

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 03/04/2026
NAME OF PROVIDER OR SUPPLIER Four Seasons Nursing Center of Westland		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake: 274990Based on observation, interview, and record review, the facility failed to protect the resident's privacy for four residents (R904, R905, R906, and R907) of four residents reviewed for resident rights. Findings include: A review of documentation submitted to the State Agency (SA) revealed the following, On 2/12/26 at approximately 8:30pm Administrator was notified by Corporate Compliance Officer that a call had come in that employee [Licensed Practical Nurse, LPN B] posted a [Social Media] Story Clip of resident [R904] in the [NAME] Day room at approximately 7:50pm . On 3/4/26 at 12:53 PM, an attempt to contact LPN B via phone was to no avail.A review of the facility's interview of LPN B revealed she recorded a fall as part of the facility fall investigation process using her personal phone. She explained she thought she deleted the video prior to leaving the facility and was notified by a previous facility employee that she had posted the video to her social media account. A review of photo stills taken from LPN B's social media account shows residents sitting in the common area of the facility, faces clearly shown.A review of R904's medical record revealed they were admitted into the facility on 1/9/18 with a diagnosis of Alzheimer's Disease. The resident is severely cognitively impaired.A review of R905's medical record revealed they were admitted into the facility on 6/18/25 with a diagnosis of Schizophrenia and a moderate cognitive impairment. A review of R906's medical record revealed they were admitted into the facility on 5/10/25 with a diagnosis of Dementia and a moderate cognitive impairment. A review of R907's medical record revealed they were admitted into the facility on 3/26/25 with a diagnosis of Dementia and a severe cognitive impairment. On 3/4/26 at 3:10 PM, the Director of Nursing (DON) was interviewed regarding the incident and explained that LPN B took a video of the camera system using her cell phone to better understand the resident's fall. He reports he thought the video was encrypted and would be deleted prior to her leaving the facility. He further explained the situation was an accident that should not have occurred.A review of the facility's Social Media and Electronic Communications policy revealed the following, .1. Employees are strictly prohibited from transmitting by way of any electronic media any resident-related image or information that may be reasonably anticipated to violate resident rights to confidentiality or privacy. This includes information that could degrade or embarrass the resident. 2. Employees will not post or share posts that would disseminate any information regarding a resident .During the onsite survey, past noncompliance (PNC) was cited after the facility implemented actions to correct the noncompliance which included: Element 1-Identification of Affected ResidentGuardians/POAs (Power of Attorneys) of all residents identifiable in the posted content were contacted and informed of the incident.Element 2-Identification of Resident with Potential to be AffectedAll residents residing in the facility had the potential to be affected by the deficient practice. No additional residents were identified in the social media post beyond those already identified.Element 3-Systemic Changes ImplementedFacility policies on Telephone Usage including Communication devises and Social Media and Electronics reviewed.All staff received re-education on the above policiesFacility Management and IDT (Interdisciplinary team) members were re-educated on the same policiesManagement and IDT were instructed that only the (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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Administrator may access and set up video camera playback; the door lock to the camera rooms was changed to restrict access.[LPN B] was suspended, interviewed, and computer access removed and received disciplinary action.The Director of Nursing received education related to oversight responsibilities. Element 4-Monitoring to Ensure Ongoing ComplianceThe Administrator or designee will conduct weekly audits three times per week for four weeks on random unit to ensure staff are not using cell phone in resident care areas.The Administrator or designee will conduct random staff queries regarding Cell Phone and Social [NAME] policies three times per week for four weeks. Element 5-Date of ComplianceThe Administrator is responsible for ensuring full compliance.Compliance was achieved on 2/13/26.The facility was able to demonstrate monitoring of the corrective action and maintained compliance.</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>This citation pertains to Intake: 2789064Based on interview and record review, the facility failed to administer medications properly to one resident (R901) of one reviewed for medication administration. Findings include:A review of information submitted to the State Agency (SA) revealed the following, .[R901's] sister was in facility visiting and was laying in the patient's bed .The nurse came in and administered the patient's medications to the family member .911 had to be called and the family member had to be transported to the hospital .A review of R901's medical record revealed they were admitted into the facility on 2/16/26 with diagnoses which included Diabetes, Other Cirrhosis of the Liver, and Heart Failure. Further review revealed the resident was cognitively intact and required assistance with activities of daily living.On 3/4/26, a request for documentation including transfers to the hospital was requested from the facility. A document was provided indicating the following, On 2/24/26 at approximately 0930 (9:30am), the sister of resident [R901] was present in the resident's room and was observed lying in the resident's bed while the resident was not in the room. When the nurse [Licensed Practical Nurse -LPN A], entered the room to administer the resident's morning medications for [R901]. The nurse subsequently left the medications with the sister. Shortly thereafter the sister independently contacted 911 .the medications delivered to the resident's room included Metformin (used to lower blood sugar levels), spironolactone (water pill), and Flomax (used to make urinating easier) .On 3/4/26 at 11:43 AM, an interview was completed with LPN A regarding their R901's sister consuming R901's medications. LPN A explained he went into the resident's room to administer medications and observed the resident's sister lying in the bed. R901's sister indicated to him that she would ensure R901 took the medications when they returned to the room. LPN A acknowledged he left the medications in the resident's room and shortly after was informed the sister had contacted 911 and was transported to the hospital. On 3/4/26 at 2:26 PM, R901 was interviewed regarding their sister consuming their medications. R901 explained they were in the dining room, and their sister was in their room. Upon returning, the sister informed them they had taken their medications left in the room by the nurse. R901 explained the sister indicated they were feeling dizzy and called 911 and was subsequently transported to the hospital. A review of R901's active physician orders and February Medication Administration Record (MAR) revealed the resident was ordered and was checked off as being administered the following at 9:00am on 2/24/26: Metformin HCl Oral Tablet 1000 MG (milligrams), Tamsulosin HCl Oral Capsule 0.4 MG, Lactulose Oral Solution 10 GM/15ML (Lactulose), and House Liquid Protein. On 3/4/26 at 2:57 PM, the Director of Nursing (DON) was asked about the incident regarding the consumption of medications by R901's sister and explained the nurse should have followed the five rights of medication administration, and ensured the resident took the medication.A review of the facility's Medication Administration policy revealed the following, .medications are administered in accordance with the following rights of medication administration: right resident, right medication, right dose, right route, right time and frequency, right documentation, right of resident to refuse, and right clinical indication .procedure: .Administer medication: remain with resident until administration of medication is complete .</p>		