STATEMENT O	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	PLE CON	ISTRUCTION		ATE SURVEY LETED
		824350				12/7/2	023
	VIDER OR SUPPLIE	ER ENTER OF WESTLAND			STREET ADDRESS, CITY, STATE 8365 NEWBURGH RD WESTLAND, MI 48185	, ZIP CO	DE
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	ATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	/IDER'S PLAN OF CORRECTION ( RECTIVE ACTION SHOULD BE CF FERENCED TO THE APPROPRIA DEFICIENCY)	OSS-	(X5) COMPLETION DATE
E0000 SS=	Preparedness S Michigan Depart Regulatory Affai Certification. At t Nursing Center ( substantial comp for participation	2023, an Emergency urvey was conducted by the ment of Licensing and rs, Bureau of Survey and the survey, Four Seasons Of Westland was found not in pliance with the requirements in Medicare/Medicaid at 42 hergency Preparedness.	E0000				
E0039 SS= F	§418.113(d)(2), (2), §482.15(d)(2) §483.475(d)(2), (2), §485.542(d) §485.727(d)(2), (2), §494.62(d)(2) CORFs at §485. "Organizations" §485.920, RHCs ESRD Facilities [facility] must col- emergency plan do all of the follo scale exercise if every 2 years; or based exercise if facility-based fur years; or (B) If th actual natural or requires activation the [facility] is ex- next required co facility-based fur the onset of the additional exerci- opposite the year exercise under p	uirements §416.54(d)(2), §441.184(d)(2), §460.84(d) 2), §483.73(d)(2), §484.102(d)(2), §485.68(d) (2), §485.625(d)(2), §485.920(d)(2), §491.12(d) 2). *[For ASCs at §416.54, 68, REHs at §485.542, OPO, under §485.727, CMHCs at s/FQHCs at §491.12, and at §494.62]: (2) Testing. The nduct exercises to test the annually. The [facility] must wing: (i) Participate in a full- nat is community-based r (A) When a community- s not accessible, conduct a not exercise every 2 he [facility] experiences an man-made emergency that on of the emergency plan, sempt from engaging in its mmunity-based or individual, nctional exercise following actual event. (ii) Conduct an se at least every 2 years, in the full-scale or functional baragraph (d)(2)(i) of this cted, that may include, but is	E0039	place o docume On 12/2 top exe Elemer The Ad require Emerge Elemer The Ma require Require submitt Perform further complia Elemer The Ma continu respons complia	quired EP testing Requirement of In 6/1/23 related to Active Shoot ents were not given at time of si 27/23 facility will complete EP T process on Active Shooter. In #2 ministrator and Maintenance Di een educated on EP testing ments for E039 and facility polic ency Preparedness. It #3 aintenance Director will audit mod d drills to ensure yearly EP Tes- ement is met. Deficiencies will be tately corrected. Findings will be red to the facility Quality Assuran nance Committee for review and recommendation until substantiance ance is achieved and maintainent ti #4 aintenance Director is responsible ed monitoring. The Administrator sible for continued regulatory	er, urvey. able rector by for onthly e nce d al d. le for	1/12/2024
LABORATORY	DIRECTOR'S OR P	ROVIDER/SUPPLIER REPRESENT,	ATIVE'S SIGNA	TURE	TITLE	(X6) DA	TE
Electronical	y Signed					12/21	/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.

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING		ISTRUCTION		ATE SURVEY PLETED	
		824350	B. WING			12/7/2	2023	
AME OF PRO	VIDER OR SUPPLIE	R			STREET ADDRESS, CITY, ST	ATE, ZIP CC	DE	
OUR SEAS	ONS NURSING CI	ENTER OF WESTLAND			8365 NEWBURGH RD WESTLAND, MI 48185			
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	L /IDER'S PLAN OF CORRECTIO RECTIVE ACTION SHOULD BE FERENCED TO THE APPROPI DEFICIENCY)	CROSS-	(X5) COMPLETIC DATE	
	scale exercise the individual, facility or (B) A mock dia exercise or work facilitator and indi- using a narrated emergency scent statements, direct questions design emergency plan, response to and all drills, tabletop events, and revise plan, as needed. 418.113(d):] (2) provide care in the hospice must do in a full-scale exer based every 2 ye community base conduct an indiv exercise every 2 experiences a na emergency plan, engaging in its n community-base facility-based fur the onset of the Conduct an addi years, opposite to functional exerci of this section is include, but is no A second full-sca community-base functional exerci drill; or (C) A tab	following: (A) A second full- lat is community-based or -based functional exercise; saster drill; or (C) A tabletop shop that is led by a cludes a group discussion , clinically-relevant ario, and a set of problem cted messages, or prepared led to challenge an (iii) Analyze the [facility's] maintain documentation of exercises, and emergency se the [facility's] emergency *[For Hospices at Testing for hospices that he patient's home. The nduct exercises to test the at least annually. The the following: (i) Participate ercise that is community ears; or (A) When a d exercise is not accessible, idual facility based functional years; or (B) If the hospice atural or man-made requires activation of the the hospital is exempt from ext required full scale d exercise or individual notional exercise following emergency event. (ii) tional exercise following emergency event. (ii) tional exercise that is d or a facility based se; or (B) A mock disaster letop exercise or workshop acilitator and includes a						

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	relevant emerge problem stateme prepared questic emergency plan. provide inpatient must conduct ex emergency plan must do the follo annual full-scale based; or (A) Wh exercise is not a annual individual exercise; or (B) I natural or man-m requires activatic the hospice is ex next required full facility-based fur the onset of the o Conduct an addi may include, but following: (A) A s that is communit functional exerci- drill; or (C) A tab led by a facilitato discussion using relevant emerge problem stateme prepared questic emergency plan. response to and all drills, tabletop events and revis plan, as needed. §441.184(d), Ho at §485.625(d):] Hospital, CAH] m test the emerger [PRTF, Hospital,	a using a narrated, clinically- ncy scenario, and a set of ints, directed messages, or ons designed to challenge an (3) Testing for hospices that care directly. The hospice ercises to test the twice per year. The hospice wing: (i) Participate in an exercise that is community- nen a community-based ccessible, conduct an of facility-based functional f the hospice experiences a hade emergency that on of the emergency plan, tempt from engaging in its -scale community based or notional exercise following emergency event. (ii) tional annual exercise that is not limited to the second full-scale exercise y-based or a facility based se; or (B) A mock disaster letop exercises or workshop or that includes a group a narrated, clinically- ncy scenario, and a set of onts, directed messages, or ons designed to challenge an (iii) Analyze the hospice's maintain documentation of exercises, and emergency te the hospice's emergency te the hospice's emergency to rest at §482.15(d), CAHs (2) Testing. The [PRTF, nust conduct exercises to icy plan twice per year. The CAH] must do the following: an annual full-scale exercise						

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	community-base conduct an annu functional exerci Hospital, CAHJ e or man-made em activation of the is exempt from ef full-scale commu- facility-based fur the onset of the Conduct an [add and that may inc following: (A) A s that is communit facility-based fur mock disaster dr or workshop that includes a group narrated, clinical scenario, and a s directed messag designed to chal (iii) Analyze the [ maintain docume exercises, and e the [facility's] em [For PACE at §4 PACE organizati to test the emerge The PACE organ following: (i) Pari scale exercise th (A) When a com accessible, cond facility-based fur PACE experiend made emergency p from engaging ir community base	y-based; or (A) When a d exercise is not accessible, al individual, facility-based se; or (B) If the [PRTF, xperiences an actual natural hergency that requires emergency plan, the [facility] ngaging in its next required unity based or individual, actional exercise following emergency event. (ii) itional] annual exercise or lude, but is not limited to the second full-scale exercise y-based or individual, a actional exercise; or (B) A ill; or (C) A tabletop exercise is led by a facilitator and discussion, using a ly-relevant emergency set of problem statements, es, or prepared questions lenge an emergency plan. facility's] response to and entation of all drills, tabletop mergency events and revise ergency plan, as needed. * 60.84(d):] (2) Testing. The on must conduct exercises jency plan at least annually. hization must do the ticipate in an annual full- tat is community-based; or munity-based exercise is not luct an annual individual, netional exercise; or (B) If the es an actual natural or man- y that requires activation of alan, the PACE is exempt in its next required full-scale d or individual, facility-based se following the onset of the						

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OUR SEAS	ONS NURSING C	ENTER OF WESTLAND			8365 NEWBURGH RD WESTLAND, MI 48185		
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	exercise every 2 full-scale or func paragraph (d)(2) conducted that in to the following: exercise that is of individual, a facil exercise; or (B) / tabletop exercise facilitator and industry using a narrated emergency scent statements, direct questions design emergency plan, response to and all drills, tabletop events and revis plan, as needed. §483.73(d):] (2) conduct exercise at least twice per unannounced st emergency proc ICF/IID] must do in an annual full- community-base conduct a nanuf functional exerci facility experience made emergency per exempt from eng scale community based functional of the emergence additional annual but is not limited second full-scale	aff drills using the edures. The [LTC facility, the following: (i) Participate scale exercise that is					

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IAME OF PRC	VIDER OR SUPPLIE	R			STREET ADDRESS, CITY, STA	ATE, ZIP CC	DE	
OUR SEAS	ONS NURSING CI	ENTER OF WESTLAND			8365 NEWBURGH RD WESTLAND, MI 48185			
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	drill; or (C) A tab that is led by a fa discussion, using relevant emerge problem stateme prepared questic emergency plan. facility] facility's n documentation of exercises, and e the [LTC facility] needed. *[For IC Testing. The ICF/III Participate in an that is community- base conduct an annu functional exerci- experiences an a emergency plan, engaging in its n community-base functional exerci- emergency ven annual exercise th individual, facility or (B) A mock dis exercise or work facilitator and ind using a narrated emergency scen statements, direc questions design emergency plan, response to and	se; or (B) A mock disaster letop exercise or workshop acilitator includes a group g a narrated, clinically- ncy scenario, and a set of ints, directed messages, or ons designed to challenge an (iii) Analyze the [LTC response to and maintain f all drills, tabletop mergency events, and revise facility's emergency plan, as F/IDs at §483.475(d)]: (2) f/ID must conduct exercises gency plan at least twice per D must do the following: (i) annual full-scale exercise y-based; or (A) When a d exercise is not accessible, al individual, facility-based se; or. (B) If the ICF/IID actual natural or man-made requires activation of the the ICF/IID is exempt from ext required full-scale d or individual, facility-based se following the onset of the t. (ii) Conduct an additional that may include, but is not owing: (A) A second full- iat is community-based or an <i>r</i> -based functional exercise; saster drill; or (C) A tabletop shop that is led by a cludes a group discussion, dincically-relevant ario, and a set of problem cted messages, or prepared hed to challenge an (iii) Analyze the ICF/IID's maintain documentation of exercises, and emergency						

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	plan, as needed. (2) Testing. The exercises to test annually. The HH Participate in a fi community-base comduct an annu functional exerci- the HHA experie man-made emer activation of the exempt from eng full-scale commu- facility based fun the onset of the of Conduct an addi years, opposite t functional exerci- of this section is include, but is no A second full-sca community-base based functional disaster drill; or ( workshop that is includes a group narrated, clinical scenario, and a s directed messag designed to chal (iii) Analyze the I maintain docume exercises, and e the HHA's emerg OPOs at §486.31 must conduct ex emergency plan. following: (i) Cont tabletop exercise	se the ICF/IID's emergency *[For HHAs at §484.102] (d) HHA must conduct the emergency plan at least HA must do the following: (i) ull-scale exercise that is d; or (A) When a d exercise is not accessible, al individual, facility-based se every 2 years; or. (B) If nces an actual natural or gency that requires emergency plan, the HHA is jaging in its next required unity-based or individual, notional exercise following emergency event. (ii) tional exercise every 2 he year the full-scale or se under paragraph (d)(2)(i) conducted, that may ot limited to the following: (A) ale exercise that is d or an individual, facility- exercise; or (B) A mock C) A tabletop exercise or led by a facilitator and discussion, using a ly-relevant emergency set of problem statements, es, or prepared questions lenge an emergency plan. HA's response to and entation of all drills, tabletop mergency events, and revise gency plan, as needed. *[For 60] (d)(2) Testing. The OPO ercises to test the The OPO must do the duct a paper-based, e or workshop at least top exercise is led by a						

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		824350	B. WING _	B. WING			2023	
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	using a narrated emergency scen statements, dire- questions desigr emergency plan actual natural or requires activatio the OPO is exen required testing of the emergence OPO's response documentation c emergency ever and OPO's] eme RNCHIs at §403 RNHCI must cor emergency plan following: (i) Cor tabletop exercise tabletop exercise top talla tabletop exercise tabletop exercise tabletop exercise tabletop exercise tabletop exercise tabletop exercise tabletop exercise tabletop exercise top tabletop exercise top tabletop exercise top tabletop exercise tabletop exercise tabletop exercise tabletop exercise tabletop exercise tabletop exercise tabletop exercise tabletop exercise tabletop exercise top tabletop exercise tabletop exercise top tabletop exercise tabletop exercise top tabletop exercise tabletop exercise top tabletop exercise tabletop exercise tabl	cludes a group discussion, , clinically relevant ario, and a set of problem cted messages, or prepared hed to challenge an . If the OPO experiences an man-made emergency that on of the emergency plan, not from engaging in its next exercise following the onset y event. (ii) Analyze the to and maintain of all tabletop exercises, and ths, and revise the [RNHCI's ergency plan, as needed. *[ .748]: (d)(2) Testing. The nduct exercises to test the . The RNHCI must do the nduct a paper-based, e at least annually. A e is a group discussion led sing a narrated, clinically- ncy scenario, and a set of ents, directed messages, or ons designed to challenge an . (ii) Analyze the RNHCI's maintain documentation of cises, and emergency se the RNHCI's emergency MENT is not met as eview and interview, the facility exercises to test the emergency ully, including unannounced ne emergency procedures. The cipate in a full-scale exercise -based or when a community- not accessible, an individual, he facility based experiences an						

AND PLAN OF	STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/SUPPLIER/SUPPLIER         AND PLAN OF CORRECTION       (X1) PROVIDER SUPPLIER         NAME OF PROVIDER OR SUPPLIER       824350         FOUR SEASONS NURSING CENTER OF WESTLAND		A. BUILDING	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING STREET ADDRESS, CITY, ST 8365 NEWBURGH RD WESTLAND, MI 48185		ATE SURVEY LETED 2023 DE
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULAT	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING IFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF CORRECTIVE ACTION SHOL REFERENCED TO THE AF DEFICIENCY	JLD BE CROSS- PROPRIATE	(X5) COMPLETION DATE
	requires activation facility is exempt f based or individua exercise for 1 year actual event. The f additional exercise limited to a second community-based tabletop exercise th led by a facilitator, relevant emergenc statements, directe questions designed plan. The facility r and maintain docu exercises, and eme facility's emergenc deficient practice of residents in the evo community-wide i Findings Include: On December 7, 2 revealed the facility documentation the exercise for calend documentation wa time of surveyor e:	023 at 2:10 PM, record review y failed to provide their required table-top lar year 2023. No supporting s presented to surveyor by the xit. re confirmed interview with the ce Assistance and Director at				

Facility ID: 824350

If continuation sheet Page 9 of 36

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CON		3) DATE SURVEY OMPLETED	
		824350	B. WING	B. WING		_ 12/7/2023	
NAME OF PRO	VIDER OR SUPPLIE	R			STREET ADDRESS, CITY, STATE, ZIP	CODE	
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K0000	INITIAL COMME	ENTS	K0000				
	Michigan Depart Regulatory Affai Certification. At 1 Nursing Center of substantial comp for participation CFR 482.90(a), applicable provis the National Fire 101, Life Safety of NFPA 99, Hea The facility is a 1 (222) construction is fully sprinklered smoke detection open to the corri The facility has 1	urvey was conducted by the ment of Licensing and rs, Bureau of Survey and the survey, Four Seasons of Westland was found not in pliance with the requirements in Medicare/Medicaid at 42 Life Safety from Fire and the sions of the 2012 Edition of Protection Agency (NFPA) Code and the 2012 Edition alth Care Facilities Code.					
K0211 SS= E	<ul> <li>General Aisles exit discharges, are in accordance means of egress free of all obstrue emergency, unle through 18/19.2. This REQUIREN evidenced by:</li> <li>Based on observat failed to ensure ai- exit discharges, ex</li> </ul>	s - General Means of Egress , passageways, corridors, exit locations, and accesses e with Chapter 7, and the is continuously maintained ctions to full use in case of ess modified by 18/19.2.2 11. 18.2.1, 19.2.1, 7.1.10.1 IENT is not met as tion and interview, the facility sles, passageways, corridors, it locations and accesses are in Chapter 7, and continuously	K0211	repaired padlock by Autu exit doo reasona single o allow dd Elemen The ma on K 21 Directo means	mmer wing exit door has been d to open with reasonable force. The was removed from the patio exit ga mn wing. The Physical Therapy Roo or has been repaired to open with able force. The Autumn wing day roo loor top hinge has been corrected to bor to close to a tight smoke tight fit. t #2 intenance staff have been educated 1 requirements. The Maintenance r has conducted rounds to ensure th of egress is continuously free of all tion to full use in case of an	ate om om o	

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	<ul> <li>case of an emerge 7.1.10.1. This defit the 151 residents if</li> <li>Findings Include:</li> <li>1) On December 7 AM observation re Summer wing did as required by NF 7.2.1.4.5.1.</li> <li>2) On December 7 PM observation re Autumn Wing had was padlocked. TI result in residents</li> <li>3) On December 7 PM observation re Room exit door to reasonable amoun 101 2012 edition,</li> <li>4) On December 7 PM observation re Dayroom single d the front side of th could potentially r a smoke-tight fit.</li> <li>These findings we</li> </ul>	<ul> <li>all obstructions to full use in ncy as required by 19.2.1 and icient practice could affect 30 of n the event of a fire.</li> <li>7, 2023, at approximately 11:40 evealed the exit door for the not open with reasonable force PA 101 2012 edition,</li> <li>7, 2023, at approximately 1:06 evealed the patio gate exit by the l a posted exit sign and the gate nis deficient practice could unable to exit in an emergency.</li> <li>7, 2023, at approximately 12:47 evealed the Physical Therapy of the outside did not open with a t of force as required by NFPA 7.2.1.4.5.</li> <li>7, 2023, at approximately 1:16 evealed the Autumn Wing oor top hinge was installed on the door. This deficient practice result in the door not closing to the confirmed by the ctor at the time of observation</li> </ul>		audit M means obstruc emerge correcte facility C Commit recomm is achie Elemen The Ma continue	intenance Director or designe eans of Egress daily to ensur of egress is continuously free tion to full use in case of an ncy. Deficiencies will be imme ad. Findings will be submitted Quality Assurance Performan- tee for review and further nendation until substantial cor ved and maintained. t #4 intenance Director is responsed monitoring. The Administra- sible for continued regulatory	e the of all ediately to the ce npliance ible for	
K0222 SS= E	required means equipped with a the use of a tool	gress Doors Doors in a of egress shall not be latch or a lock that requires or key from the egress side e of the following special	K0222	stating opened	t #1 age was placed on the Autum Pull until alarm sounds door c in 15 seconds audible alarm by the gate has	an be	1/12/2024

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FOUR SEAS	ONS NURSING C	ENTER OF WESTLAND			8365 NEWBURGH RD WESTLAND, MI 48185			
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	TEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	LIDER'S PLAN OF CORRECTIO RECTIVE ACTION SHOULD BE FERENCED TO THE APPROPI DEFICIENCY)	CROSS-	(X5) COMPLETIO DATE	
	SECURITY THR special locking a security needs o one locking devi each door and p the rapid remova control of locks; carried by staff a reliable means a times. 18.2.2.2.5 19.2.2.6 SPEC ARRANGEMEN arrangements fo patient are used Locking requirer addition, the lock that fail safely so power to the dev by a supervised and the locked ss complete smoke constantly monit within the locked sprinkler and det to unlock the doo 18.2.2.2.5.2, 19. DELAYED-EGR ARRANGEMEN egress locking s accordance with on door assemb hazard contents throughout by ar automatic fire de approved, super system. 18.2.2.2 CONTROLLED ARRANGEMEN Egress Door ass accordance with	nents: CLINICAL NEEDS OR EAT LOCKING Where rrangements for the clinical f the patient are used, only ce shall be permitted on rovisions shall be made for al of occupants by: remote keying of all locks or keys it all times; or other such vailable to the staff at all 5.1, 18.2.2.2.6, 19.2.2.2.5.1, CIAL NEEDS LOCKING TS Where special locking r the safety needs of the all of the Clinical or Security nents are being met. In the safety needs of the automatic sprinkler system pace is protected by a detection system (or is ored at an attended location I space); and both the tection systems are arranged ors upon activation. 2.2.2.5.2, TIA 12-4 ESS LOCKING TS Approved, listed delayed- ystems installed in 7.2.1.6.1 shall be permitted lies serving low and ordinary in buildings protected a tatomatic sprinkler 4.4, 19.2.2.2.4 ACCESS- EGRESS LOCKING TS Access-Controlled teembles installed in 7.2.1.6.2 shall be permitted. 2.2.2.4 ELEVATOR LOBBY		Elemen All resic potentia Mainter to ensu and tho Elemen The ma K 222 r Directo to ensu alarms volume correcte to the fa Commi recommi is achie Elemen The Ma continu	dents residing in the facility h al to be affected by citied pra- hance Director has complete- re egress doors have proper use with audible alarms have at #3 intenance staff has been edi- equirements. The Maintenar r or designee will conduct da re proper signage is posted, with audible sound have pro- . Deficiencies will be immedi- ed. Findings will be submitted acility Quality Assurance Per tee for review and further nendation until substantial co- eved and maintained. ti #4 intenance Director is respon ed monitoring. The Administi sible for continued regulatory	ctice. The d rounds signage sound. ucated on ice ily audits and those per ately d monthly formance ompliance sible for rator is		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	(X2) MULTIPLE CONSTRUCTION A. BUILDING			ATE SURVEY PLETED
		824350	B. WING				2023
NAME OF PRC	VIDER OR SUPPLIE	R			STREET ADDRESS, CITY, STATE	E, ZIP CC	DE
FOUR SEAS	FOUR SEASONS NURSING CENTER OF WESTLAND				8365 NEWBURGH RD WESTLAND, MI 48185		
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULAT	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECTION ( RECTIVE ACTION SHOULD BE CF FERENCED TO THE APPROPRIA DEFICIENCY)	ROSS-	(X5) COMPLETION DATE
	Elevator lobby ex accordance with on door assembli throughout by an automatic fire de approved, super system. 18.2.2.2 This REQUIREM evidenced by: Based on observat failed to ensure do egress are not equi requires the use of side unless meetin arrangements for c with 19.2.2.5.1 a locking arrangement 19.2.2.2.5.2, delay accordance with 1° egress doors in acc elevator lobby exit 19.2.2.2.4. This de of the 151 resident Findings Include: 1) On December 7 AM observation re needs wing 15 sec not have approved ALARM SOUND IN 15 SECONDS' by NFPA 101 201 2) On December 7 PM observation re patio area has dela "PUSH UNTIL AN	OCKING ARRANGEMENTS kit access door locking in 7.2.1.6.3 shall be permitted ies in buildings protected approved, supervised tection system and an vised automatic sprinkler .4, 19.2.2.2.4 IENT is not met as ion and interview, the facility ors in a required means of pped with a latch or lock that a tool or key from the egress g the special locking dinical needs in accordance and 19.2.2.2.6, special needs ents in accordance with ed egress locking in 9.2.2.2.4, access-controlled cordance with 19.2.2.2.4, or t access in accordance with ficient practice could affect 30 is in the event of a fire.					

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 824350	Á. BUILDI	TIPLE CONSTRUCTION NG	_ COMP	ATE SURVEY LETED <b>023</b>
FOUR SEAS		ER ENTER OF WESTLAND	ID	STREET ADDRESS, CITY 8365 NEWBURGH RD WESTLAND, MI 48185 PROVIDER'S PLAN OF CORRE	5	DE (X5)
PRÉFIX TAG	audible alarm by t was tested.	NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION) he gate sounded when the gate ere confirmed by the ctor at the time of observation	PREFIX TAG	CORRECTIVE ACTION SHOUL REFERENCED TO THE APP DEFICIENCY)		COMPLETIOI DATE
K0223 SS= E	Self-Closing Dev passageway, sta horizontal exit, s area enclosure a the closed positi release device c automatically clo throughout the s facility upon acti- fire alarm system detectors design through the oper detection system system, if install 18.2.2.2.7, 18.2. This REQUIREN evidenced by: Based on observat failed to ensure do stairway enclosure or hazardous area closed position un with 7.2.1.8.2, as 19.2.2.2.8. This de of the 151 residen Findings Include:	Closing Devices Doors with vices Doors in an exit airway enclosure, or moke barrier, or hazardous are self-closing and kept in on, unless held open by a omplying with 7.2.1.8.2 that bees all such doors moke compartment or entire vation of: * Required manual n; and * Local smoke ted to detect smoke passing hing or a required smoke n; and * Automatic sprinkler ed; and * Locas of power. 2.2.8, 19.2.2.2.7, 19.2.2.2.8 MENT is not met as tion and interview, the facility bors in an exit passageway, e, horizontal exit, smoke barrier are self-closing and kept in the less held open in accordance required by 19.2.2.2.7 and efficient practice could affect 12 ts in the event of a fire.	K0223	Element #1 The door to the Central Supply closed and the wedge was rem Element #2 Facility staff has been educated all doors are kept in closed pos propped open. Element #3 The Maintenance Director or de audit doors daily to ensure Doo Closing Devices are in closed p propped open. Deficiencies will immediately corrected. Findings submitted to the facility Quality Performance Committee for rew further recommendation until su compliance is achieved and ma Element #4 The Maintenance Director is rei continued monitoring. The Adm responsible for continued regula compliance.	oved. d to ensure that ition and not esignee will rs with Self- position and not be s will be Assurance view and ubstantial aintained. sponsible for ninistrator is	1/12/2024

STATEMENT OF AND PLAN OF C		(X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER: 824350	A	X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DA COMP 12/7/2	
NAME OF PROVIDER OR SUPPLIER						STREET ADDRESS, CITY, STATE,	ZIP CO	DE
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)		1	ID PREFIX TAG	COR	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS- REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	door to be self-clos 2010 edition, 6.1.4 These findings wer	ent practice does not allow the sing as required by NFPA 80 .2. re confirmed by the tor at the time of observation						

STATEMENT OF	DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	TIPLE CONST	TRUCTION	(X3) DATE SURVEY COMPLETED		
		824350	B. WING			12/7/2	2023	
FOUR SEASC		ENTER OF WESTLAND		8 V	STREET ADDRESS, CITY, STATE, 2 3365 NEWBURGH RD NESTLAND, MI 48185			
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	CORRE	DER'S PLAN OF CORRECTION (EA ECTIVE ACTION SHOULD BE CRO ERENCED TO THE APPROPRIATE DEFICIENCY)	SS-	(X5) COMPLETION DATE	
K0291 SS= E	Emergency lighti duration is provid accordance with This REQUIREM evidenced by: Based on observat failed to ensure au 1-1/2 hour duratio with 7.9, as requir practice could affe event of an emerge Findings Include: 1) On December 7 AM observation re the Front Office w NFPA 101 2012 e emergency lightin 2) On December 7 AM observation re the kitchen above not illuminated wi Edition, 7.9.2.6 re- maintained.	ting Emergency Lighting ng of at least 1-1/2-hour led automatically in 7.9. 18.2.9.1, 19.2.9.1 IENT is not met as ion and interview, the facility tomatic emergency lighting of n is provided in accordance ed by 19.2.9.1. This deficient ct 12 of the 151 residents in the ency. , 2023, approximately 10:35 evealed the emergency light for as not illuminated when tested. dition, 7.9.2.6 requires g to be maintained. , 2023, approximately 11:15 evealed the emergency light in Dry Storage the right bulb was ten tested. NFPA 101 20112 quires emergency lighting to be re confirmed by the ctor at the time of observation	K0291	been repa the emerge been rep Element a Maintena on all em- illuminate Element a The Main audit Eme Emergen Deficienc Findings Quality A for review substantia maintaine Element a The Main continued	rgency light for the front office h aired to illuminate. The right bul gency light above Dry Storage h laced. #2 ance Director has conducted aud ergency lights to ensure they a #3 ntenance staff has been educate ents of K 291 Emergency Lighti ntenance Director or designee w ergency lights monthly to ensure lights are illuminating proper ices will be immediately correcte will be submitted to the facility surance Performance Commit w and further recommendation u ial compliance is achieved and ed. #4 ntenance Director is responsible d monitoring. The Administrator ble for continued regulatory	lb on has dits ed on ng. /ill e ly. ed. tee until	1/12/2024	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	À. ÉUILDI	TIPLE CONSTRUCTION	_ COMP	ATE SURVEY
		824350	B. WING		12/7/2	2023
IAME OF PRO	VIDER OR SUPPLIE	R		STREET ADDRESS, CITY	, STATE, ZIP CO	DE
OUR SEAS	ONS NURSING CI	ENTER OF WESTLAND		8365 NEWBURGH RD WESTLAND, MI 48185		
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHOULD REFERENCED TO THE APPF DEFICIENCY)	D BE CROSS-	(X5) COMPLETIO DATE
K0293 SS= E	Exit and direction accordance with illumination also lighting system. one-story existin 30 occupants wh obvious.) This REQUIREM evidenced by: Based on observat failed to ensure ex displayed in accor illuminated and se system as required practice could affe event of a fire. Findings Include: On December 7, 2 observation reveal maintenance room illuminated. NFPA requires continuou	t Signage 2012 EXISTING hal signs are displayed in 7.10 with continuous served by the emergency 19.2.10.1 (Indicate N/A in g occupancies with less than here the line of exit travel is IENT is not met as ion and interview, the facility it and directional signs are dance with 7.10, continuously rved by the emergency lighting 1 by 19.2.10.1. This deficient for 10 of the 151 residents in the 023, at approximately 1:35 PM ed the exit sign by the had bulbs that were not A 101 2012 edition, 7.10.5.2.1 is illumination for lighted signs. re confirmed by the ctor at the time of observation	K0293	Element #1 The exit sign bulbs were replace Maintenance Room Door. Element #2 Maintenance Director has condu on all exit signs to ensure they i Element #3 The maintenance staff has beer requirements of K 293. The Mai Director or designee will audit E weekly to ensure Exit Signs are properly Deficiencies will be ir corrected. Findings will be subm facility Quality Assurance Perfoo Committee for review and further recommendation until substantia is achieved and maintained. Element #4 The Maintenance Director is res continued monitoring. The Adm responsible for continued regula compliance.	ucted audits Iluminate. n educated on ntenance xit Signs illuminating nmediately nitted to the mance al compliance eponsible for nistrator is	1/12/2024
K0321 SS= E	Areas - Enclosur protected by a fin resistance rating doors) or an auto system in accord When the approv extinguishing sys	s - Enclosure Hazardous re Hazardous areas are re barrier having 1-hour fire (with 3/4 hour fire rated omatic fire extinguishing lance with 8.7.1 or 19.3.5.9. ved automatic fire stem option is used, the eparated from other spaces	K0321	Element #1 The lint screens on the 3 comm have been cleaned. Mop heads placed in the dryers. Element #2 Laundry and Housekeeping wer the process of cleaning the lint s the dryers and not putting mop l dryers.	are no longer re educated on screens are	1/12/2024

STATEMENT OF AND PLAN OF CO		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 824350	Á. BUILDII	NG		ĊOM	DATE SURVEY PLETED 2023
		024330	5. mile			_ 12/7/2023	
NAME OF PROVI	DER OR SUPPLIE	ĒR			STREET ADDRESS, CITY, S	TATE, ZIP CO	DDE
FOUR SEASON	NS NURSING C	ENTER OF WESTLAND			8365 NEWBURGH RD WESTLAND, MI 48185		
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	ATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECTI RECTIVE ACTION SHOULD B FERENCED TO THE APPROF DEFICIENCY)	E CROSS-	(X5) COMPLETION DATE
	accordance with closing or autom have nonrated o plates that do no bottom of the do zone locations o deficient in REM Area Automatic Boiler and Fuel- Laundries (large Repair, Mainten Soiled Linen Rote e. Trash Collecti gallons) f. Comb Rooms/Spaces ( Laboratories (if of see K322) This REQUIREN evidenced by: Based on observat failed to provide F fire barrier having (with 3/4 hour fire fire extinguishing shall be separated resisting partitions 8.4. Doors shall be closing and permi applied protective inches from the bo practice could affe fire. Findings Include: 1) On December 7	ng partitions and doors in 8.4. Doors shall be self- iatic-closing and permitted to r field-applied protective et exceed 48 inches from the or. Describe the floor and f hazardous areas that are ARKS. 19.3.2.1, 19.3.5.9 Sprinkler Separation N/A a. Fired Heater Rooms b. r than 100 square feet) c. ance, and Paint Shops d. oms (exceeding 64 gallons) on Rooms (exceeding 64 ustible Storage (over 50 square feet) g. classified as Severe Hazard - MENT is not met as tion and interview, the facility fazardous areas protected by a 1-hour fire resistance rating rated doors) or an automatic system in accordance with When the approved automatic system option is used, the areas from other spaces by smoke a and doors in accordance with e self-closing or automatic- tted to have nonrated or field- plates that do not exceed 48 ottom of the door. This deficient ect 6 occupants in the event of a		housek require Directo daily to and mo Deficiel Finding Quality for revie substar maintai Elemen The Ma continu	aintenance staff and laundry eeping staff has been educ ments of K 321. The House r or designee will audit lint s ensure lint screens are free p heads are not placed in or ncies will be immediately co s will be submitted to the fa Assurance Performance Co ew and further recommenda tital compliance is achieved ned. at #4 aintenance Director is respo ed monitoring. The Adminis	ated on keeping screens e from lint dryers. prrected. ucility ommittee ation until d and nsible for strator is	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 824350	Á. BUILDI	NG	ISTRUCTION	COMP	(X3) DATE SURVEY COMPLETED 12/7/2023	
IAME OF PRO	OVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, 2				ZIP CODE	
OUR SEAS	ONS NURSING C	ENTER OF WESTLAND			8365 NEWBURGH RD WESTLAND, MI 48185			
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	TEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE C FERENCED TO THE APPROPRI DEFICIENCY)	ROSS-	(X5) COMPLETIO DATE	
K0324 SS= F	screens. This coul the combustible li 2) On December 7 PM interview reverses mop heads are driving the potentially result in the potentially result in These findings were Maintenance Dire and interview. Cooking Facilities equipment is protection Operations, unle equipment (i.e., microwaves, hot for food warming accordance with cooking facilities smoke compart patients comply 18.3.2.5.3, 19.3. in smoke compart patients comply 18.3.2.5.4, 19.3. protected accord are not required hazardous areas	dry Room had uncleaned lint d potentially cause a fire with nt and heat from the dryers. 7, 2023, at approximately 12:25 ealed, when asked how washed ed a laundry staff replied, "put ads exposed to heat could n a dryer fire. re confirmed by the ctor at the time of observation s Cooking Facilities Cooking tected in accordance with ard for Ventilation Control on of Commercial Cooking small appliances such as plates, toasters) are used g or limited cooking in 18.3.2.5.2, 19.3.2.5.2 * open to the corridor in nents with 30 or fewer with the conditions under 2.5.3, or * cooking facilities rtments with 30 or fewer with conditions under 2.5.4. Cooking facilities fing to NFPA 96 per 9.2.3 to be enclosed as s, but shall not be open to the 5.1 through 18.3.2.5.4,	K0324	Hood Ir The sto minute right on has betwee Elemer The ma Activity require Elemer The Ma audit m "Owner audit w above s Activity	has obtained the "Owners Mc has obtained the "Owners Mc hspection" documentation for 2 ove in the Activities room has h timer device installed. The bar of the kitchen hood above the s en repaired to ensure no space on the baffle plates. In t#2 aintenance staff, Dietary Mana Director have been educated ments of K 324 Cooking Facili	2023. had a 60- ifle to the teamer es are ger, and on ties. e will tion on nd will en hood on the to	1/12/2024	
	This REQUIREN	gh 19.3.2.5.5, 9.2.3, TIA 12-2 IENT is not met as ion, record review and		Finding Quality for revio substar maintai Elemer		ty mittee on until nd		

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CON	STRUCTION		(X3) DATE SURVEY COMPLETED	
		824350	B. WING				12/7/2023	
AME OF PRO	VIDER OR SUPPLIE	R			STREET ADDRESS, CITY, ST		DDE	
OUR SEASONS NURSING CENTER OF WESTLAND					8365 NEWBURGH RD WESTLAND, MI 48185			
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	TEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECTIO RECTIVE ACTION SHOULD BE FERENCED TO THE APPROP DEFICIENCY)	CROSS-	(X5) COMPLETIO DATE	
	<ul> <li>facilities are prote 96, unless meeting 19.3.2.5.3 or 19.3.</li> <li>through 19.3.2.5.5</li> <li>deficient practice - residents in the ev</li> <li>Findings Include:</li> <li>1) On December 7</li> <li>review revealed the evidence of the ree</li> <li>Inspection" for the suppression syster</li> <li>supporting docum</li> <li>surveyor by the tin</li> <li>These findings wee facility Maintenant</li> <li>the time of record</li> <li>Findings Include:</li> <li>2) On December 7</li> <li>PM, observation r</li> <li>provide the stove required lock-out</li> <li>required lock-out</li> <li>required by NFPA</li> <li>(9).</li> <li>3) On December 7</li> <li>AM, observation for on the kitchen hood a space in between</li> <li>deficient practice - build-up in the kit</li> </ul>	7, 2023 at 12:40 PM, record the facility failed to provide quired "Owners Monthly Hood cir installed range hood in for calendar year 2023. No entation was presented to ne of surveyor exit. re confirmed interview with the ce Assistance and Director at			ed monitoring. The Administ sible for continued regulatory ance.			

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(3) DATE SURVEY OMPLETED	
		824350	B. WING		1:	2/7/2023	
OUR SEASO		ENTER OF WESTLAND	STREET ADDRESS, CITY, S 8365 NEWBURGH RD WESTLAND, MI 48185			FATE, ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	ITEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	CORF	IDER'S PLAN OF CORRECTION (EAC RECTIVE ACTION SHOULD BE CROSS FERENCED TO THE APPROPRIATE DEFICIENCY)		
K0331 SS= E	and Ceiling Finis wall and ceiling f interior surfaces movable walls, p a flame spread r The reduction in sprinkler system permitted. 10.2, flame spread rat This REQUIREM evidenced by: Based on observat failed to ensure in have a flame sprea permitted to be rea by 19.3.3.1 and 19 could affect 12 oc Findings Include: On December 7, 2 observation reveal Conference Room approved flame sp required by NFPA documentation wa	Ceiling Finish Interior Wall th 2012 EXISTING Interior inishes, including exposed of buildings such as fixed or varitions, columns, and have ating of Class A or Class B. class of interior finish for a as prescribed in 10.2.8.1 is 19.3.3.1, 19.3.3.2 Indicate ing(s). IENT is not met as ion and interview, the facility terior wall and ceiling finishes drating of Class A or B, unless tuced by 10.2.8.1, as required 0.3.3.2. This deficient practice cupants in the event of a fire. 023, at approximately 2:45 PM ed wood paneling in the . The facility did not present read rating documentation as 101 2012 edition, 10.2.8.1. No is available by survey exit. re confirmed by the ctor at the time of observation	K0331	installed approve is not av Control a Flame Retarda are a Cl and smo Elemen Mainten remaind no othei Mainten K331. Elemen The Mai conduct Flame C followed Fire Ret Deficien Findings Quality for revie substan maintain Elemen The Mai	It has identified that paneling was d in approximately the 1970 s, the ed flame spread rating documentati vailable. The facility will apply a Fla Class A Varnish Basecoat followed e control Class A Varnish Fire int Topcoat, base coat and top coar ass A with a flame spread rating of oked developed 160-240. t #2 nance Director has audited the ler of the building to ensure there a r paneled areas within the facility. T nance Director has been educated of t #3 intenance Director or designee will monthly audit of paneling to ensur Control Class A Varnish Basecoat d by a Flame Control Class A Varni tardant Topcoat does not wear off. Incies will be immediately corrected. Is will be submitted to the facility Assurance Performance Committee w and further recommendation unt tial compliance is achieved and ned. t #4 intenance Director is responsible for ed monitoring. The Administrator is ible for continued regulatory	on me d by t f 20 are Fhe on re sh e til	

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 824350	À. ÉUILDI	NG	STRUCTION	(X3) DATE SURVEY COMPLETED <b>12/7/2023</b>	
	DVIDER OR SUPPLIE	ENTER OF WESTLAND			STREET ADDRESS, CITY, STAT 8365 NEWBURGH RD WESTLAND, MI 48185	E, ZIP CO	DE
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	ATEMENT OF DEFICIENCIES ACY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	CORF	IDER'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE C FERENCED TO THE APPROPRI DEFICIENCY)	ROSS-	(X5) COMPLETIO DATE
K0345 SS= F	and Maintenance tested and maint approved progra requirements of Code, and NFPA Signaling Code. acceptance, mai readily available NFPA 72 This REQUIREM evidenced by: Based on observat failed to ensure th and maintained in program complyin and records are rea 19.6.1.3, 9.6.1.5, N deficient practice of the event of a fire. Findings Include: On December 7, 2 PM observation re have the date of m format visible on t required by NFPA date installed 3/8/2 two batteries.	e Alarm System - Testing e A fire alarm system is tained in accordance with an m complying with the NFPA 70, National Electric A 72, National Fire Alarm and Records of system ntenance and testing are . 9.6.1.3, 9.6.1.5, NFPA 70, MENT is not met as ion and interview, the facility e fire alarm system was tested accordance with an approved g with NFPA 70 and NFPA 72, adily available as required by NFPA 70 and NFPA 72. This could affect all 151 residents in	K0345	citied pr batteries month/y Elemen The Fire policy h appropr educate Elemen The Ma audit mo month/y Deficier Findings Quality for revie substan maintain Elemen The Ma continue	ility has had Eagle Security co actice and the fire panel alarn s now have the manufacture rear date on them. t #2 e Alarm Testing and maintena as been reviewed and deeme iate. Maintenance staff have b ed on the requirements of K 34 t #3 intenance Director or designer onthly for required manufactur rear on Fire Alarm Panel batte icies will be immediately corre s will be submitted to the facili Assurance Performance Com ew and further recommendation tial compliance is achieved ar ned. t #4 intenance Director is responsi- ied monitoring. The Administra- ible for continued regulatory	nce d been -5. e will e ries. cted. ty mittee n until id ble for	1/12/2024
K0351 SS= E	System - Installa	n - Installation Spinkler tion 2012 EXISTING and hospitals where	K0351		t #1 Ility has had Dynamic Fire Pro ne door closer to ensure it is m		1/12/2024

STATEMENT OF AND PLAN OF (	DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 824350	À. BUILDIN	IG	STRUCTION		ATE SURVEY LETED 2023
	/IDER OR SUPPLIE	ENTER OF WESTLAND			STREET ADDRESS, CITY, S 8365 NEWBURGH RD WESTLAND, MI 48185	TATE, ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	ATEMENT OF DEFICIENCIES ACY MUST BE PRECEDED BY FORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	CORF	IDER'S PLAN OF CORRECT RECTIVE ACTION SHOULD E FERENCED TO THE APPRO DEFICIENCY)	BE CROSS-	(X5) COMPLETION DATE
	throughout by ar sprinkler system 13, Standard for Systems. In Typ alternative prote- permitted to be s protection in spe local regulations hospitals, sprink clothes closets of where the area of 6 square feet an the closet footpri Standard for Insi Systems. 19.3.5 19.3.5.4, 19.3.5. 9.7.1.1(1) This REQUIREM evidenced by: Based on observat failed to ensure ho construction type a approved automat accordance with N 19.3.5.1 through 1 and 9.7.1.1(1). Th 12 of the 151 resid Findings Include: 1) On December 7 AM observation re 18 inches from the and above the Spr door. NFPA 25 20 clearance to be ma installation standa	Attruction type, are protected approved automatic in accordance with NFPA the Installation of Sprinkler e I and II construction, ction measures are substituted for sprinkler cific areas where state or prohibit sprinklers. In lers are not required in of patient sleeping rooms of the closet does not exceed d sprinkler coverage covers int as required by NFPA 13, tallation of Sprinkler .1, 19.3.5.2, 19.3.5.3, 5, 19.4.2, 19.3.5.10, 9.7, MENT is not met as ion and interview, the facility ospitals where required by are protected throughout by an ic sprinkler system in MFPA 13, as required by 9.3.5.5, 19.4.2, 19.3.5.10, 9.7 is deficient practice could affect lents in the event of a fire.		the Spri grill has area. Elemen Mainten on all de Elemen The ma requirer Mainten monthly allowed head ar patio. D correcte facility C Commit recommis achie Elemen The Ma continue	ance Director has conductor for closers. t #3 intenance staff has been entenance of K 351 requirements ance Director or designee that no door closers are with clearance from the pende d that no gas grill is store eficiencies will be immedia ad. Findings will be submit Quality Assurance Perform tee for review and further nendation until substantial wed and maintained. t #4 intenance Director is respired monitoring. The Admini- ible for continued regulator	m. The gas overed patio ted audits educated on nts. The will audit within the ent sprinkler d on the ately ted to the nance compliance onsible for istrator is	

AND PLAN OF	STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLI/         AND PLAN OF CORRECTION       (X1) PROVIDER/SUPPLIER/CLI/         B24350       824350         NAME OF PROVIDER OR SUPPLIER       FOUR SEASONS NURSING CENTER OF WESTLAND		À. BUILDIN	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING STREET ADDRESS, CITY, STATE, 8365 NEWBURGH RD WESTLAND, MI 48185			ATE SURVEY LETED 023 DE
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULAT	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	L IDER'S PLAN OF CORRECTION (E. RECTIVE ACTION SHOULD BE CRO FERENCED TO THE APPROPRIATI DEFICIENCY)	DSS-	(X5) COMPLETION DATE
1/0050	grill under a non-s roof on the patio. T potentially result in source operated un These findings we Maintenance Direc and interview.	vealed a propane gas fueled prinklered combustible wooden This deficient practice could n a fire event due to a fire ider a combustible structure. re confirmed by the ctor at the time of observation					
K0353 SS= F	Sprinkler System Automatic sprink are inspected, te accordance with Inspection, Testii Water-based Fire Records of syste inspection and te secure location a sprinkler system system test system supply so REMARKS inforr non-required or p system. 9.7.5, 9. This REQUIREM evidenced by: Based on observat failed to ensure the standpipe systems maintained in accor records are readily 9.7.7, 9.7.8 and NI	b) Who provided c) Water	K0353	wall per The esc head in the recorrepaired cable w the cloc replace Office a been la Adminis now be stored I head. Elemen Mainter on close walls. Elemen The ma front off requirer Mainter monthly maintai immedii submitte	S inch ceiling drywall and 6x6 dry netration areas have been repair cutcheon cover for the ceiling spr room 205-2 has been replaced a essed sprinkler head has been d by Dynamic Fire Protection. Th ire penetrating the ceiling tile abo k in the Activity Room has been d. The sprinkler drains in the Die and Autumn Wing Janitor closet h beled. The items in the closet in strator office and Front Office hav en removed to ensure there is no ess than 18 inches from the sprin t #2 nance Director has conducted au ets, sprinkler drains, ceiling tiles,	ed. inkler and eove tician have the ze bithing hkler dits and e udit e udit	1/12/2024

AND PLAN OF	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER: 824350 NAME OF PROVIDER OR SUPPLIER			PLE CONSTRUCTION G STREET ADDRESS, CITY, S	со́мр _ <b>12/7/2</b>		
				8365 NEWBURGH RD WESTLAND, MI 48185	STATE, ZIF CO	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULAT	TEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY ORY OR LSC IDENTIFYING IFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT CORRECTIVE ACTION SHOULD REFERENCED TO THE APPRO DEFICIENCY)	BE CROSS-	(X5) COMPLETION DATE	
	AM observation re drywall penetration and a 6x6 inch dry above the door. Th potentially allow h protection of the do of the sprinkler sys 2) On December 7 PM observation re the ceiling sprinkle 2 in Room 205. Th an unprotected are 3) On December 7 PM observation re head was recessed This deficient prace spray pattern of the 4) On December 7 AM observation re maintain the ceilin Activities Room. A the ceiling tile. 5) On December 7 AM observation re sprinkler drain was edition, 13.3.2.2 (6 valves are identifie 6) On December 7 PM observation re janitor room sprint NFPA 25 2011 edi inspections to verifisions.	, 2023, at approximately 12:25 vealed the escutcheon cover for rr head was missing above Bed is deficient practice resulted in a around the sprinkler head. , 2023, at approximately 12:37 vealed the ceiling sprinkler above Bed 2 in Room 205. tice could potentially affect the e sprinkler head. , 2023, at approximately 11:55 vealed the facility failed to g tile above the clock in the A cable wire was penetrating , 2023, at approximately 11:27 vealed the Dietician Office is not labeled. NFPA 25 2011 b) requires inspections to verify		Element #4 The Maintenance Director is resp continued monitoring. The Admin responsible for continued regulate compliance.	istrator is		

STATEMENT OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER:	A	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		824350		B. WING			12/7/2023	
NAME OF PROV	/IDER OR SUPPLIE	R				STREET ADDRESS, CITY, STATE,	ZIP CO	DE
FOUR SEASC	ENTER 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	COR	IDER'S PLAN OF CORRECTION (E. RECTIVE ACTION SHOULD BE CRO FERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE	
	storage closet has s inches from the spi practice could obst sprinkler head. 8) On December 7. AM observation re closet has shelf sto the sprinkler head. obstruct the spray p These findings wer	vealed the Administrator shelf storage less than 18 rinkler head. This deficient ruct the spray pattern of the , 2023, at approximately 10:32 vealed the Front Office storage rage less than 18 inches from This deficient practice could pattern of the sprinkler head. re confirmed by the tor at the time of observation						

	TEMENT OF DEFICIENCIES PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLI/ IDENTIFICATION NUMBER: 824350		Á. BUILDI	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED 12/7/2023			
	ovider or supplie	ENTER OF WESTLAND		STREET ADDRESS, CITY, STATE, ZIP CODE 8365 NEWBURGH RD WESTLAND, MI 48185				
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SHOUL REFERENCED TO THE APP DEFICIENCY)	D BE CROSS-	(X5) COMPLETION DATE		
K0374 SS= E	Barrie Subdivisic Smoke Barrier D in smoke barrier bonded wood-co that resists fire for protective plates permitted. Doors fire window asse self-closing or au require latching, swing in the dire opening provides 32 inches for sw 19.3.7.6, 19.3.7. This REQUIREM evidenced by: Based on observat failed to ensure do inch solid bonded construction that r self-closing or au minimum width or 19.3.7.6, 18.3.7.8 practice could affe event of a fire. Findings Include: On December 7, 2 AM observation re for the Spring win fit. The coordinato the astragal to close	MENT is not met as ion and interview, the facility yors in smoke barriers are 1-3/4 wood-core doors or esists fire for 20 minutes, are omatic-closing and provide a f 32 inches as required by and 19.3.7.9. This deficient ect 25 of the 151 residents in the 023, at approximately 10:45 evealed the cross-corridor doors g did not close to a smoke tight or does not allow the door with	K0374	Element #1 The cross-corridor on Spring U repaired to ensure the door clo tight fit. Element #2 Maintenance Director has conc on all doors to ensure a smoke Element #3 The maintenance staff has bee requirements of K 374. The Ma Director or designee will audit to cross-corridor doors to ensure Doors have a smoke tight fit. D be immediately corrected. Find submitted to the facility Quality Performance Committee for ree further recommendation until si compliance is achieved and ma Element #4 The Maintenance Director is re continued monitoring. The Adm responsible for continued regul compliance.	ses to a smoke lucted audits tight fit. n educated on intenance veekly of Smoke Barrie eficiencies will ings will be Assurance view and ubstantial aintained. sponsible for ninistrator is	1/12/2024		

STATEMENT O AND PLAN OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 824350	À. BUILDI	TIPLE CONSTRUCTION	_ COMP	ATE SURVEY LETED
	VIDER OR SUPPLIE			STREET ADDRESS, CITY, 8365 NEWBURGH RD WESTLAND, MI 48185		
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	ATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHOULD REFERENCED TO THE APPR DEFICIENCY)	BE CROSS-	(X5) COMPLETIOI DATE
K0711 SS= F	and Relocation F for the protection evacuation in the Employees are p kept informed with plan, and a copy available with tel security. The pla response require and provides for components per 18.7.1.3, 18.7.2. 19.7.1.1 through 19.7.2.2, 19.7.2. This REQUIREN evidenced by: Based on observat failed to ensure th protection of all re in the event of an periodically instru plan, the plan is re basic response required the event of an em Findings Include: On December 7, 2 AM observation re map provided for emergency prepar the smoke barriers residents to an are of the smoke barriers	MENT is not met as tion and interview, the facility ere is a written plan for the esidents and for their evacuation emergency, employees are icted in their duties under the eadily available, addresses the puired by staff and provides all puired by 19.7.1.1 through 2, 19.7.2.2 and 19.7.2.3. This could affect all 151 residents in tergency. 2023, at approximately 10:30 evealed the evacuation plan survey and those in the edness books did not identify s. Staff cannot evacuate a of refuge without knowledge	K0711	Element #1 The evacuation floor plan maps updated to identify smoke barrie have been placed in the Emerge Preparedness books. Element #2 Facility staff has been educated evacuation floor plan maps and smoke barriers. Element #3 The maintenance staff has beer requirements of K 711. The Main Director or designee will audit m Emergency Preparedness books documentation. Deficiencies will immediately corrected. Findings submitted to the facility Quality / Performance Committee for revi further recommendation until su compliance is achieved and mai Element #4 The Maintenance Director is rest continued monitoring. The Admin responsible for continued regula compliance.	rrs. New maps ency on the facility identified educated on ntenance onthly s for proper be will be Assurance ew and bstantial ntained. ponsible for nistrator is	1/12/2024

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLI ID PLAN OF CORRECTION IDENTIFICATION NUMBER: 824350		Á. BUILDI				ATE SURVEY LETED
NAME OF PROVIDER OR SUPPLIER         FOUR SEASONS NURSING CENTER OF WESTLAND         (X4) ID       SUMMARY STATEMENT OF DEFICIENCIES			ID	830 WE	STREET ADDRESS, CITY, STATE, ZIP CO 8365 NEWBURGH RD WESTLAND, MI 48185		
PREFIX TAG	(EACH DEFICIEN FULL REGULA <sup>-</sup> II	CY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	PREFIX TAG	CORREC	R'S PLAN OF CORRECTION TIVE ACTION SHOULD BE ( RENCED TO THE APPROPR DEFICIENCY)	ROSS-	(X5) COMPLETIOI DATE
K0712 SS= F	transmission of a simulation of em drills are held at times under vary quarterly on eac with procedures part of establishe conducted betwe coded announce of audible alarms This REQUIREM evidenced by: Based on record ra failed to ensure fin of a fire alarm sig emergency fire co times under varyir least quarterly on planning and cond competent persons leadership as requ 19.7.1.7. This defi 151 facility reside Findings Include: On December 7, 2 review revealed th required fire drills fire drills for the 1 2023, were held at The fire drills for the 1 Quarter of 2023, v PM, respectfully.	rills Fire drills include the a fire alarm signal and ergency fire conditions. Fire expected and unexpected ing conditions, at least h shift. The staff is familiar and is aware that drills are een 9:00 PM and 6:00 AM, a ment may be used instead s. 19.7.1.4 through 19.7.1.7 IENT is not met as eview and interview, the facility re drills include the transmission nal and simulation of nditions, are held at unexpected ag circumstances, conducted at each shift and responsibility for lucting drills is assigned only to s who are qualified to exercise ired by 19.7.1.4 through cient practice could affect all nts in the event of a fire. 023 at 10:41 AM, record the facility failed to conduct their at "unexpected time". The st Shift, 3rd and 4th Quarter of a 10:05 AM for both quarters. the 2nd Shift, 1st and 2nd vere held at 3:23 PM and 3:40 The fire drills for the 3rd Shift, er of 2023, were held at 5:06 , respectfully.	K0712	times unde conducted Element #2 The mainte requiremer at varied til Element #3 The Mainte audit monti circumstan immediatel submitted t Performano further reco compliance Element #4 The Mainte continued r	re drills will be held at une er varying circumstances, at least quarterly on each annot staff has been edunts for the fire drills to be comes and with varied circun annot Director or designe hly fire drill times and ces. Deficiencies will be y corrected. Findings will be to the facility Quality Assur ce Committee for review a commendation until substar e is achieved and maintain a senance Director is respons monitoring. The Administra e for continued regulatory	shift. cated on onducted nstances. ee will oe ance nd tital ed. ible for	1/12/2024

TATEMENT OF DEF ND PLAN OF CORR		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A (X2) MULTIPLE CONSTRUCTION A. BUILDING			X3) DATE SURVEY COMPLETED
		824350				2/7/2023
AME OF PROVIDER	OR SUPPLIE	R		ST	REET ADDRESS, CITY, STATE, ZI	IP CODE
OUR SEASONS N	IURSING CE	ENTER OF WESTLAND			65 NEWBURGH RD ESTLAND, MI 48185	
PRÉFIX (EA	CH DEFICIEN	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY 'ORY OR LSC IDENTIFYING IFORMATION)	ID PREFIX TAG	CORREC	ER'S PLAN OF CORRECTION (EAC CTIVE ACTION SHOULD BE CROS RENCED TO THE APPROPRIATE DEFICIENCY)	
facili		re confirmed interview with the ce Assistance at the time of				
SS= E Smo shall prov any flam oxyQ haza post shall for n occu and entra that (3) S resp requ whe (5) A safe whe cont into read is pe This evid Base faile adop	king regulati i include not isions: (1) Si room, ward, mable liquits en is used o ardous locati ed with signs l be posted v o smoking. ( ipancies whe signs are pro- bible shall irement of 12 re the patien design shall re smoking is ainers with s which ashtra ily available rmitted. 18.7 REQUIREV enced by: d on observat	tions Smoking Regulations ons shall be adopted and less than the following moking shall be prohibited in or compartment where s, combustible gases, or r stored and in any other on, and such area shall be s that read NO SMOKING or vith the international symbol 2) In health care ere smoking is prohibited ominently placed at all major idary signs with language oking shall not be required. vatients classified as not be prohibited. (4) The 8.7.4(3) shall not apply t is under direct supervision. oncombustible material and be provided in all areas s permitted. (6) Metal elf-closing cover devices ys can be emptied shall be to all areas where smoking 7.4, 19.7.4 IENT is not met as	K0741	fence for the have been Smoking in Element # Facility star may not si butts on the equipment Element # The Maintraudit group equipment Deficiencia Findings w Quality As for review substantia maintained Element # The Maintraudit Continued	the butts on the ground around the outdoor medical gas equipment of removed and more signs for Non Area have been put up on fen diff have been educated that they moke near or dispose of cigarett the ground near the medical gas t. 3 enance Director or designee will not around outdoor medical gas t for cigarette butts 3x's weekly. es will be immediately corrected vill be submitted to the facility surance Performance Committee and further recommendation un I compliance is achieved and d. 4 enance Director is responsible f monitoring. The Administrator is e for continued regulatory	ent o ce. y te l l. ee ttil

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/C AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 824350			À	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 12/7/2023	
	VIDER OR SUPPLIE					STREET ADDRESS, CITY, STATE	, ZIP CO	DE
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 REFIX TAG	COR	IDER'S PLAN OF CORRECTION (E RECTIVE ACTION SHOULD BE CR FERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
	PM observation re ground by the fence equipment that has deficient practice of These findings we	023, at approximately 12:15 vealed cigarette butts on the e for the outdoor medical gas posted no smoking signs. This could potentially ignite a fire. re confirmed by the ctor at the time of observation						

STATEMENT OF C	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 824350	À. BUILDI	TIPLE CONSTRUCTION	СО́МР	ATE SURVEY LETED 2023	
	/IDER OR SUPPLIE	ER ENTER OF WESTLAND		8365 NEWBURG	STREET ADDRESS, CITY, STATE, ZIP CO 8365 NEWBURGH RD WESTLAND, MI 48185		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIESIDPROVIDER'S PLAN OF CORRECTION (EACH(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)PREFIX TAGCORRECTIVE ACTION SHOULD BE CROSS- REFERENCED TO THE APPROPRIATE DEFICIENCY)			HOULD BE CROSS- E APPROPRIATE	(X5) COMPLETION DATE		
K0912 SS= D	Systems - Řecej have at least ond dependable grou maintaining low- mating plug. In p receptacles in pa play rooms, and nurseries, are lis employ a listed of room, ground-fai are listed. 6.3.2. 99) This REQUIREN evidenced by: Based on observat failed to ensure po the requirements of NFPA 99. This de occupant in the ev Findings Include: On December 7, 2 AM observation re have the Front Off GFCI outlet. Grou by NFPA 99-2012 (6) within 6 feet o practice creates ar location. These findings we	ns - Receptacles Electrical bracles Power receptacles e, separate, highly unding pole capable of contact resistance with its bediatric locations, attient rooms, bathrooms, activity rooms, other than ted tamper-resistant or cover. If used in patient care ult circuit interrupters (GFCI) 2.6.2 (F), 6.3.2.2.4.2 (NFPA MENT is not met as tion and interview, the facility ower receptacles comply with of 6.3.2.2.6.2(F) and 6.3.2.4.2 of ficient practice could affect 1 ent of an electrical shock.	K0912	Element #4 The Maintenance Directo continued monitoring. The A GFCI outlet has been in where Front Office water into. Element #2 Front office staff has been Ground Fault protection b 6 feet of water source. Element #3 The Maintenance Directo audit monthly to ensure G 6 feet of water source. De immediately corrected. Do immediately corrected. Do immediately corrected. Do immediately corrected. Fi submitted to the facility Q Performance Committee further recommendation of compliance is achieved a Administrator is responsit regulatory compliance.	e Element #1 hstalled to outlet cooler is plugged n educated on being required within r or designee will GFCI plugs are within eficiencies will be ndings will be ruality Assurance for review and until substantial nd maintained.	1/12/2024	
K0918 SS= F	Electrical System	ns - Essential Electric Syste ns - Essential Electric ance and Testing The	K0918	Element #1 The facility has installed a operated light in the Tran		1/12/2024	

STATEMENT OI AND PLAN OF (	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	à. Buildi	NG	STRUCTION	ĊOMP	ATE SURVEY LETED
		824350	B. WING			12/7/2	2023
NAME OF PROV	/IDER OR SUPPLIE	ER			STREET ADDRESS, CITY, ST	TATE, ZIP CO	DE
FOUR SEASC	ONS NURSING C	ENTER OF WESTLAND			8365 NEWBURGH RD WESTLAND, MI 48185		
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	ATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	CORR	IDER'S PLAN OF CORRECTION RECTIVE ACTION SHOULD B FERENCED TO THE APPROF DEFICIENCY)	E CROSS-	(X5) COMPLETIO DATE
	and associated e supplying service 10-second criter monthly test, a p annually confirm safety and critice and testing of th- switches are per NFPA 110. Gene weekly, exercise times a year in 2 exercised once e continuous hours conditions inclue start and automa EES loads, and personnel. Maint energy power se accordance with circuit breakers a a program for pe components is e manufacturer ret of maintenance a and readily avail and circuits are to and readily avail and circuits are to and separate fro Minimizing the p emergency power consideration foi 6.5.4, 6.6.4 (NFF 111, 700.10 (NF This REQUIREN evidenced by: Based on observat failed to ensure ge power sources and capable of supplyi	er alternate power source equipment is capable of e within 10 seconds. If the ion is not met during the process shall be provided to this capability for the life al branches. Maintenance e generator and transfer formed in accordance with erator sets are inspected d under load 30 minutes 12 0-40 day intervals, and every 36 months for 4 s. Scheduled test under load le a complete simulated cold atic or manual transfer of all are conducted by competent tenance and testing of stored purces (Type 3 EES) are in NFPA 111. Main and feeder are inspected annually, and priodically exercising the stablished according to quirements. Written records and testing are maintained able. EES electrical panels marked, readily identifiable, m normal power circuits. ossibility of damage of the er source is a design r new installations. 6.4.4, PA 99), NFPA 110, NFPA PA 70) MENT is not met as		requirem Element The Mai audit mo light in th operatio correcte facility C Committ recomm is achiev Element The Mai continue	ance staff was educated of hents of K 918. #3 ntenance Director or desig onthly to ensure the battery he Transfer Switch room is nal Deficiencies will be ir d. Findings will be submitte Quality Assurance Performa- tee for review and further endation until substantial c ved and maintained. #4 ntenance Director is respo ed monitoring. The Adminis ible for continued regulator	nee will -operated fully mmediately ed to the ance compliance nsible for strator is	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 824350	À. BUILDI	NG	Č	X3) DATE SURVEY COMPLETED 2/7/2023
	OVIDER OR SUPPLIE	R ENTER OF WESTLAND			STREET ADDRESS, CITY, STATE, ZI 8365 NEWBURGH RD WESTLAND, MI 48185	IP CODE
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULAT	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	/IDER'S PLAN OF CORRECTION (EAC RECTIVE ACTION SHOULD BE CROS FERENCED TO THE APPROPRIATE DEFICIENCY)	
K0923 SS= E	readily available a 6.6.4 of NFPA 99, 700.10 of NFPA 7 affect all 151 resid emergency. Findings Include: On December 7, 2 PM observation re have a battery-ope in the Transfer Sw These findings we Maintenance Direc and interview. Gas Equipment - Storag Gas Equi Container Storag 3,000 cubic feet designed, constr accordance with >300 but <3,000 are outdoors in a enclosed interior combustible cons outdoors) that ca gases are not sto are separated fro (5 feet if sprinkle of noncombustib minimum 1/2 hr. than or equal to 3 smoke compartm areas with an ag or equal to 300 c	FPA 110, and records are s required by 6.4.4, 6.5.4 and NFPA 110, NFPA 111 and 0. This deficient practice could ents in the event of an 023, at approximately 12:05 vealed the facility failed to rated emergency light installed itch Room. The confirmed by the ctor at the time of observation of the time of observation confirmed by the ctor at the time of observation of the time of observation confirmed by the ctor at the time of observation of the time of observation of the time of the time of observation of the time of the time preduct of the time of the time of the time of the time of time of the time of the time of time of the time of time time of time of the time of time time of time time of time time of time time of time of the time of time time of time time of time time of time time of time of time time of time time time time of time time time time of time time time time time time of time time time time time time time time	K0923	Room of (es) So concen Elemer Facility Oxyger oxygen The Ma Therap ensure Oxyger are not will be i submitt Perform further complia Elemer The Ma continu	sility has placed signage on the Ox- door that reads "Caution: Oxidizing red Within No Smoking". Oxygen trator were removed from the area at #2 staff was educated on having prop o Signage on door and not storing concentrators in Oxygen room. at #3 aintenance Director, Respiratory ist, or designee will audit weekly to the proper signage is on door of o room and that oxygen concentrat stored in Oxygen Room. Deficience immediately corrected. Findings wi ed to the facility Quality Assurance nance Committee for review and recommendation until substantial ance is achieved and maintained.	Gas

STATEMENT O AND PLAN OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLI/ IDENTIFICATION NUMBER:			ISTRUCTION	(X3) DA COMPI	ATE SURVEY LETED
		824350	B. WING			12/7/2023	
					STREET ADDRESS, CITY, STATE,		
NAME OF PRO	VIDER OR SUPPLIE	ĸ			STREET ADDRESS, CITY, STATE,	ZIP COI	DE
FOUR SEASC	ONS NURSING CE	ENTER OF WESTLAND			8365 NEWBURGH RD WESTLAND, MI 48185		
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULAT	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	/IDER'S PLAN OF CORRECTION (E RECTIVE ACTION SHOULD BE CR( FERENCED TO THE APPROPRIAT DEFICIENCY)	DSS-	(X5) COMPLETION DATE
	storage room, wh wording as a mir OXIDIZING GAS SMOKING." Stor are used in order from the supplier segregated from employs cylinder gauge, a thresho empty is establis marked to avoid in the open are p 11.3.1, 11.3.2, 1 99) This REQUIREN evidenced by: Based on observat failed to ensure stor meet all requireme and 11.6.5 of NFP could affect 20 of of a fire. Findings Include: 1) On December 7 PM observation re not have signage of CAUTION: OXID WITHIN NO SMO 99 2012 edition, 1 2) On December 7 PM observation re less than 5 feet fro Oxygen Room. NI least a 5-foot separ	oor or gate of a cylinder here the sign includes the himum "CAUTION: G(ES) STORED WITHIN NO rage is planned so cylinders r of which they are received . Empty cylinders are full cylinders. When facility is with integral pressure old pressure considered hed. Empty cylinders are confusion. Cylinders stored protected from weather. 1.3.3, 11.3.4, 11.6.5 (NFPA IENT is not met as ion and interview, the facility prage of nonflammable gasses ents of 11.3.1 through 11.3.4 A 99. This deficient practice the 151 residents in the event cylinder gasses on the door that reads" DZING GAS(ES) STORED DKING" as required by NFPA 1.3.4.2. (2023, at approximately 12:27 vealed 2 oxygen concentrators m the oxygen cylinders in the FPA 99 11.3.2.3(2) requires at ration of combustibles or used in the same area.		complia	ance.		

STATEMENT OF AND PLAN OF C	DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER:				STRUCTION	(X3) DA COMPI	ATE SURVEY LETED
		B. WING			12/7/2	023		
NAME OF PROVIDER OR SUPPLIER						STREET ADDRESS, CITY, STATE,	ZIP COI	DE
FOUR SEASONS NURSING CENTER OF WESTLAND						8365 NEWBURGH RD WESTLAND, MI 48185		
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULAT	TEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY 'ORY OR LSC IDENTIFYING IFORMATION)	PRE	ID EFIX AG	COR	IDER'S PLAN OF CORRECTION (E/ RECTIVE ACTION SHOULD BE CRO FERENCED TO THE APPROPRIATI DEFICIENCY)	SS-	(X5) COMPLETION DATE
		re confirmed by the ctor at the time of observation						