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	06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Four Seasons Nursing Center of Westland	8365 Newburgh Road 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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake MI0015340. Based on interview and record review, the facility failed to ensure appropriate documentation of administration and accountability of controlled substances for one (R903) of four residents reviewed for medication administration. Findings include: Review of a complaint filed with the State Agency included allegations that R903 was admitted for a five-day hospice respite stay and did not receive their medications either at all, or as prescribed, including controlled substances (liquid morphine-for pain and lorazepam-antianxiety). Review of the clinical record revealed R903 was admitted into the facility on 5/27/25 and discharged on 6/1/25. Diagnoses included: encounter for palliative care, multiple sclerosis, pseudobulbar affect, attention-deficit hyperactivity disorder, other seizures, stiff-man syndrome, and diplopia. According to the Minimum Data Set (MDS) assessments, there was only an entry assessment documented and a discharge return not anticipated assessment with an Assessment Reference Date (ARD) of 6/1/25 that was In Progress (incomplete). Review of R903's medication order summary and Medication Administration Records (MARs) from 5/27/25 - 6/1/25 included the following: Lorazepam Injection Solution 2 MG/ML (Milligram/Milliliters) Inject 4 mg intramuscularly as needed (prn) for Anxiety One time Max a day. Per the MAR, there were no prn administrations documented. Lorazepam Oral Tablet 0.5 MG Give 1 tablet by mouth every 8 hours as needed (prn) for Anxiety/Restlessness/Muscle spasm. Per the MAR, there were no prn administrations documented. Morphine Sulfate (Concentrate) Oral Solution 20 MG/ML Give 0.25 ml by mouth every 4 hours as needed (prn) for Pain/SOB (Shortness of Breath). Per the MAR, there were no prn administrations documented. There were no controlled substance records available for review in R903's electronic medical record. (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/10/25 at 4:55 PM, the Director of Nursing (DON) was requested to provide all controlled substance records for R903, including what was provided at the time of admission and what was provided at the time of discharge. On 6/11/25 at 9:00 AM, the DON provided the controlled substance proof of use records for R903's morphine sulfate and lorazepam and reported the medication was handed off by the EMS (Emergency Medical Staff) staff upon admission and provided to EMS at time of discharge. The DON was asked to review the controlled substance forms to verify the nurse's initials and documentation included on these forms. The following was included on these controlled substance records: Lorazepam 0.5 MG Give 1 tablet by mouth every 8 hours prn for anxiety/restlessness - Amt. Received: 30 tablets; Date Received 5/27/25. The documented removal included: 5/29 0700 (7:00 AM) QTY (Quantity) USED 1 QTY REM (Remaining) 29. Initialed by Nurse 'G'. 5/29 1100 (11:00 AM) QTY USED 1 QTY REM 28. Initialed by Nurse 'G' and another Nurse that was illegible. 5/29 1800 (6:00 PM) QTY USED 1 QTY REM 27. Initialed by Nurse 'G' and another Nurse that was illegible and scribbled out. 5/30 0800 (8:00 AM) QTY USED 1 QTY REM 26. Initialed by Nurse 'G'. 5/30 12P (12:00 PM) QTY USED 1 QTY REM 25. Initialed by Nurse 'G'. 5/30 6P (6:00 PM) QTY USED 1 QTY REM 24. Initialed by Nurse 'G'. 5/30 1800 (6:00 PM) QTY USED 1 QTY REM 23. Initialed by Nurse 'G'. 5/30 11PM (11:00 PM) QTY USED 1 QTY REM 22. Initials illegible and the DON was unable to identify the Nurse's initials. This document was initialed by Nurse 'D' and unknown EMS staff (as reported by the DON on the day of discharge) and was not dated. Morphine Sul (Sulfate) Sol (Solution) 100mg/5mL Give 0.25 ML by mouth Q (Every) 4 hours PRN (As needed) for PAIN/SOB - Amt. Received: 30ML; Date Received 5/27/25. The documented removal included: 5/29 0800 (8:00 AM) QTY USED 0.25 QTY REM 29.75. Initialed by Nurse 'G'. 5/29 1300 (1:00 PM) QTY USED 0.25 QTY REM 29.75. Initialed by Nurse 'G'. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5/29 1700 (5:00 PM) QTY USED 0.25 QTY REM 29.75. Initialed by Nurse 'G'. All of the above entries were scribbled out and marked as ERROR and FULL with Nurse 'G's initials. This document was initialed by Nurse 'D' and unknown EMS staff (as reported by the DON on the day of discharge) and was not dated. None of the above morphine or lorazepam were documented as administered on the MAR (the MAR was left blank); nor were there any progress notes or other documentation to explain why this medication was removed. The progress notes and vital signs documented R903 as having 0 pain and there was nothing identified about the resident having anxiety/restlessness to correspond with the above medication removal. On 6/11/25 at 9:13 AM, the DON reported Nurse 'F' initialed the receipt of the medication upon admission to the facility on 5/27/25 and Nurse 'D' at discharge on [DATE]. The DON reported the other Nurse's initials for the documented removal of the medication was Nurse 'G'. The DON was unable to confirm the third set of initials, acknowledged the illegible initials and multiple error entries for the liquid morphine medication and reported they weren't sure who or why some of the entries had additional illegible initials. When asked why Nurse 'G' would document three removals of the liquid morphine on the same day, at three separate times, then make an scribbled entry of ERROR and FULL if the medication had been removed separately and no documented wasting of the medication, the DON reported maybe the nurse made an error. When asked if the error occurred the first time, how were the other two errors done, the DON offered no further explanation. When asked what the facility's process was for the documentation of removal and administration of controlled substances, the DON reported the nurses should be documenting the administration on the MAR. When asked how it could be determined the resident received the medication if it was documented as pulled but not administered, the DON acknowledged the concern but offered no further explanation. They were requested to provide a copy of the documentation provided and a policy regarding controlled substances. On 6/11/25 at 11:40 AM, Nurse 'G' was attempted to be contacted by phone. There was no answer, and the mailbox was full unable to accept any messages. On 6/11/25 at 11:43 AM, Nurse 'G' was sent a detailed text message to return the call. There was no response from Nurse 'G' by the end of the survey. On 6/11/25 at 12:12 PM, a phone interview was conducted with the Hospice RN (Registered Nurse) Clinical Manager (Nurse 'Q'). When asked about the discrepancies with R903's medications, Nurse 'Q' reported that they could review Nurse 'R's notes from their visit with the resident on 5/29/25. Nurse 'Q' reported Nurse 'R' noted concerns with a seizure medication being found on the floor, need for an updated medication list to be sent to the facility, and that they had spoken to and sent Unit Manager 'B' the updated medication list. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/11/25 at 12:45 PM, an interview was conducted with Unit Manager 'B'. When asked about R903's concerns with medication and discussion with the hospice nurse on 5/29/25, Unit Manager 'B' reported they couldn't recall specific details but did recall the hospice nurse was going to get an updated medication list sent over. When asked if that ever happened, Unit Manager 'B' reported that did not and further reported it was later in the day on a Friday, recall there being a lot going on at that time and the resident discharged that Sunday (6/1/25). Unit Manager 'B' was asked to review the controlled substance records and acknowledged the concerns. When asked if they had identified any concerns prior to this review, Unit Manager 'B' reported they had not. They were informed of that this surveyor wanted to conduct an interview with Nurse 'G' but had not responded to phone call, or text message and Unit Manager 'B' reported they had attempted to reach Nurse 'G' at least ten times today and was not responding to them either. Unit Manager 'B' was asked why a nurse would document three separate times of removal of liquid morphine, then document all as an ERROR and FULL if each administration would be documented at the time of removal/administration and there was no documentation of the medication being wasted, Unit Manager 'B' reported they were not able to offer any further explanation as to why that was done. According to the facility's policy titled, Controlled Medication Guidelines dated 3/20/2024: .When the licensed nurse removes the controlled medication from the package, they will document the quantity removed and the quantity left on the Controlled Drug Receipt/Record/Disposition Form. After Administration of the controlled medication the licensed nurse will document the administration on the medication administration record .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview and record review, the facility failed to ensure proper storage and discarding of medications in one of eight medication carts affecting three residents (R906, R907 and R908) of three residents reviewed for medication storage. Findings include: On 6/11/25 at 10:28 AM, upon walking onto the Spring Unit, an unlocked medication cart was observed with no licensed staff present. Additionally, the monitor on the top of the cart was left open with personal information in view to anyone that walked by for R907. The medication cart had an insulin pen (Lantus Solostar for R907) stored directly on top of the cart. Upon opening the unlocked top drawer of the medication cart, there were several clear medicine cups with pills in each cup. One of the cups contained five pills (later identified by Registered Nurse, RN 'E', as medication for R906); one cup had a white pill and another cup contained a white pill. At 10:30 AM, RN 'E' was observed exiting a seperate resident's room. When asked about the unlocked cart, open monitor and insulin stored on top of the cart, RN 'E' proceeded to engage the lock and stated another resident needed their help so they just went in. When asked what the protocol was for when they left the medication cart, RN 'E' reported they should've locked the cart before helping the resident. RN 'E' was asked to open the top drawer and when asked about the pill cups in the top drawer and reported they were for R906. When asked to confirm the medications in the cup, RN 'E' identified the medication as Levetiracetam 500 MG (Milligrams), Duloxetine 60 MG, Atenolol 25 MG, Amlodipine 2.5 MG, and Losartan Potassium 100 MG. When asked about the other two cups, RN 'E' reported the other two cups had to be wasted. When asked who they were for and what the pills were, RN 'E' reported one is for R908 it's it's their shaking pill. RN 'E' reported that pill was on the floor so they were going to waste it. When asked why it wasn't wasted immediately, they offered no response. When asked about the third cup of medication, RN 'E' reported it was for R908 they don't get it anymore in the morning so I was going to waste it. When asked why the medication would be removed for administration if the order had been verified as part of the current/acitve medication administration, RN 'E' offered no response. On 6/11/25 at 10:42 AM, an interview was conducted with the Director of Nursing (DON). When informed of the observations of the medication storage and interview with RN 'E', the DON reported that should not have occurred. The DON was asked what their facility's process was for storage and disposal of medication, the DON reported they would have to defer to their facility policy but further reported the medications should not be stored in the cart if not administered, the cart should not have been left unlocked, with insulin stored on the top of the cart. According to the facility's policy titled, Medication and Treatment Storage dated 8/7/2023: .All medications and biologicals will be stored in locked compartments (i.e., medication carts .During a medication pass, medications must be under the direct observation of the person administering medications or locked in the medication storage area/cart .