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	824350	A. BUILDING _____ B. WING _____	**1/10/2025**

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F0000 SS=	INITIAL COMMENTS Four Seasons Nursing Center of Westland was surveyed for an Abbreviated survey on 1/10/25. Intake: MI00149416 Census = 158	F0000		
F0684 SS= G	Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: This citation pertains to Intake Number MI00149416. Based on interview and record review, the facility failed to address a change in condition in a timely manner for one (R801) of two residents reviewed for changes in condition, resulting in the resident being transferred to the hospital where they were found to have a blood sugar of 1200 (normal range 60-120 mg/dl - milligrams per deciliter), fever, and difficulty breathing requiring mechanical ventilation. Findings include: A review of a complaint submitted to the State Agency (SA) revealed an allegation that R801's family member noticed R801 had	F0684		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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	"swelling in his arms, legs and belly" starting around 12/11/24. It was brought to the nurse's attention that R801 was "sleeping more and wouldn't wake up fully...was slow to wake and it was not normal..." It was documented R801's condition was more noticeable "a week prior to resident being sent out to hospital on 1/3/25". The complaint alleged that nobody did anything about R801's change in condition until 1/3/25 when a nurse called to notify the complainant that R801 was not breathing good, was given a breathing treatment, and was sent to the hospital an hour later. It was alleged when R801 got to the hospital, they had "sepsis, sugar level was 1200, oxygen level was very low, breathing was not good, eyes were rolling in the back of his head" and the resident vomited which went into his lungs. R801 required mechanical ventilation. On 1/10/25 at 12:24 AM, an interview was conducted with one of R801's family members (Family Member 'A') via the telephone. Family Member 'A' reported they visited R801 on 12/21/24, 12/23/24, 12/25/24, 12/26/24, 12/28/24, 12/30/24, and 1/1/25. On 1/1/25, Family Member 'A' reported they spoke with the nurse because R801 appeared swollen, was sleeping a lot, and had no control of his arm. Family Member 'A' reported if they picked up R801's arm, it would fall back down. Family Member 'A' reported the nurse said R801 was not swollen and that a physician would be in on Thursday or Friday to check on the resident (1/2/25 or 1/3/25). It was explained by Family Member 'A' that when they saw R801 on 1/1/25, he looked like he was in pain, was not responding as much, and sleeping more. According to Family Member 'A', the physician came on 1/3/25 "but it was too			

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	late" and he had to be rushed to the hospital. Family Member 'A' said they first noticed a change with R801 on 12/21/25 which was reported to the nurse and "multiple" Certified Nursing Assistants (CNA). On 12/25/24, "he just did not seem right" and they "had to shake him real hard to wake him up". A review of R801's clinical record revealed R801 was admitted into the facility on 3/9/23, readmitted on 5/9/24, and discharged to the hospital on 1/3/25 with diagnoses that included: acute kidney failure, type 2 diabetes mellitus, dysphagia (difficulty swallowing), dementia, seizures, hypertension, and aphasia (difficulty speaking). R801 received all nutrition and medication via a Percutaneous Endoscopic Gastrostomy (PEG) tube (a tube inserted into the stomach to deliver nutrition). A review of R801's Minimum Data Set (MDS) assessment dated 12/13/24, R801 had unclear speech, severely impaired cognition, physical and verbal behaviors, rejected care at times, and was dependent on staff for most activities of daily living (ADLs). A review of R801's progress notes revealed the following: On 12/21/24 at 10:30 AM, Licensed Practical Nurse (LPN) 'C' documented, "Resident complained he did not feel like himself and refused to get up this morning x 3, residents vitals signs were taken (they were within normal limits)...will continue to monitor..." There were no additional progress notes in the clinical record until 1/3/25. On 1/3/25 at 10:30 AM, LPN 'D' documented, "Resident observed in bed with difficulty			

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	breathing. Coarse crackles can he heard on inspiration. Resident only responds to painful stimuli. SPO2 (blood oxygen level) 80 (percent), BP (blood pressure) 106/90, P (Pulse) 92, R (respirations) 24, T (temperature) 99.2 (degrees Fahrenheit - F). DR (doctor) notified orders are to transfer to ER (emergency room). family notified." On 1/3/25, Physician 'G' documented, "Called by nurse and texted to come to see the patient for acute resp (respiratory) failure, breathing heavy, vitals abnormal, reached and the nurse had suctioned lot of mucus but still patient was breathing at rate of 24-28 and low BP and gurgling, o2 was low around 80-87% on oxygen, neb (nebulizer) treatment given, pt seemed uncomfortable and using accessory muscles, called the floor in charge nurse, called family, called 911 and signed out to them the case and paperwork given to them. 40 minutes with patient..." A review of a "Hospital Transfer Form" for R801 revealed R801 was transferred to the hospital on 1/3/25 at 11:00 AM for "Respiratory Infection". R801's vitals at that time were BP 142/96, HR 96, RR 18, Temp 99.8, O2 Sat 89. A review of R801's hospital records revealed R801 arrived at the emergency room on 1/3/25 at 11:35 AM. Further review of the hospital records revealed the following: An "Emergency Department Encounter Note" dated 1/3/25 revealed, "...presents to emergency department with report of altered mental status. Initial report was obtained from EMS (emergency medical services) who states they were called for altered mental status and found the patient			

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	essentially unresponsive with severe tachypnea (rapid, shallow breathing), saturating in the 70s. They placed the patient on a nonrebreather mask...glucose read as high and they transported the patient here...Further history was provided later in the stay by patient's sister who states that she has been concerned that his mental status has been declining for several days and he has appeared more bloated...Upon arrival...patient is spontaneously fluttering his eyes but will not track and does not respond to pain. He is tachycardic (elevated heart rate) and profoundly tacypneic with a respiratory rate in the 40s or 50s with very wet lung sounds. He is also hot to the touch with an axillary temperature of 103 degrees (F). Respiratory therapy was present upon arrival and attempted oral suctioning, patient did not gag and thick whitish secretions were removed with some improvement in lung sounds..." R801 required intubation because they were concerned "that failure to secure his airway would lead to death within hours with high concern for aspiration, possible CHF (congestive heart failure), and sepsis". The note further documented, "Soon after intubation, a number of laboratory studies returned confirming high glucose which had been shown earlier however this was greater than 1200 mg/dl with accompanying worsening of renal function, severe hyponatremia (low sodium in the blood. However this could be a typo as (R801's) sodium was elevated per laboratory results) adequate <sic> potassium...need to multiple medications in the setting of septic shock, HHS (Hyperosmolar Hyperglycemic State - a serious complication of diabetes that causes			

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	very high blood sugar, dehydration and confusion), and severe acid-base derangements...(antibiotics) were provided for broad-spectrum coverage for presumptive aspiration pneumonia and patient was transferred to the ICU (intensive care unit) in critical condition...I provided a brief recounting of patient's critical condition sharing that he may not survive the hospitalization..." A review of R801's vital signs during triage in the ED revealed his temperature was 103.5 degrees F, heart rate was 125 beats per minute, and respiratory rate was 64 breaths per minute. On 1/9/25 at 4:15 PM, an interview was conducted with LPN 'D' via the telephone. LPN 'D' was the nurse assigned to R801 on 1/3/25 when he was transferred to the hospital. LPN 'D' reported when she arrived for her shift (day shift) on 1/3/25, the previous shift nurse reported R801 seemed "congested" and that he required suctioning. LPN 'D' reported seeing the suction machine at R801's bedside. LPN 'D' said it was reported that R801 was fighting with the CNAs less during care and seemed to have less energy. LPN 'D' reported that during her rounds around 7:00 AM, R801 was observed sleeping. Around 10:00 AM, LPN 'D' found R801 in respiratory distress and explained R801 was "congested", "had a low pulse ox", and "was having a hard time breathing". After R801 was found in that condition, LPN 'D' said she contacted Physician 'G' who asked her to text him what was going on. LPN 'D' reported Physician 'G' said to wait to send R801 out until the family gave consent so the family was contacted. About 40 minutes later, Physician 'G' showed up at the facility			

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	and LPN 'D' explained she was unaware he was coming to the facility. Physician 'G' told LPN 'D' to give the resident oxygen which she said she already did and to give R801 a nebulizer treatment. LPN 'D' remembered R801's oxygen was low and his blood sugar was high, but blood pressure was stable. When queried about whether applying oxygen improved the oxygen levels, LPN 'D' reported it did not and so then she gave him the nebulizer treatment. LPN 'D' explained she had to leave the resident to find a mask in order to give the breathing treatment. LPN 'D' said she reported R801's change in condition to the Unit Manager (LPN 'B') and told her she was calling the doctor. Once R801 was evaluated by Physician 'G', the decision was made to send R801 out via 911. LPN 'D' reported that it was "within an hour" between the time she first discovered R801 had a change in condition and the time the physician arrived and R801 was sent to the hospital. On 1/10/25 at 10:00 AM, an interview was conducted via the telephone with CNA 'F', who was regularly assigned to R801 and worked the midnight shift on 1/2/25. CNA 'F' reported she was very familiar with R801. When queried about any changes that were noticed with R801 leading up to his hospitalization on 1/3/25, CNA 'F' reported "around Christmas time" R801 seemed like he had a "little fever" and "felt warm so that day she did not get him out of bed. CNA 'F' explained that she notified the nurse on duty and R801 stayed in bed that day and he was okay the following day. When queried about anything unusual on 1/2/25 midnight shift, CNA 'F' said R801 was "a little congested" and the nurse had to suction him on the morning of 1/3/25. CNA 'F' reported that			

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	R801 was sleeping more often that before. On 1/10/25 at 10:42 AM, an interview was conducted via the telephone with Registered Nurse (RN) 'E', who was assigned to R801 on the midnight shift of 1/2/25 going into the morning of 1/3/25. When queried about R801's presentation on the midnight shift of 1/2/25, RN 'E' stated, "nothing was unusual" during the night, that he slept through the night as usual, and that he typically woke up during morning rounds and did not like to be bothered. RN 'E' reported she usually sees him around 5:00 AM to give him morning medications, but on that day got to him around 6:00 AM. On that day, when RN 'E' took R801's vital signs "he just looked at me and was more compliant". According to RN 'E', R801's typical behavior was "he fights me" when taking vital signs and on 1/3/25, "he didn't argue which was not typical behavior for him". RN 'E' reported she did not remember anything abnormal with R801's vital signs. RN 'E' reported R801 had "congestion" and said that was "normal for him". RN 'E' reported R801's "mouth was dirty" and so she attempted to "clean his mouth". The CNA that changed him around 6:30 AM reported that R801 was quieter than normal and was not resistant to care as he often was. When queried about whether R801 required suctioning, RN 'E' reported R801 was trying to spit whatever was in his mouth out, but had difficulty, that she tried to suction R801's mouth, but he clenched his mouth and "gripped his teeth" and she was unable to suction his mouth. When queried about whether the physician was notified of R801's change in behavior and need to be suctioned, but unable to do it, RN 'E' reported she did not contact the doctor because it was already after 7:00 AM and			

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	she was there late. When queried about why she did not document any of the changes and behavior exhibited by R801, RN 'E' reported she documented the vital signs only. On 1/10/25 at approximately 10:55 AM, an interview was conducted with LPN 'B', the unit manager for the Spring Unit where R801 resided. When queried about the unit manager's responsibility during a resident's change in condition, LPN 'B' reported she typically followed up once the event was documented or if a nurse reported something to her, she would let them know what they were supposed to do next. LPN 'B' reported if a nurse asked for help, she would assist. LPN 'B' reported she would follow up during a change in condition, depending on what was going on. When queried about what occurred with R801 on the morning of 1/3/25, LPN 'B' reported she arrived at the facility, looked at the 24 hour report (there was nothing regarding R801 on there), rounded on the Autumn and Spring unit. At some point, R801's nurse told her the resident was having a change in condition and that she was going to call the doctor. LPN 'B' said she told the nurse to let her know if she needed anything and left the Spring unit to go to the Autumn unit. About an hour later, LPN 'B' was paged overhead to report to Spring Unit. Physician 'G' was in the hallway and said "This nurse needs help now!" and said to give R801 intravenous Lasix (a diuretic) which they did not have in the facility and he said to call 911. At that time, LPN 'B' called 911 and got the paperwork ready to transfer R801 to the hospital. When queried about expectations for documenting and/or calling the physician if a resident did not present as usual and/or if they required suctioning, LPN 'B' reported she would have expected a			

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	progress note and the physician to be called, as well as a note on the 24 hour report so that any additional monitoring or follow up could be completed. On 1/10/25 at 12:04 PM, an interview was conducted via the telephone with Physician 'G'. When queried about what occurred with R801 on the day he was sent to the hospital, Physician 'G' reported the nurse texted him and reported R801 had trouble breathing, had high respiratory rate, and was gurgling. Physician 'G' reported he ordered suctioning and a breathing treatment and told her to call 911. Physician 'G' said they always want to see if they can stabilize and handle a change in condition in the facility before sending the patient out, but when he saw R801 "you could see on his face he was going down". When queried about whether he was notified of R801's need to have his mouth suctioned and that the nurse was unable to do it on the midnight shift of 1/2/25, Physician 'G' reported he was not aware and it was expected that if there were any significant changes, even if vital signs were stable, to contact him to ensure no additional monitoring or treatment was needed. Physician 'G' reported he was always available via text message. On 1/10/24 at approximately 12:15 PM, an interview was conducted with the Director of Nursing (DON). When queried about what the facility's protocol was when a resident had a change in condition, the DON reported the nurse should document a progress note and/or on the change of condition assessment, contact the physician, assess the resident. When queried about the midnight nurse having to suction R801's mouth on the early morning of 1/3/25 and			

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	that she said she was unable to, and what should have been done, the DON did not offer a response. When queried about whether LPN 'C' should have contacted the physician on 12/21/24 when R801 presented with not feeling well and not getting out of bed as usual, the DON said based on the documentation, LPN 'C' assessed R801 appropriately. When queried about whether additional monitoring should have been done afterward, the DON did not offer a response. A review of the facility's policy titled, "Change in Condition Notification" revealed, "...The nurse will notify...the resident's physician/practitioner...when there is...A significant change in the resident's physical, mental, or psychosocial status...The nurse will document in the resident's medical record information relative to the resident's change in medical/mental condition or status (i.e. assessment, notifications, interventions, and response)..."			