LPN G acknowledged a skin assessment or additional nursing assessment to describe the wound should have been completed by LPN H, and was not found. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/13/24 at 4:00 p.m., concerns were reviewed with the DON related to R702 not being sent out emergently after a fall with an open, bleeding head wound (laceration) while being on a blood thinner (Eliquis), the lack of a comprehensive nursing/skin assessment at the time of the incident, and the lack of timely physician response and notification of the Medical Director, per interviews and facility policies. The DON reported they understood the concerns and confirmed LPN H was no longer employed at the facility. Review of the policy, Fall Management Guidelines, dated 12/13/2023, revealed, .Post fall evaluation: If a resident has just fallen or is observed on the floor without a witness to the event, evaluate for possible injuries to the head, neck, spine, and extremities prior to moving the resident .Complete a head-to-toe skin evaluation. If there is evidence of injury, provide appropriate first aide and/or obtain medical treatment immediately .Notify the resident's medical practitioner . Review of the policy, Physician Services, revised 3/20/2024, revealed, .A physician is responsible for supervising the medical care of residents, including but not limited to: .Monitoring changes in the resident's medical status. Providing consultation or treatment when contacted by the facility .Ordering a resident's transfer to the hospital .The facility ensures 24-hour (physician care) if the attending physician is not available to supervise the care of the resident. The attending physician may designate another physician to act on their behalf, if they are not available .The facility medical director may act on their behalf. Review of the policy, Change in Condition Notification, dated 8/09/2023, revealed, It is the policy to notify the resident, his or her attending physician/practitioner .of changes in the resident's medical/mental condition and/or status. The nurse will notify the resident, the resident's physician .when there is: An accident or incident involving the resident which results in an injury and has the potential for requiring physician/practitioner intervention, a need to alter the resident's medical treatment significantly such as .an acute condition .A need to transfer .the resident from the facility .The nurse will document in the resident's medical record information relative to the resident's change in medical/mental condition or status (i.e. assessment, notifications, interventions, and response) .