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	07/30/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake 2569649.Based on observation, interview, and record review, the facility failed to protect one resident's right (R703) out of one reviewed to be free from mental abuse and verbal abuse by staff.An allegation of staff to resident abuse involving Staff F and R703 was submitted to the state agency around 7/9/25.On 7/30/25 at 9:45 AM, R703 was observed sitting up in their wheelchair in their room. When the resident was asked about the incident involving Certified Nursing Assistant (CNA) F on 7/9/25, they said the nursing assistant came in that morning to empty my catheter bag. I told them to be sure it was closed because it has been leaking. The nursing assistant got smart with me and said she knew how to do her job. So, I called her a B**** and spelled it out to her. We argued. The nursing assistant then proceeded to pull my covers off me and throw them on the floor and threw water at me. I was trying to use my call light to call for help, but she pulled it away from me and put it on the wheelchair where I could not get to it. The nursing assistant then threatened to come and give me a black eye.On 7/30/25 at 11:55 AM, an interview was held with Registered Nurse (RN) H. RN H was asked about the incident on 7/9/25. RN H said the resident requested to see me because they trust me in which I visited the resident in their room. The nurse reported that during morning rounds the nursing assistant came in the room and threw water on them. RN H confirmed they immediately got the Nursing Home Administrator (NHA).On 7/30/25 at 1:45 PM, CNA F was interviewed via telephone. CNA F was asked what happened on the morning of the incident involving R703. CNA F explained they went into the room and turned on the light. R703 said asked to turn the light off. R703 asked to make sure to empty my catheter bag. I explained that it is done every day. R703 started saying, that I don't do s*** and calling me names. R703 kept calling names and I ignored them. The resident started hitting me in the back with the remote control. As I was removing the roommates old water cups, the resident knocked it out of my hand, and it got all on the covers. CNA F explained they then took the remote control from the resident and placed it on the roommate's table, pulled the blankets off them because they were wet. R703 asked, if they were going to get more covers and I told them I am not bringing you covers. I will someone else bring you covers. You can get the cover yourself. and did not go back in the room once they left. On 7/30/25 at 2:45 PM, the Director of Nursing (DON) was interviewed. The DON confirmed the incident between CNA F and R703. When asked what their expectation for residents and abuse. The DON replied, My expectation is that residents will be free from abuse and neglect.R703 medical record was reviewed and revealed the resident was admitted to the facility on [DATE] and had diagnoses of Multiple Sclerosis, Depression, and Type II Diabetes with poly neuropathy. R703's Brief Interview for Mental status assessment dated [DATE] was a 14/15 indicating intact cognition. A review of the Abuse Policy and Procedure dated 5/24/23 revealed, 'Residents have the right to be free from abuse, neglect, exploitation, mistreatment, and misappropriation of resident property. The facility will develop and implement written policies and procedures that include: Screening potential employees and prospective residents. Training new and existing staff on prohibiting, preventing, and identifying abuse, neglect, exploitation, mistreatment, and misappropriation of resident property, reporting procedures, dementia and behavior management. Prohibiting, Preventing, and Identifying abuse, neglect, mistreatment, exploitation, and misappropriation of resident property. Reporting any allegations of abuse, neglect, mistreatment, exploitation, and misappropriation or resident property including reporting a reasonable suspicion of a crime to the State Survey Agency and other officials in accordance with state law. Investigating allegations of abuse, neglect, misappropriation, mistreatment, and exploitation to include protecting residents during the investigation, and taking necessary actions as a result of the investigation. Establishing coordination with the QAPI program.' During the onsite survey, past noncompliance (PNC) was cited after the facility implemented actions to correct the noncompliance which included the following: Element #1 Immediately suspended employee upon notification from resident. Resident was assessed, no injuries noted, and no pain was reported. Physician and family were notified of alleged incident . Resident's roommates were interviewed. Staff statements were taken. Facility Social Work completed 3 days well check visits for Resident. Behavioral Health Psychiatric Services offered to Resident. Police were called, and a report was filed, Detective was assigned, and the case was closed. CNA was given disciplinary action related to Resident Right resulted in Termination. Element #2 1. Interview able residents within the assignment set were queriedElement #31. Facility policy on Resident Rights and Abuse was reviewed and deemed appropriately2 . Facility staff were reeducated on Resident Rights and Abuse Policies

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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. This citation pertains to Intake 1246198Based on observation, interview, and record review, the facility failed to apply compression stockings for one resident (R700) out of two reviewed for following physician orders. Findings include:A review of Intake called into the State Agency noted R700's legs are swollen and painful. On 7/30/2025 at 9:48 AM, R700 was observed lying in bed. R700 was observed to have heel boots on and nothing else. R700 reported they are supposed to have compression stockings on to help with the swelling in their legs, but the facility staff have only been put them on once or twiceA review of the medical record revealed R700 was admitted into the facility on 3/20/2024 with the following medical diagnoses, Muscle Weakness and Disorder of Muscle. A review of the most recent Minimum Data Set (MDS) assessment revealed a Brief Interview for Mental Status score of 12/15 indicating an impaired cognition. R700 also required staff assistance with bed mobility and transfers.A review of active physician orders revealed the following, please apply (name of compression stockings) to BLE (Bilateral Lower Extremities) .Schedule: on at 6:00 AM and doff (take off) at 10:00 PM. It was noted on the Medication Administration Record (MAR) the compression stockings were signed off by the nurse as having been applied at 6:00 AM on 7/30/2025.On 7/30/2025 at 10:41 AM and 11:48 AM, R700 was observed in bed. No compression stockings were applied or in place to the bilateral lower extremities.At 1:15 PM Licensed Practical Nurse (LPN) C was queried about the resident compression stockings. LPN C was shown the physician's order and confirmed that R700 did not have any on. LPN C went on to say they would try and find some for R700.On 7/30/2025 at 1:48 PM, an interview was conducted with the Director of Nursing (DON). The DON stated they were aware of the issue and reported they expect compression stockings to be applied as ordered.A review of a facility policy titled, Physician and Practitioner Orders did not address following physician orders.

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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. This citation pertains to Intake 2564064Based on interview and record review, the facility failed to prevent the development of an unstageable pressure ulcer (Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because the wound bed is obscured by slough or eschar) for one resident (R702) out of one reviewed for pressure ulcers. Findings include:A review of Intake called into the State Agency noted R702 admitted into the facility with their skin intact and developed an unstageable pressure ulcer on their coccyx/buttocks while in the facility due to not being turned and repositioned, as well as delayed incontinence care.A review of the medical record revealed R702 was admitted into the facility on 5/7/2025 with the following medical diagnoses, Muscle Weakness and Lymphedema. A review of the most recent Minimum Data Set (MDS) assessment revealed a Brief Interview for Mental Status (BIMS) score of 13/15 indicating an intact cognition. R702 also required staff assistance with bed mobility and transfers.Further review of the admission skin evaluation dated 5/7/2025 noted R702 did not have any skin abnormalities.Further review of progress notes revealed an open area was observed on R702's buttocks 6/4/2025.Further review of a skin evaluation dated 6/11/2025 noted the wound measured 6.4 cm (centimeters) x 3.5 cm x 2.5 with a depth of 0.2 cm with progress of wound noted as deteriorating.On 7/30/2025, an interview was completed with Wound Care Nurse (WCN) A. WCN A reported the day they were doing wound rounds; they were informed that R702 had an open area. WCN A reported they immediately had the wound care physician assess them and put in an order and interventions. WCN A was asked what interventions were put in place for R702 prior to them developing the wound. WCN A reported they implement turning and repositioning for all at risk patients. WCN A reported they are unsure how R702 developed the wound.On 7/30/2025 at 1:52 PM, an interview was conducted with the Director of Nursing (DON). The DON reported they were informed about the wound when the WCN informed them about it. The DON reported they only knew that it was discovered on 6/4/2025 and the WCN saw it immediately and treated it and implemented interventions.A review of a facility policy titled, Skin and Wound Guidelines did not address the prevention of wound development.