

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 04/09/2026
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)		
<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** This citation pertains to Intake number 2980818. Based on observation, interview, and record review, the facility failed to protect the resident's (R82) right to be free from physical abuse by another resident (R45) out of five reviewed for abuse. Findings include: A review of an Incident and Accident (I/A) report dated 4/6/2026 noted the following, Nurse was called to the front lobby to remove the resident (R45). Front desk coordinator stated that The resident (R45) began hitting and grabbing onto another resident (R82) from a different unit. This all occurred in the lobby and was witnessed. Further review of a progress note in R82's medical record dated 4/6/2026 noted the following, At 18:58 (6:58pm) resident was hit in the head by another resident, writer assessed resident, skin and pain assessment complete, 1/10 pain, BP (Blood Pressure) 126/64, RR (Respiration Rate) 17 P (Pulse) 90, unit manager A, NP (Nurse Practitioner [Name]), administrator and family notified. A review of the medical record revealed R82 admitted into the facility on 1/8/2026 with the following medical diagnoses, Anemia and Muscle Weakness. A review of a Minimum Data Set assessment dated [DATE] revealed a Brief Interview for Mental Status score of 11/15 indicating an impaired cognition. R82 also required staff assistance with bed mobility and transfers. On 4/8/2026 at 8:48 AM, an interview was conducted with R82. R82 reported they were sitting in the front lobby with some other residents and R45 followed them to the front lobby. R82 reported R45 came behind them and started banging them in the head and yelling. R82 reported somebody moved them away from R45 and a couple nurses came and took R45 to their room. R82 reported they were then taken to their room and the nurse checked them out. A review of the medical record revealed R45 was most recently admitted into the facility on 8/16/2025 with the following medical diagnoses, Major Depressive Disorder and Vascular Dementia with Agitation. R45 was noted to have impaired cognition. Further review of R45's behavior care plan initiated on 1/10/2022 noted the following focus, [R45] exhibits Alt (Alteration) in BEHAVIORS/MOOD aeb (As Evidenced By) periods of increased agitation, physical threatening behaviors of holding [their] fist up at others, yelling, irritability, resistive w/ (with) care, taking showers, noted phy. (physical) altercation w/ other res's (residents) of punching, hit by another res, personal space concerns and confrontational behaviors w/ others, easily agitated/angered. Recent rm (room) change off of the Dementia /Behavioral unit and at time difficult to redirect. On 4/8/2026 at 2:11 PM, R45 was observed in their wheelchair, rolling down the hallway independently where R82 resided. R45 was unable to be interviewed regarding the incident. On 4/8/2026 at 12:28 PM, a phone interview was conducted with Receptionist B. Receptionist B reported R82 was at their desk and R45 was seen following behind R82. Receptionist B reported they were getting money for another resident when they heard yelling and screaming so they turned around and saw R45 hitting R82. Receptionist B reported they immediately removed R82 and called the nurse for R45. On 4/8/2026 at 12:47 PM, an interview was conducted with Unit Manager (UM) A. UM A reported they were working on a nurse's cart that day and was called over after the incident. UM A reported they helped take R45 to their room and informed the nurse on duty on who to call and had the visitors write down their statements. UM A reported R45 does have aggressive behaviors and can be agitated when someone is in their space. UM (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>A was asked what interventions have been put in place since the incident, and they responded, I just keep a close eye on them. On 4/8/2026 at 1:56 PM, an interview was conducted with the Nursing Home Administrator (NHA). The NHA reported they reviewed the video from the incident and were still collecting statements from witnesses. The NHA reported at 6:51 PM, R82 came and sat in the front lobby and about 10 seconds later R45 came behind them and began swatting R82 towards the left shoulder and neck. The NHA reported the video showed Receptionist B then moved R82 and a nurse came to move R45 who was being resisting and aggressive. The NHA said based on the camera footage, they were unable to substantiate physical contact was actually made, despite R82 and Receptionist B confirming physical contact was made. The NHA was asked what interventions had been put in place for R45 to ensure this does not happen again. The NHA reported the psychiatrist would be in to see them on 4/10/2026, and they had increased monitoring for R45. A review of R45's behavior care plan showed the most recent interventions were initiated on 3/20/2024. No updated interventions, such as increasing monitoring of the resident were noted on the behavior care plan. Further review of the progress notes for R82 and R45 did not reveal any updated progress notes since the resident-to-resident incident occurring on 4/6/2026. On 04/9/2026 at 12:57 PM, an interview was conducted with the Director of Nursing (DON) about the incident. The DON reported they were still completing their investigation within the facility. The DON reported that while the investigation is being completed, they are doing increased monitoring and watching R45's triggers. A review of a facility policy titled, Abuse revealed the following, Residents have the right to be free from abuse, neglect, exploitation, mistreatment, and misappropriation of resident property.</p>		