STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	824519	A. BUILDING _____ B. WING _____	**2/22/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMEDICA SKILLED NSG & REHAB CANTON	**7025 LILLEY ROAD CANTON, MI 48187**

(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 22, 2022, an Emergency Preparedness Survey was conducted by the Michigan Department of Licensing and Regulatory Affairs. At the survey Promedica Skilled Nursing and Rehab, Canton was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.73, Emergency Preparedness.	E0000		
E0015 SS= F	Subsistence Needs for Staff and Patients §403.748(b)(1), §418.113(b)(6)(iii), §441.184(b)(1), §460.84(b)(1), §482.15(b)(1), §483.73(b)(1), §483.475(b)(1), §485.625(b)(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal.	E0015	E015- Policies/Procedures for Sheltering in Place: The facility reviewed its Emergency Preparedness Manual and identified the lack of a documented policy for the amount of water to have on-hand in case of a shelter-in-place emergency. The facility established the amount of water to have on premises as 3 gallons per patient per day, also for staff and visitors, times three days and addended the shelter in place policy. The facility submitted it to the QAPI committee for review and recommendation. The committee approved the submitted policy for implementation. The facility educated staff on the addended sheltering in place policy and inserted into the Emergency Preparedness Manual effective 3/23/2022	3/23/2022

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

Electronically Signed | 03/07/2022

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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	*[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to develop, at a minimum, policies and procedures that address; the provision of subsistence needs for staff and patients whether they evacuate or shelter in place, including, but not limited to: Food, water, medical and pharmaceutical supplies, alternate sources of energy to maintain temperatures to protect patient health and safety and for the safe and sanitary storage of provisions, emergency lighting, fire detection, extinguishing and alarm systems, and sewage and waste disposal. This deficient practice could affect 95 out of 95 occupants in the event of a disaster which triggers a shelter-in-place emergency. Findings Include: On February 22, 2022, at approximately 11:445 AM. record review revealed the facility failed to produce a policy for emergency water to have on			

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	hand in the facility incase of a shelter-in-place emergency. The Administrator confirmed these findings during interview at the time of record review.			
K0000 SS=	INITIAL COMMENTS On February 22, 2022, A Life Safety Recertification Survey was conducted by the Michigan Department of Licensing and Regulatory Affairs, Bureau of Community and Health Systems. At the survey, Promedica Skilled Nursing and Rehab, Canton was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(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 2 story building of type II (222) construction built in 2005, with a type II (000) addition in 2011. The building is fully sprinklered and has supervised smoke detection in the corridors and spaces open to the corridors. The facility has 150 certified beds. At the time of the survey the census was 95. The requirement at 42 CFR, subpart 483.90 (a) is NOT MET as evidenced by:	K0000		
K0351 SS= F	Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic	K0351	K-351 Sprinkler System – Installation The facility identified the BBQ and patio furniture stored under the overhang of the first-floor dining room. The BBQ and patio furniture were removed from the area under	3/23/2022

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	sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure nursing homes and hospitals where required by construction type are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, as required by 19.3.5.1 through 19.3.5.5, 19.4.2, 19.3.5.10, 9.7 and 9.7.1.1(1). This deficient practice could affect 95 out of 95 occupants in the event of a fire emergency. Findings Include: On February 22, 2022 at approximately 11:00 AM. observation revealed the facility failed to provide automatic fire sprinkler protection for the overhang of the first floor dining area. Outdoor furniture and a propane BBQ with tank was observed in the unsprinklered area. The Administrator confirmed these findings during interview at the time of record review.		the overhang and stored in an appropriate location on 3/8/2022. The facility identified that all patients that reside at the facility could be affected. The Administrator educated the Maintenance Director on appropriate equipment storage. The Maintenance Director/Designee will conduct random weekly audits, times four weeks, to ensure outdoor equipment is stored in the appropriate space. The administrator will review findings and submit to the QAPI Committee for further review and recommendation.	