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	02/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Four Seasons Nursing Center of Westland	8365 Newburgh Rd Westland, MI 48185

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(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** 32220 Based on observation, interview and record review the facility failed to provide timely repositioning for four dependent residents (R34, R44, R97, R118) of five reviewed for positioning. Findings include: Resident #34 On 02/10/25 at 9:38 AM, 12:29 PM, 1:54 PM, and 2:35 PM, R34 was observed to be on their backside in a specialty bed with the head of the bed elevated around 30-45 degrees and a foam wedge was on the mattress at the foot of bed. On 02/11/25 at 8:10 AM, 8:35 AM, 9:30 AM, and 11:41 AM, R34 was observed to be on their backside in bed and a foam wedge was on the mattress at the foot of bed. The head of the bed was up around twenty or thirty degrees. On 02/11/25 at 12:09 AM, 12:39 PM, and 12:43 PM, R34 was observed to be in bed dressed in a hospital style gown, turned toward the door. A foam wedge was visible behind the torso on the left side. At 12:51 PM, 2:02 PM, and 2:59 PM, the head of the bed was around 45 degrees and the wedge was behind the torso at the left side. R34 leaned over to the right edge of the bed. At 2:01 PM staff entered the room. At 2:02 PM, R34 was observed to be in bed as before with the wedge to the left side. On 02/12/25 at 8:04 AM, R34 was observed to be in bed with the head of the bed up around 45 degrees and the foam wedge was behind the torso at the left side. R34 leaned over to right edge of the bed. A review of the record for R34 revealed R34 was admitted into the facility on [DATE]. Diagnoses included Dementia, Diabetes, Heart Disease and Stroke. A review of the care plan initiated 05/23/19 documented, . has alteration in mobility . reposition in bed or gerichair at least q (every) two hours and prn (as needed) . The Minimum Data Set (MDS) assessment dated [DATE] documented severely impaired cognition, impaired range of motion to the upper and lower extremities on one side, and required substantial or maximal assistance to roll left and right. R34 required substantial or maximal assistance or was dependent for all activities of daily living except eating. Resident #44 On 02/10/25 at 9:53 AM and 12:31 PM, R44 was observed to be on their backside in a specialty bed. (continued on next page)

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 02/11/25 at 8:20 AM, 9:27 AM, and 11:51 AM, R44 was observed to be on their backside in bed dressed in a hospital style gown. At 12:13 PM, hospice staff entered the room and elevated the head of the bed R44 remained on their backside in bed. At 12:42 PM and 1:45 PM, R44 appeared on their backside in bed with the head of the bed elevated around 45 degrees. A review of the record for R44 revealed R44 was admitted into the facility on [DATE]. Diagnoses included Parkinson's, Pulmonary Disease and Stroke. A review of the care plan initiated 12/18/22 documented a self care deficit and bed mobility was a two person assist and R44 required frequent turning and repositioning. The Minimum Data Set (MDS) assessment dated [DATE] documented impaired cognition, impaired range of motion to one or both the upper and lower extremities, and required substantial or maximal assistance to roll left and right. R34 required substantial or maximal assistance or was dependent for all activities of daily living. Resident #97 On 02/10/25 at 4:01 PM, R97 was observed to be on their backside in bed, dressed in a hospital style gown, their head was on the left corner of the pillow and the body down in the bed. The head of the bed was elevated. R97's legs were flexed in a frog legged position. No positioning devices were visible at the sides. On 02/11/25 at 8:21 AM, 8:55 AM, 11:39 AM, 12:46 PM, and 12:52 PM, R97 was observed to be on their backside in bed with the head of the bed elevated around 45 degrees. R97's legs were flexed in a frog legged position. No positioning devices were visible at the sides. On 02/12/25 at 9:34 AM and 1:52 PM, R97 was observed to be on their backside in bed with the head of the bed elevated around 45 degrees. R97's legs were flexed in a frog legged position. No positioning devices were visible at the sides. A review of the record for R97 revealed R97 was admitted into the facility on [DATE]. Diagnoses included Dementia, Paralysis of the left side, Stroke and Contracture of the Left Knee. The care plan initiated 05/23/20 documented a self care deficit and bed mobility required a two person assist. The risk for pressure ulcer formation care plan documented the need for surface support, pressure redistribution, position changes and offloading. The Minimum Data Set (MDS) assessment dated [DATE] documented severely impaired cognition, impaired range of motion to both the upper and lower extremities, and required substantial or maximal assistance to roll left and right. R97 required substantial or maximal assistance or was dependent for all activities of daily living. Resident #118 On 02/10/25 at 12:00 PM, 12:54 PM, 2:06 PM and 4:06 PM, R118 was observed to be on their backside in bed on a specialty mattress, specialty boots on the feet, and the head of the bed around 20-30 degrees. No devices were observed to position R118. Per a physician note dated 2/6/25, R118 had a pressure wound to the coccyx (tailbone). On 02/11/25 at 11:55 AM, 12:55 PM, 2:06 PM, and 2:33 PM. R118 was observed to be on their backside in bed with the head of the bed around 20-30 degrees. No devices were observed at the sides of the torso to position R118 off the coccyx wound area. The resident did not make any attempts to move. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/11/25 at 2:33 PM, Certified Nursing Assistant (CNA) C entered the room of R118. At 2:39 PM, along with CNA C , R118 was observed with no positioning devices seen at the sides of the torso. On 02/11/25 at 2:59 PM, R118 appeared in the same position as before. On 02/12/25 at 10:05 AM, R188 was returned from dialysis to the hallway outside their door. R188 was on their backside in the recliner. On 02/12/25 at 11:27 AM, a wound observation of the coccyx wound was completed with the wound care nurse. R118 was observed to be on their backside in bed. A flat pillow was observed under the left shoulder area of R118. The pillow did not provide any visible turn or position change. A review of the record for R118 revealed R118 was admitted into the facility on [DATE]. Diagnoses included Dementia, Diabetes and Pressure Ulcer of the Sacral (lower back, coccyx) Region. The care plan initiated 03/22/24 documented a self care deficit and bed mobility required a two person assist. The actual pressure injury care plan also documented the need for .frequent turning and repositioning . The Minimum Data Set (MDS) assessment dated [DATE] documented severely impaired cognition, impaired range of motion to both the upper and lower extremities, and R118 was dependent on staff to roll left and right. R118 was dependent for all activities of daily living. On 02/12/25 at 8:11 AM, the Director of Nursing (DON) reported residents unable or who don't reposition themselves should be turned frequently and did not provide specific time frames. It was noted that the standard was to reposition every two hours at least. At 11:14 AM the DON reported repositioning was required even with a specialty mattress in place. A review of the facility policy titled, Repositioning issued 08/09/23 revealed, The purpose of this procedure is to provide guidelines to promote comfort, assist in preventing skin breakdown, promote circulation and provide pressure relief for bed bound and chairbound residents . Resident who are immobile and/or dependent on staff for repositioning should be repositioned at least every two hours .

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50223 Based on observation, interview, and record review, the facility failed to administer the correct tube feeding formula for one resident (R119) of four reviewed for tube feeding. Findings include: On 2/10/25 at 9:46 AM, R119 was observed lying in bed. A bottle of Jevity 1.5 tube feeding dated 2/9/25 was observed to be hanging on a pole in their room. On 2/11/25 at 9:19 AM, two bottles of Jevity 1.5 tube feeding, one of which was dated 2/10/25 and the other dated 2/9/25 was observed in the trash can next to R119's bed. A review of R119's record revealed they were admitted to the facility on [DATE] with the following diagnosis: Benign Neoplasm of Meninges (brain tumor) and Dysphagia, oropharyngeal (inability to swallow). Further record review revealed a Brief Interview for Mental Status score of 11 indicating moderate cognitive impairment. A review of R119's physician orders revealed the following: active order dated 1/29/25 Enteral feed two times a day Nutren 2.0 @88ml/hr (milliliters per hour) x 12 hours providing 1056ml (hang 5 pm to 5 am) with autoflush of 80ml/hr x 12 hrs providing 960ml fluids. A second active order dated 1/25/25 Jevity 1.5 55ml/hr provides 1320ml, Flush 30ml to provide 1873ml one time a day for nutrition. A review of R119's Febuary 2025 Medication Administration Record (MAR) revealed both Nutren and Jevity were listed and both marked as given on 2/1/25-2/10/25 A review of R119's progress note revealed the following dietician notes: 1/27/25 Resident readmitted to facility, TF (tube feeding) orders adjusted with plans plans to get resident back to TF orders that (they) were on prior to going out to facility. WIll continue to monitor resident's tolerance of titrating up to goal of 88ml/hr (mililiters per hour) x 12 hrs (hours) with autoflush of 80ml/hr x 12 hrs. Current orders are Nutren 2.0 @65ml/hr x16 hrs with autoflush of 60ml/hr (hang 4pm to 8 am). Resident is noted to have significant weight gain upon returning to facility. Resident did recieve IV (intravenous) fluids in hospital which could have contributed to weight gain. Full nutritional assessment in progress. 1/28/25 Increase feedings to 75ml/hr X 14 hrs providing 1050ml, 2100Kcal, 88gm protein, 726ml free water with autoflush of 70ml/hr x14 hr providing 960ml additional fluids plus 20-30ml with medications, and 150ml q (every) shift-100% needs met via PEG (percutaneous endoscopic gastrostomy). WIll continue to monitor tolerance of new orders. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1/29/25 .Resident is NPO (nothing by mouth) diet order and enteral feedings. ENN (enteral nutrition) is 1900-2100 for wt (weight) gain. Residents goal for enteral feeding is Nutren 2.0 88ml/hr x 12 hrs providing 1056ml, 2112kcal (kilocalories), 88gm (gram) protein, and 739ml fluids with autoflush of 80ml/hr x 12 hrs with 150ml flush q (every) shift and additional fluids of 20-30ml with medications . On 2/12/25 at 9:52 AM, Licensed Practical Nurse (LPN B) confirmed R119 has been getting Jevity 1.5 tube feeding from 5 pm to 5 am daily. After reviewing R119's orders, LPN B confirmed R119 should have been receiving Nutren instead of Jevity and explained both tube feeding orders were active but the order for Nutren was placed by the dietician and was more recent than the order for Jevity. On 2/12/25 at 10:23 AM, The Registered Dietician (RD) explained they write the orders for tube feeding and the formula and rate is calculated based on the individual resident's nutritional needs and R119 was receiving Nutren 2.0 at 88ml/hr for 12 hours to provide their nutritional needs. After reviewing R119's record the RD confirmed there was also an order for Jevity 1.5 that had been entered by a nurse. The RD explained nurses do not typically enter tube feeding orders. After reviewing R119's February 2025 MAR the RD confirmed both Nutren and Jevity were marked as given on 2/1/25-2/10/25. On 2/12/25 at 10:42 AM the Director of Nursing (DON) explained there should only be one order for tube feeding entered by the dietician and that order should be followed. A review of the facility's policy titled Tube Feeding-Formula Administration, Flushing, and Unclogging revealed: Verify physicians order. Prior to administration.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 32220 Based on observation, interview, and record review, the facility failed to ensure the medication error rate was less than five percent resulting in two medications errors in 32 opportunities for a 6.25% medication error rate. Findings include: On 02/11/25 at 9:03 AM, a medication pass observation was conducted with Registered Nurse (RN) F for R108. The Lanthanum Carbonate, 1000 mg (milligram) supplement was not available to be given. RN F attempted to pull two calcium carbonate 500 mg tablets and was then asked to review the order. The Lanthanum carbonate was not given. A review of the January 2025 and February 2025 Medication administration record and electronic medical record medication progress notes documented the medication was not given and or not available. The February 2025 MAR documented the medication had been given 19 times. A pharmacy receipt request for the Lanthanum Carbonate was requested and a response via email dated 03/12/25 at 2:14 PM by the Director of Nursing revealed, Discussed again with dialysis regarding this medication - Order was active, but labs drawn on 1/31 at facility indicated normal phosphorus levels and 2/4 labs drawn in dialysis indicated level was low so they continued to monitor and nephrology requested no phosphorous binders so it was not delivered by them. They rounded at facility and indicated medication order should be discontinued and that (R108) should not have received the medication since (their) return from the hospital. On 02/12/25 at 8:22 AM, RN H was observed to prepare medications for R60. RN H dispensed a Sennasides 8.6 mg pill from the over the counter stock instead of the ordered Sennasides with Docusate Sodium 8.6 mg/50 mg pill. On 02/12/25 at 9:52 AM, Licensed Practical Nurse (LPN) I was observed to prepare medications for R40. LPN I dispensed two Sennasides 8.6 mg pills from the over the counter stock instead of the ordered Sennasides with Docusate Sodium 8.6 mg/50 mg pills. On 02/12/25 at 11:14 AM, the medication concerns were reviewed with the Director of Nursing who reported they would check into the concerns. A review of the facility policy titled, Medication Administration issued 08/07/23 revealed, .Medications are administered in accordance with the following rights of medication administration: Right resident, Right medication, Right dose, Right route, Right time and frequency .Read transcribed physician order on the MAR: resident name, medical?on name, dosage, route, and interval ordered . A review of the facility policy titled, Medication Error issued 08/23/23 revealed, .A medication error is defined as the preparation or administration of drugs or biological which is not in accordance with physician's orders, manufacturer specifications, or accepted professional standards and (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	principles of the professional(s) providing services. Examples of medications errors include: Omission - a drug is ordered but not administered. Unauthorized drug - a drug is administered without a physician ' s order. Wrong dose (e.g., Dilantin 12 mL ordered, Dilantin 2 mL given). Wrong route of administration (e.g., ear drops given in eye). Wrong dosage form (e.g., liquid ordered, capsule given). Wrong drug (e.g., vibramycin ordered, vancomycin given) .

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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. 32220 Based on observation, interview, and record review, the facility failed to ensure medications were dated when opened in two of five medications carts and two of two medication rooms reviewed. Findings include: On 02/12/25 at 8:43 AM, the Spring unit front cart was reviewed with Regeistered Nurse (RN) H revealed an Arnuity inhaler was not labeled with a resident identifier and not dated when opened on the inhaler nor the box. On 02/12/25 at 9:01 AM, the Spring unit back cart was reviewed with Licensed Practical Nurse (LPN) J a lispro insulin was not dated when opened and was without a resident identifier. On 02/12/25 at 11:12 AM, the Winter medication storage room was reviewed with LPN K, one tuberculin derivative vial was not dated when opened on the vial nor the box. On 02/12/25 at 11:51 AM, the Summer medication storage room was reviewed with LPN J, one tuberculin derivative vial was not dated when opened on the vial. On 02/12/25 at 11:14 AM, the Director of Nursing (DON) reported the tuberculin vials should be dated when opened. A review of the manufacturer's insert for the tuberculin vial revealed, .Vials in use more than 30 days should be discarded due to possible oxidation and degradation which may affect potency . A review of the prescribing information for the Arnuity Inhaler revealed, Arnuity Ellipta should be stored inside the unopened moisture-protective foil tray and only removed from the tray immediately before initial use. Discard Arnuity Ellipta 6 weeks after opening the foil tray or when the counter reads 0 (after all blisters have been used), whichever comes first .

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 22960 Based on observation, interview, and record review, the facility failed to ensure pureed food items were of the proper consistency. This deficient practice had the potential to affect all 9 residents receiving a pureed diet texture. Findings include: 02/10/25 at 12:15 PM, the lunch tray-line service was observed in the main kitchen. A pan of pureed carrots was observed on the steam table. The mixture was observed with visible small chunks of orange carrot bits, mixed in with a pale orange viscous substance. On 02/10/25 at 12:25 PM, a puree test tray was obtained. A taste test of the pureed carrots revealed small chunks of carrots, that required chewing before swallowing. On 02/10/25 at 12:30 PM, Dietician M and Chef L were shown the pureed carrots and asked if the texture looked acceptable for a pureed diet. Both stated the pureed vegetable was not the proper consistency, and that the vegetable would be pulled from the steam table and re-made. According to an IDDSI (International Dysphagia Diet Standardization Initiative) chart posted in the facility kitchen, for a pureed diet, the appearance should be smooth, and the texture should be like pudding with no lumps.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49102 Based on observation, interview, and record review, the facility failed to maintain infection control practices by removing used urinals from overbed tables for three residents (R26, R122, 135) out of three residents reviewed for infection control practices. Findings Include: R26 On 02/10/25 at 9:15 AM, R26 was observed laying in bed watching television and a urinal half filled with yellowish urine sitting on over bed table. The resident was preparing for breakfast. A review of R26's medical record revealed R26 was admitted on [DATE] with diagnoses of atheroscloratic heart disease, muscle weakness, and atrial fibrillation. A review of R26's Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview of Mental status (BIMS) assessment of 15/15 indicating resident is cognitively intact. R22 On 02/10/25 at 9:20 AM, R122 was observed laying in bed watching television with a urinal noted quarter filled with yellowish urine sitting on the over bed table. R122 had recently had breakfast and tray was being being picked up by staff. A review of R122's medical record revealed R122 was admitted on [DATE] with diagnoses of cervical disc disorder and anemia. A review of R122's Minimum Data Set (MDS) assessment dated on 12/26/2024 revealed a Brief Interview of Mental Status (BIMS) assessment of 10/15 which indicated resident had moderate cognitive impairment. R135 On 02/10/25 at 9:30 AM, R135 was observed sitting up halfway in bed in their room. R135 was noted with a urinal filled with yellowish urine sitting on the over bed table. A review of R135's medical record revealed R135 was admitted on [DATE] with the diagnoses of fracture of lower end of right ulna, disorder of the muscle, and osteoarthritis. A review of R135's Minimum Data Set (MDS) assessment dated on 1/08/25 revealed a Brief Interview of Mental Status (BIMS) assessment of 9/15 indicating moderare cognitive impairment. On 2/12/25 at 10:15 AM, an interview was held with the Infection Control Nurse A. Nurse A asked about residents' urinals on over bed table. Nurse A confirmed urinals should not be stored on overbed tables. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility policy titled, Infection Control - Standard and Transmission-Based Precautions revealed the following: To provide guidelines for standard and transmission-based precautions to control the spread of infection to residents, visitors, and employees .Standard precautons are designed to reduce the risk of transmittng microorganisms from both recognized and unrecognized sources of infection in healthcare settings. Standard precautions are designed to protect both employees and residents from contact with infectious agents. Standard precautions relate to: Blood, Bodily fluids, secretions, and excretions, Non-intact skin, Mucous membranes. Standard precautions include: Hand hygiene (handwashing with soap and water or use of an alcohol-based sanitizer), and Personal protective equipment (PPE) when exposure to blood, body fluids, excretions, and secretions.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32220 Based on observation, interview, and record review, the facility failed to ensure call lights were in reach for two (R42, R24) of two dependent residents. Findings include: R42 On 02/12/25 at 9:13 AM, R42 was observed to be in a recliner at the nurse's station outside the door to the dining room. At 10:19 AM, R42 was observed to have been returned to bed and changed into a hospital style gown. The call light was tucked under the left edge of pillow for their head. R42 was asked if they could reach the call light. R42 attempted to reach the light with their right hand but was not able to reach the call light. R42 was not able to move their left arm to reach the light. R42 reported it had been affected by a stroke. A review of the record for R42 revealed R42 was admitted into the facility on [DATE]. Diagnoses included Stroke and Heart Disease. The care plan initiated 06/18/20 documented an alteration in mobility related to limited range of motion to the left shoulder. The care plan did not provide an intervention for call light placement. The care plan initiated 12/11/19 documented a self care deficit and the need for feeding assistance with meals, and bed mobility required a two person assist. 50223 R24 On 2/10/25 at 9:29 AM, R24 was observed lying in bed with the call light hanging on the wall behind the bed, out of the residents reach. At 12:10 PM, 1:48 PM, and 3:16 PM, R24 was observed in bed with the call light hanging on the wall behind the bed out of reach. When asked if they could reach their call light R24 responded no. When asked what they would do if they needed help, R24 responded I don't know. On 2/11 at 9:27 AM, and 12:31 PM, R24 was observed in bed with the call light hanging on the wall behind the bed out of reach. A review of R24s record revealed they were admitted to the facility on [DATE] with a diagnosis of Unspecified Dementia. Further review of R24s record revealed a Brief Interview for Mental Status (BIMS) score of one, indicating severe cognitive impairment. On 2/12/25 at 10:01 AM, Licensed Practical Nurse (LPN) E confirmed every resident should have call light within reach. On 2/12/25 at 10:42 AM, the Director of Nursing (DON) explained call lights should always be in reach. (continued on next page)

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	02/12/2025

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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy titled: Call Light Accessibility and Timely Response revealed the following: . Staff will ensure the call light is plugged in, functioning, within reach of residents, and secured, as needed. The call system will be accessible to residents while in their room at bedside as well as in the bathroom and shower room.