STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	824350	A. BUILDING _____ B. WING _____	**2/12/2025**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000 SS=	Initial Comments On February 12, 2025, an Emergency Preparedness Survey was conducted by the Michigan Department of Licensing and Regulatory Affairs, Bureau of Survey and Certification. At the survey Four Seasons Nursing center of Westland was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.73, Emergency Preparedness.	E0000		
K0000 SS=	INITIAL COMMENTS On February 12, 2025, a Life Safety Recertification Survey was conducted by the Michigan Department of Licensing and Regulatory Affairs, Bureau of Survey and Certification. At the survey, Four Seasons Nursing Center of Westland was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 482.90(a), Life Safety from Fire and the applicable provisions of the 2012 Edition of the National Fire Protection Agency (NFPA) 101, Life Safety Code and the 2012 Edition of NFPA 99, Health Care Facilities Code. The facility is a 1 story building of Type II (222) construction, built in 1961. The building is fully sprinklered and has supervised smoke detection in the corridors and spaces open to the corridors. The facility has 180 certified beds. At the time of the survey the census was 164.	K0000		

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

Electronically Signed | 02/23/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K0211 SS= E	Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure aisles, passageways, corridors, exit discharges, exit locations and accesses are in accordance with Chapter 7. This deficient practice could affect 78 of 164 facility residents in the event of a fire or other emergency situation where evacuation is required. Findings Include: On February 12, 2025 at 11:46 AM, observation revealed the exit gate from the resident courtyard is equipped with a 15 - second delay device. However, the exit sign on the gate and the posted 15 - second delay instructional signage are severely faded and unreadable. These findings were confirmed in interview with the facility Maintenance Director and the Regional Operation Director at the time of observation.	K0211	Element #1 The exit and 15-second delay instructional signage has been replaced. Element #2 The Maintenance Staff have been re-educated on the K211 requirements. The Maintenance Director has conducted rounds to ensure there are no other faded emergency exit and 15-second delay signage. Element #3 The Maintenance Director or designee will audit emergency exit means of egress signage 1xWkx4WKs then 1X Monthly to ensure the facility has no faded emergency exit and 15-second delay signage. Deficiencies will be immediately corrected and findings will be reported to the facility Quality Assurance Performance Committee for review and further recommendation until substantial compliance is achieved and maintained. Element #4 The Maintenance Director is responsible for continued monitoring. The Administrator is responsible for continued regulatory compliance. Date of compliance 3/7/25	3/7/2025
K0345 SS= F	Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the	K0345	Element #1 Deficient practice #1 The facility has had Summit Fire Protection correct the citied practice to ensure the remote fire alarm annunciator at the Summer	3/7/2025

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	requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure the fire alarm system was tested and maintained in accordance with an approved program complying with NFPA 70 and NFPA 72. This deficient practice could affect all 164 facility residents in the event of a fire emergency. Findings Include: On February 12, 2025 at 9:57 AM, observation revealed the remote fire alarm annunciator at the Summer Hall Nurse Station and the Electrical Room displayed incorrect times. The panels read:11:14 AM, 2/12/2025 and 12:45 PM, 2/12/2025, respectfully. These findings were confirmed in interview with the facility Maintenance Director and the Regional Operation Director at the time of observation. Findings Include: On February 12, 2025, at approximately 11:05 AM, record review revealed the facility failed to record an annual and a semiannual visual testing of the fire alarm initiating devices. These findings were confirmed by the		Hall Nurse Station and Electrical Room displayed times are correct. Deficient practice #2 The facility has had Summit Fire Protection complete and record an annual and semi annual visual testing of the fire alarm initiating devices. Element #2 The Fire Alarm Testing and Maintenance policy has been reviewed and deemed appropriate. Maintenance staff has been re-educated on K345 requirements. Element #3 The Maintenance Director or designee will conduct monthly audits to ensure the Fire Alarm System is tested and maintained. Deficiencies will be immediately corrected and findings will be reported to the facility Quality Assurance Performance Committee for review and further recommendation until substantial compliance is achieved and maintained. Element #4 The Maintenance Director is responsible for continued monitoring. The Administrator is responsible for continued regulatory compliance. Date of compliance 3/7/25	

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	Administrator and Assistant Maintenance Director and at the time of record review and interview.			
K0353 SS= F	Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to provide sprinkler system maintenance and testing as required by NFPA 25. This deficient practice could affect all 164 facility residents in the event of a fire emergency. Findings Include: 1) On February 12, 2025 at 9:39 AM, observation revealed a ceiling tile penetration at the electrical conduit for the ceiling mounted exit sign at the fire-rated cross corridor doors in the Summer Hall by Room	K0353	Element #1 Deficient practice #1 The ceiling tile penetration at the electrical conduit for the ceiling mounted exit sign at the fire rated cross corridor doors in the Summer hall by room 203 has been repaired. The combustible personal items stored within 18 inches of the sprinkler head in room has been removed. The 3 grease and lint laden sprinkler heads above the tray line in the kitchen have been cleaned. The 4 dirty sprinkler heads in the main dining room have been cleaned. The ceiling tile penetration with annular space around the security camera at the Autumn hall employee exit has been repaired. The sprinkler escutcheon plate in the Accounts/HR office restroom has been repaired. The ceiling tile penetration at the WIFI Booster mounting in the corridor at the MDS office has been repaired. The ceiling tile penetration at the mounted exit sign in the Winter hall at cross corridor fire doors by 401 has been repaired. The ceiling tile penetration at the heat duct grill covers in Winter hall at room 408 and at Winter hall nurses' station have been repaired. Deficient practice #2 The facility has recorded/completed the 5-year internal pipe inspection and fire department connection of the sprinkler system. The dry pendant heads in the dietary cooler and freezer have been replaced. Element #2 Maintenance Director has conducted visual audits on sprinkler heads, ceiling tiles, walls,	3/7/2025

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	203. 2) On February 12, 2025 at 9:42 AM, observation revealed the combustible personal items stored within 18" of the sprinkler heads in the Summer Hall, Room 209. 3) On February 12, 2025 at 10:22 AM, observation revealed (3) grease and lint laden sprinkler heads above the tray line in the Kitchen. 4) On February 12, 2025 a 10:59 AM, observation revealed (4) dirty sprinkler heads in the main Dining Room. 5) On February 12, 2025 at 11:17 AM, observation revealed ceiling tile penetration with annular space around the security camera at the Autumn Hall Employee Exit. 6) On February 12, 2025 at 11:57 AM, observation revealed sprinkler escutcheon plate separating from the ceiling tile creating an annular space in the Accounts Office Restroom. 7) On February 12, 2025 at 11:59 AM, observation revealed ceiling tile penetration at the WiFi booster mounting in the corridor at the MDS Office. 8) On February 12, 2025 at 12:12 PM, observation revealed ceiling tile penetration at the electrical conduit the mounted exit sign in the Winter Wall at the cross corridor fire doors by Room 401. 9) On February 12, 2025 at 12:15 PM, observation revealed ceiling tile penetration		pipes, and dietary cooler and freezer. Elements #3 Maintenance staff have been re-educated on K353 requirements. The maintenance Director or designee will conduct monthly audits of various ceiling tiles, storage closets, sprinkler heads/escutcheon, internal pipe and fire department connection of the sprinkler system, and the cooler and freezer dry pendant heads to ensure sprinkler system is properly maintained. Deficiencies will be immediately corrected and findings will be reported to the facility Quality Assurance Performance Committee for review and further recommendation until substantial compliance is achieved and maintained. Element #4 The Maintenance Director is responsible for continued monitoring. The Administrator is responsible for continued regulatory compliance. Date of compliance 3/7/25	

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	at the heat duct grill covers in the Winter Hall at Room 408. 10) On February 12, 2025 at 12:28 PM, observation revealed ceiling tile penetration at the heat duct grill covers at the Winter Hall Nurse Station. These findings were confirmed in interview with the facility Maintenance Director and the Regional Operation Director at the time of observation. Findings Include: On February 12, 2025, at approximately 11:05 AM, record review of the document titled "Fire Sprinkler Systems- General Information Sheet" dated 2/29/24, revealed the facility failed to: 11) record the 5-year internal pipe inspection and fire department connection of the sprinkler system. 12) replace the dry pendant heads in the cooler and freezer. These findings were confirmed by the Administrator and Assistant Maintenance Director and at the time of record review and interview.			

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K0371 SS= E	Subdivision of Building Spaces - Smoke Compar Subdivision of Building Spaces - Smoke Compartments 2012 EXISTING Smoke barriers shall be provided to form at least two smoke compartments on every sleeping floor with a 30 or more patient bed capacity. Size of compartments cannot exceed 22,500 square feet or a 200-foot travel distance from any point in the compartment to a door in the smoke barrier. 19.3.7.1, 19.3.7.2 Detail in REMARKS zone dimensions including length of zones and dead-end corridors. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure smoke barriers were provided to form at least 2 smoke compartments on every floor as required by 19.3.7.1 and 19.3.7.2. This deficient practice could affect 48 of 164 facility residents in the event of a fire emergency. Findings Include: On February 12, 2025 at 10:00 AM, observation revealed the fire-rated door from the Personal Belongings Storage to the main Laundry was propped open by a rope. This deficiently could allow fire, toxic smoke and products of combustion to spread to other occupied, uninvolved spaces of the facility should a fire start in the Laundry area. These findings were confirmed in interview with the facility Maintenance Director and the Regional Operation Director at the time of observation.	K0371	Element #1 The rope on the door from the Personal Belongings Storage to the Main Laundry door was immediately removed. Laundry staff was immediately educated on not propping open the fire rated door. Element #2 Maintenance staff has conducted audits to ensure other fire rated doors are not propped open. Element #3 Facility staff has been re-educated on not propping open any fire rated doors. Maintenance staff was re-educated on K371 requirements. Maintenance Director or designee will conduct random audits on Fire Rated Doors not being propped open 1XWk x 4WKS to ensure staff is not propping open Fire Rated doors. Deficiencies will be immediately corrected and findings will be reported to the facility Quality Assurance Performance Committee for review and further recommendation until substantial compliance is achieved and maintained. Element #4 The Maintenance Director is responsible for continued monitoring. The Administrator is responsible for continued regulatory compliance. Date of compliance 3/7/25	3/7/2025

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K0711 SS= F	Evacuation and Relocation Plan Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure there is a written plan for the protection of all residents and for their evacuation in the event of an emergency, employees are periodically instructed in their duties under the plan as required by 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2 and 19.7.2.3. This deficient practice could affect all 164 residents in the event of an emergency. Findings Include: On February 12, 2025, at approximately 9:35 AM record review revealed the facility did not include the required criteria of "transmission of alarms to fire department" in their fire safety plan. These findings were confirmed by the Administrator and Assistant Maintenance Director and at the time of record review and interview.	K0711	Element #1 The facility has updated the Fire Safety Plan to include the “Transmission of alarms to fire department”. Element #2 Facility staff has been re-educated on the updated Fire Safety Plan. Element #3 Maintenance staff and Administrator have reviewed K711 requirements. Maintenance Director or designee will review the Fire Safety Plan yearly to ensure proper documentation and requirements are included in the plan. Deficiencies will be immediately corrected and findings will be reported to the facility Quality Assurance Performance Committee for review and further recommendation until substantial compliance is achieved and maintained. Element #4 The Maintenance Director is responsible for continued monitoring. The Administrator is responsible for continued regulatory compliance. Date of compliance 3/7/25	3/7/2025