STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	824350	A. BUILDING _____ B. WING _____	**10/9/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUR SEASONS NURSING CENTER OF WESTLAND	**8365 NEWBURGH RD WESTLAND, MI 48185**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000 SS=	INITIAL COMMENTS Four Seasons Nursing Center Of Westland was surveyed for an Abbreviated survey on 10/09/23. Intakes: MI00138663, MI00138953, MI00139624, MI00139930, and MI00139950. Census= 161.	F0000		
F0689 SS= G	Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to provide activities of daily living care in a safe manner, for one resident (R701), resulting in a fall from bed with injury of a fractured vertebrae. Findings include: This citation pertains to Intake MI00139950. A review of the Intake noted, "Allegations: Details: It was alleged the resident fell off the bed while receiving care and sustained a fractured vertebrae." On 10/9/23 at 2:45 PM, R701 was observed at the nurses station, sitting in a wheelchair, with a neck brace on. A review of R701's progress notes revealed, "9/17/2023 21:08 Nursing - Progress Note Text:	F0689	Element 1 Resident #701 continues to reside in the facility. Resident sustained cervical spine fracture as a result of the identified deficient practice. Resident returned to facility 3 days after being at hospital. Resident was placed in a c-collar and was ordered to wear it until he has followed up with Neurosurgery, with no surgical intervention completed during hospitalization. Resident 701 has been seen and examined by the Physician Team on a weekly basis. The nursing assistant assigned to resident #701 was provided immediate return demonstration training at the time of the notification. Element 2 All residents who currently reside in the facility who require physical assistance with bed mobility have the potential to be impacted by the identified event. Like residents were evaluated and none were noted with injuries related related to unsafe provision of ADL care. Element 3 All certified nurse assistants will recieve education on proper and safe techniques when providing bed mobility assistance to prevent injury during ADL care.	10/19/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/19/2023

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.

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	resident fall out of bed when CNA (certified nursing assistant) was changing [R701] onto floor, small skin tear on head, vital signs stable called DON (Director of Nursing), applied ice pack to head." On 10/09/23 at 1:22 PM, the Unit Manager was asked if R701 pushed away from the care provider during care, and explained, "yes" CNA "A" did turn away from R701. The Unit Manager further explained that CNA "A" only work on weekends. On 10/09/23 at 1:55 PM, CNA "A" was called via phone and asked about the incident regarding R701. CNA "A" stated, I was changing [R701], I turned away to go and get the towels from behind me. I think [R701] may have reached for something. I tried to catch [R701] but I couldn't." CNA "A" was asked if this was their first time taking care of R701 and stated, "No." CNA "A" explained that R701 reaching for items and falling was a new behavior that R701 had started doing. A review of R701 x-ray results dated 9/17/23 noted, Bilateral C1(cervical spine) posterior arch fractures. A review of R701 Incident and accident report noted, 9/17/23. Incident Description: CNA (CNA "A") was in room changing resident and when she went to bathroom resident (R701) fell out of bed onto floor, small skin tear on forehead, called dr. (Doctor) and wants [R701] sent to hosp (hospital) for ct of head. Immediate Action Taken: vitals signs stable, will send to hsp (hospital), gave Tylenol for pain. Met with IDT (intradiciplinary team), discussed incident. Resident fell from bed. Intervention: Inservice/educate CNA. Taught about resident confused and needs more		Element 4 As part of the Quality Assurance process, the DON or designee will conduct audits 3x per week for 4 weeks to ensure CNAs know to provide proper and safe techniques while providing bd mobility assistance. The clinical team will take immediate corrective action if an inappropriate and unsafe technique is observed. The audit findings will be submitted to the Qaulity Assurance Committee for review and recommendation for ongoing moniotring if indicated. The Director of Nursing is responsible for compliance	

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	supervision. Witness statement: [CNA "A"] Date 9/22/23. Statement: I had turned my back to get a towel, the resident stated to fall from bed, I tried to catch [R701] to prevent from falling but was unable to reach [R701] in time. I called for the nurse." A review of CNA "A's" in-service noted, "Individual in-service form- Staff member [CNA "A"]. Education Topic: Proper lifting and moving technique to prevent injury/to pull a patient in the right position. Details: Safety ... Roll patient towards you during care, do not leave unattended. Signed: [CNA "A"]. Date: 9/22/23." R701 was admitted to facility on 2/8/22 and readmitted 9/20/23. On 10/09/23 at 2:27 PM, the DON was asked the facility's expectation for safety during care. The DON explained, that an Aide not walk away from the bed and leave resident unattended.			