STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CL AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		414290	B. WING			11/18/	2022
NAME OF PRO	VIDER OR SUPPLIE	ER .			STREET ADDRESS, CITY, STATE	, ZIP COI	DE
SKLD BELTL	INE				2320 E BELTLINE SE GRAND RAPIDS, MI 49546		
(X4) ID PREFIX TAG	(EACH DEFICIENT FULL REGULA	TEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	VIDER'S PLAN OF CORRECTION (E RECTIVE ACTION SHOULD BE CR EFERENCED TO THE APPROPRIAT DEFICIENCY)	OSS-	(X5) COMPLETION DATE
E0000 SS=	Preparedness Surv Michigan Departn Regulatory Affair Certification. At the found to be not in requirements for p Medicare/Medicar The facility has 18 the survey the cen An exit conference the survey. The re discussed with the Maintenance Dire	2022, An Emergency yey was conducted by the nent of Licensing and s, Bureau of Survey and ne survey, SKLD Beltline was substantial compliance with the narticipation in d at 42 CFR 483.73. 32 certified beds. At the time of sus was 138. Be was held at the conclusion of sults of the inspection were administrator and the ctor. St 42 CFR, subpart 483.73 is not	E0000				
E0039 SS= F	§418.113(d)(2), (2), §482.15(d)(2), (4), §485.625(d), (2), §485.625(d), (2), §485.920(d)(2), *[For ASCs at §40, ""Organize CMHCs at §485, §491.12, and ES (2) Testing. The exercises to test annually. The [fat following: (i) Participate in community-base a community-base	uirements §416.54(d)(2), §441.184(d)(2), §460.84(d) 2), §483.73(d)(2), §485.68(d) (2), §485.727(d)(2), §491.12(d)(2), §494.62(d)(2). 416.54, CORFs at §485.68, ations"" under §485.727, 920, RHCs/FQHCs at §RD Facilities at §494.62]: [facility] must conduct the emergency plan icility] must do all of the a full-scale exercise that is d every 2 years; or (A) When seed exercise is not luct a facility-based	E0039	other d disaste scenari Elemer All resid by this Elemer The Plathe Mai disaste interdis Elemer The Ad random prepare substan	16/2022, the safety committee a epartments completed a tabletop or drill with an active shooter/intruio. In Two dents have the potential to be af practice. In Three ant Operations Manager re-educintenance Director to ensure table or plan activities are completed we ciplinary team annually on 12/12	ouder fected feted letop with the 2/2022. et ccy ed and	12/19/2022

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Electronically Signed 12/16/2022

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.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A (X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		414290	B. WING _			11/18/2022		
NAME OF PRO	VIDER OR SUPPLIE	ER			STREET ADDRESS, CITY, STATE	, ZIP CO	DE	
SKLD BELTL	INE				2320 E BELTLINE SE GRAND RAPIDS, MI 49546			
(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	VIDER'S PLAN OF CORRECTION (E RECTIVE ACTION SHOULD BE CR FERENCED TO THE APPROPRIAT DEFICIENCY)	OSS-	(X5) COMPLETION DATE	
	[facility] experient man-made emer activation of the is exempt from exempt from exempt from exempt from exempt from exempt from exercise at least year the full-scalunder paragraph conducted, that r limited to the folloscale exercise thindividual, facility or (B) A mock disexercise or work facilitator and incusing a narrated emergency scenstatements, direct questions design emergency plan. response to and all drills, tabletop events, and revisplan, as needed. *[For Hospices a hospices that prohome. The hospic to test the emergency based functional (B) If the hospice must accessible, conductional (B) If the hospice man-made emeractivation of the is exempt from exercise activation of the is exempt from exemp	se every 2 years; or (B) If the nees an actual natural or gency that requires emergency plan, the [facility] engaging in its next required dor individual, facility-based se following the onset of the Conduct an additional every 2 years, opposite the e or functional exercise (d)(2)(i) of this section is may include, but is not owing: (A) A second full-nat is community-based or r-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 ned to challenge an ((iii) Analyze the [facility's] maintain documentation of exercises, and emergency set the [facility's] emergency set the [facility's] emergency plan at least annually. It is devery 2 years; or experiences a natural or gency that requires emergency plan, the hospital engaging in its next required unity-based exercise or		action. The rescommit further Elemen The Ad complia	Emergency Management Plan is sults will be presented to the QA tee for review and consideration corrective actions. It Five ministrator will ensure substantiance is attained through this plar on by 12/19/2022 and for sustainance after that.	A of al ı of		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING		STRUCTION	(X3) DATE SURVEY COMPLETED		
		414290	B. WING _			11/18/	1/18/2022	
NAME OF PRO	VIDER OR SUPPLIE	ER			STREET ADDRESS, CITY, STATE	, ZIP CO	DE	
SKLD BELTL	INE				2320 E BELTLINE SE GRAND RAPIDS, MI 49546			
(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	VIDER'S PLAN OF CORRECTION (E RECTIVE ACTION SHOULD BE CR FERENCED TO THE APPROPRIA' DEFICIENCY)	OSS-	(X5) COMPLETION DATE	
	following the ons (ii) Conduct an a years, opposite t functional exerciof this section is include, but is not A second full-sca community-base functional exercidrill; or (C) A tab that is led by a fa group discussion relevant emerge problem stateme prepared questic emergency plan. (3) Testing for hocare directly. The exercises to test per year. The ho (i) Participate in that is community-base conduct an annufunctional exerciexperiences a nate mergency that remergency plan, engaging in its not community base exercise followin emergency even annual exercise limited to the foll scale exercise that its community base of un workshop led a group discussic clinically-relevan	based functional exercise set of the emergency event. dditional exercise every 2 he year the full-scale or se under paragraph (d)(2)(i) conducted, that may st limited to the following: (A) ale exercise that is d or a facility based se; or (B) A mock disaster letop exercise or workshop acilitator and includes a nusing a narrated, clinically-ney scenario, and a set of ents, directed messages, or ons designed to challenge an expices that provide inpatient the hospice must conduct the emergency plan twice spice must do the following: an annual full-scale exercise y-based; or (A) When a dexercise is not accessible, all individual facility-based se; or (B) If the hospice extural or man-made requires activation of the the hospice is exempt from ext required full-scale d or facility-based functional g the onset of the t. (ii) Conduct an additional that may include, but is not lowing: (A) A second full-lat is community-based or a actional exercise; or (B) A iil; or (C) A tabletop exercise by a facilitator that includes on using a narrated, t emergency scenario, and a attements, directed						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER		(X2) MULTIP A. BUILDING				DATE SURVEY PLETED	
	414290	B. WING _			_ 11/18	3/2022	
NAME OF PROVIDER OR SUPPLIE	I R			STREET ADDRESS, CITY, S	•	DDE	
				GRAND RAPIDS, MI 495	46		
PRÉFIX (EACH DEFICIENTAG FULL REGULAT	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	VIDER'S PLAN OF CORRECT RECTIVE ACTION SHOULD E FERENCED TO THE APPRO DEFICIENCY)	BE CROSS-	(X5) COMPLETION DATE	
to challenge and the hospice's residocumentation of exercises, and eithe hospice's emitted with the ho	epared questions designed emergency plan. (iii) Analyze sponse to and maintain fall drills, tabletop mergency events and revise tergency plan, as needed. (441.184(d), Hospitals at sat §485.625(d):] (2) (27F, Hospital, CAH] must se to test the emergency plan he [PRTF, Hospital, CAH] wing: (i) Participate in an exercise that is community-ten a community-ten actual natural or man-made requires activation of the the [facility] is exempt from ten actual natural or man-made requires activation of the the strength of the transfer of the tran						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING			(X3) DATE SURVEY COMPLETED	
		414290	B. WING			11/18/	2022
NAME OF PRO	VIDER OR SUPPLIE	R			STREET ADDRESS, CITY, STATE	ZIP CO	DE
SKLD BELTL	INE				2320 E BELTLINE SE GRAND RAPIDS, MI 49546		
(X4) ID PREFIX TAG	(EACH DEFICIENT FULL REGULATION	TEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	CORI	VIDER'S PLAN OF CORRECTION (E RECTIVE ACTION SHOULD BE CR FERENCED TO THE APPROPRIAT DEFICIENCY)	OSS-	(X5) COMPLETION DATE
	to test the emergine The PACE organ following: (i) Part scale exercise the (A) When a commaccessible, conditioned facility-based fur PACE experience made emergency promengaging in community base functional exercise exercise every 2 full-scale or functional exercise exercise every 2 full-scale or functional exercise exercise that is conducted that not the following: exercise that is conducted that not the following: exercise; or (B) A tabletop exercise facilitator and incusing a narrated emergency scenstatements, direct questions design emergency plan, as needed. *[For LTC Facility] must he emergency proceder including unannoul full-incusted in an annual full-incustion of the part o	on must conduct exercises gency plan at least annually. nization must do the ticipate in an annual full-lat is community-based; or munity-based exercise is not luct an annual individual, nctional exercise; or (B) If the less an actual natural or many that requires activation of plan, the PACE is exempt in its next required full-scale dor individual, facility-based se following the onset of the lat. (ii) Conduct an additional years opposite the year the tional exercise under (i) of this section is may include, but is not limited (A) A second full-scale community-based or lity based functional A mock disaster drill; or (C) A late or workshop that is led by a cludes a group discussion, clinically-relevant ario, and a set of problem ceted messages, or prepared led to challenge an (iii) Analyze the PACE's maintain documentation of exercises, and emergency et the PACE's emergency et the					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER:		(X2) MULTIP A. BUILDING		STRUCTION	(X3) DATE SURVEY COMPLETED		
		414290	B. WING _			11/18	/2022
NAME OF PRO	VIDER OR SUPPLIE	R	_		STREET ADDRESS, CITY, STAT	E, ZIP CO	DE
SKLD BELTL	INE				2320 E BELTLINE SE GRAND RAPIDS, MI 49546		
(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	/IDER'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE C FERENCED TO THE APPROPRI/ DEFICIENCY)	ROSS-	(X5) COMPLETION DATE
	conduct an annufunctional exercifacility experience made emergency pexempt from eng scale community based functional of the emergency additional annua but is not limited second full-scale based or an indifunctional exercifrility or (C) A tab that is led by a fadiscussion, using relevant emerge problem stateme prepared questic emergency plantacility] facility's adocumentation of exercises, and ethe [LTC facility] needed. *[For ICF/IID must the emergency plantacility] reconduct an annufunctional exerciex periences an amergency plantacility and that is community-base conduct an annufunctional exerciex periences an amergency plantacing in its normmunity-base community-base community-base	d exercise is not accessible, al individual, facility-based se. (B) If the [LTC facility] ses an actual natural or many that requires activation of olan, the LTC facility is gaging its next required a fully-based or individual, facility-exercise following the onset y event. (ii) Conduct an I exercise that may include, to the following: (A) A sexercise that is community-vidual, facility based se; or (B) A mock disaster letop exercise or workshop acilitator includes a group ga narrated, clinically-ney scenario, and a set of ents, directed messages, or ons designed to challenge an (iii) Analyze the [LTC response to and maintain if all drills, tabletop mergency events, and revise facility's emergency plan, as §483.475(d)]: (2) Testing. It conduct exercises to test olan at least twice per year. It do the following: (i) annual full-scale exercise y-based; or (A) When a dexercise is not accessible, all 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 dor individual, facility-based se following the onset of the					

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		414290	B. WING _			11/18	/2022
NAME OF PRO	VIDER OR SUPPLIE	ER			STREET ADDRESS, CITY, S	TATE, ZIP CO	DE
SKLD BELTL	INE				2320 E BELTLINE SE GRAND RAPIDS, MI 4954	16	
(X4) ID PREFIX TAG	(EACH DEFICIENT FULL REGULA	ATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	VIDER'S PLAN OF CORRECTI RECTIVE ACTION SHOULD B EFERENCED TO THE APPROF DEFICIENCY)	E CROSS-	(X5) COMPLETION DATE
	annual exercise limited to the foll scale exercise the individual, facility or (B) A mock di exercise or work facilitator and in using a narrated emergency scerstatements, dire questions designemergency plan response to and all drills, tabletor, events, and reviplan, as needed *[For HHAs at § HHA must condumergency plan must do the folloscale exercise the (A) When a compact accessible, confacility-based fur years; or. (B) If the actual natural or requires activative the HHA is exen required full-scale individual, facility following the ons (ii) Conduct an all years, opposite if functional exercion the second full-scale community-base based functional disaster drill; or	att. (ii) Conduct an additional that may include, but is not owing: (A) A second full-hat is community-based or an y-based functional exercise; saster drill; or (C) A tabletop shop that is led by a cludes a group discussion, clinically-relevant hario, and a set of problem cted messages, or prepared hed to challenge an an anion, (iii) Analyze the ICF/IID's maintain documentation of the exercises, and emergency set the ICF/IID's emergency set the exercises to test the auties community-based; or munity-based exercise is not duct an annual individual, notional exercise every 2 he HHA experiences an man-made emergency plan, not from engaging in its next le community-based or y based functional exercise set of the emergency event. Inditional exercise every 2 the year the full-scale or se under paragraph (d)(2)(i) conducted, that may be limited to the following: (A) alle exercise; or (B) A mock (C) A tabletop exercise or led by a facilitator and					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING		(X3) DATE SURVEY COMPLETED			
		414290	B. WING _			11/18	1/18/2022	
NAME OF PRO	VIDER OR SUPPLIE	I.::R			STREET ADDRESS, CITY, STA	ATE, ZIP CC	DE	
SKLD BELTL	INE				2320 E BELTLINE SE GRAND RAPIDS, MI 49546	i		
(X4) ID PREFIX TAG	(EACH DEFICIENT FULL REGULATION	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	VIDER'S PLAN OF CORRECTIO RECTIVE ACTION SHOULD BE FERENCED TO THE APPROPI DEFICIENCY)	CROSS-	(X5) COMPLETION DATE	
	narrated, clinical scenario, and a sidirected messag designed to chal (iii) Analyze the limaintain docume exercises, and ethe HHA's emergency plan. following: (i) Cortabletop exercise annually. A table facilitator and incusing a narrated emergency scenstatements, directly distributed in the opolitation of the emergency plan. actual natural or requires activation the OPO is exented in the opolitation of the emergency evented opolitation of emergency plan. Finch I say the opolitation of the emergency plan. I say the opolitation of the emergency plan. I say the opolitation of the emergency plan. I say the opolitation of the opolitation open statements of the opolitation, unrelevant emergency plan. I say the opolitation of the opolitation of the opolitation open statements of the open state	discussion, using a ly-relevant emergency set of problem statements, es, or prepared questions lenge an emergency plan. HHA's response to and entation of all drills, tabletop mergency events, and revise gency plan, as needed. 486.360] (d)(2) Testing. The act exercises to test the The OPO must do the iduct a paper-based, e or workshop at least other exercise is led by a cludes a group discussion, clinically relevant ario, and a set of problem ceted messages, or prepared need to challenge an if the OPO experiences an man-made emergency that on of the emergency plan, and of the emergency plan, and in the emergency plan, and an entation of the emergency plan, as needed. 33.748]: (d)(2) Testing. The induct exercises to test the The RNHCI must do the iduct a paper-based, at least annually. A is a group discussion led sing a narrated, clinically-ney scenario, and a set of ents, directed messages, or ins designed to challenge an (ii) Analyze the RNHCI's maintain documentation of						

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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(X4) ID PREFIX TAG	(EACH DEFICIENT FULL REGULA	ATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	VIDER'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BEFERENCED TO THE APPROFICIENCY)	E CROSS-	(X5) COMPLETION DATE
	events, and revision plan, as needed	cises, and emergency se the RNHCl's emergency MENT is not met as					
	failed to conduct of plan at least annual staff drills using the facility must partithat is community based exercise is a facility-based for actual natural or no requires activation facility is exempt based or individual exercise for 1 year actual event. The additional exercise limited to a secondominity-based tabletop exercise to led by a facilitation relevant emergency statements, direct questions designed plan. The facility and maintain document exercises, and emfacility's emergency deficient practice event staff are not emergency process.	ng the review of the facility redness Manual between					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER:		A (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		414290	B. WING _			_ 11/18	/2022
NAME OF PRO	VIDER OR SUPPLIE	R	<u>!</u>		STREET ADDRESS, CITY, S	STATE, ZIP CO	DE
SKLD BELTL	INE				2320 E BELTLINE SE GRAND RAPIDS, MI 495	46	
(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	VIDER'S PLAN OF CORRECT RECTIVE ACTION SHOULD E FERENCED TO THE APPRO DEFICIENCY)	BE CROSS-	(X5) COMPLETION DATE
	or community-bas CFR, subpart 483.						
		re confirmed during an Maintenance #1 at the time the wed.					
K0000 SS=	INITIAL COMME		K0000				
	Recertification Su Michigan Departm Regulatory Affairs Certification. At the found not in substarequirements for p Medicare/Medicai Safety from Fire a the 2012 Edition of Agency (NFPA) 1	2022, A Life Safety rvey was conducted by the ment of Licensing and s, Bureau of Survey and ne survey, SKLD Beltline was antial compliance with the articipation in d at 42 CFR 483.90(a), Life nd the applicable provisions of of the National Fire Protection 01, Life Safety Code and the FPA 99, Health Care Facilities					
	(000) construction 1968, 1971 and 19 sprinklered and ha	ngle story building of type II built in 1961, with additions in 193. The building is fully as supervised smoke detection in spaces open to the corridors.					
	The facility has 18 the survey the cent	32 certified beds. At the time of sus was 138.					
	the survey. The re-	e was held at the conclusion of sults of the inspection were Administrator and the ctor.					
	The requirement a not met as evidence	t 42 CFR, subpart 483.90(a) is eed by:					

STATEMENT O AND PLAN OF (F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A (X2) MULTIPLE CONSTRUCTION (X3) DAT COMPLE		ATE SURVEY LETED		
		414290	B. WING			11/18/	2022
NAME OF PRO	VIDER OR SUPPLIE	R	······································		STREET ADDRESS, CITY, STATE,	ZIP COI	DE
SKLD BELTL	INE				2320 E BELTLINE SE GRAND RAPIDS, MI 49546		
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K0211 SS= F	- General Aisles, exit discharges, are in accordance means of egress free of all obstructure mergency, unlethrough 18/19.2. This REQUIREM evidenced by: Based on observate failed to ensure the clear of all obstructure of all obstructure of all obstructure of obstructions during include: On 11/18/22 at 3:4 there were Isolation wheels which is a These findings we	passageways, corridors, exit locations, and accesses e with Chapter 7, and the is continuously maintained ctions to full use in case of ss modified by 18/19.2.2 11. 18.2.1, 19.2.1, 7.1.10.1 IENT is not met as ion and interview, the facility at exit access corridors were ctions in accordance with LSC In Chapter 7. This deficient exitally affect all occupants of event of delayed egress because ring an emergency evacuation. Ispm, observation revealed on carts in corridors without violation of LSC 19.2.3.4(4). re confirmed during an intenance #1 at the time	K0211	remove Elemen All resid by this remove on then Elemen The ad staff to are not All staff the beg Elemen The Ad random times for months been at halls ar wheels The res commit further Elemen The Ad complia correcti	lation carts without wheels were ad from service. In two dents have the potential to be affipractice. Hallways audited and dobstacles that did not have when. In Three ministrator/designee re-educated ensure items that do not have when in corridors when not in use. I will be educated by 12/19/2022 jinning of their next scheduled shot Four ministrator/designee will conduct a audits of the facility corridors we can use the four weeks, and monthly times three or until substantial compliance hat ained and maintained to ensure the free of obstacles that are not outlets will be presented to the QAA tee for review and consideration corrective actions.	eels I all heels or by ift. Eekly, ee has the n A of	12/19/2022
K0321 SS= E	Areas - Enclosur protected by a fin resistance rating doors) or an auto system in accord When the approventinguishing systems areas shall be so by smoke resisting	s - Enclosure Hazardous e 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. yed automatic fire stem option is used, the eparated from other spaces ng partitions and doors in 8.4. Doors shall be self-	K0321	latch ar Elemen All resid by this equipm a latch Elemen The Pla	105 has a self-close mechanism and lock as of 11/21/2022.	ected oring or with	12/19/2022

STATEMENT C AND PLAN OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		414290	B. WING _		11/18		3/2022	
NAME OF PRO	VIDER OR SUPPLIE	IER			STREET ADDRESS, CITY, STATE,	ZIP COI	DE	
SKLD BELTL	INE				2320 E BELTLINE SE GRAND RAPIDS, MI 49546			
(X4) ID PREFIX TAG	(EACH DEFICIENT FULL REGULA	TEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	VIDER'S PLAN OF CORRECTION (E RECTIVE ACTION SHOULD BE CRO FERENCED TO THE APPROPRIAT DEFICIENCY)	DSS-	(X5) COMPLETION DATE	
	have nonrated oplates that do no plates that do no plates that do no bottom of the do zone locations of deficient in REM Area Automatic Boiler and Fuel-Laundries (large Repair, Maintens Soiled Linen Rose. Trash Collecting Gallons) f. Comb Rooms/Spaces (Laboratories (if the see K322) This REQUIREM evidenced by: Based on observatifailed to provide fareas in accordance This deficient pracoccupants of the fibeing contained to Findings include: On 11/18/22 at 2:4 resident room 405 storage. The door latch and did not 1 as required by LSC. These findings we	cover 50 square feet) g. classified as Severe Hazard - MENT is not met as ion and interview, the facility or the protection of hazardous with LSC Section 19.3.2.1. ctice could potentially affect 15 acility in the event of a fire not of the hazardous area. 48pm, observation revealed was being use for equipment did not self-close to a positive ock against unauthorized entry		close m 12/12/2 Elemer The Ad random weekly, three m has bee the revi Manago The res commit further Elemer The Ad complia	nt Four ministrator/designee will conduct a audits of the construction areas times four weeks, and monthly, nonths, or until substantial complier attained and maintained to en ew and updating of the Emergenement Plan is completed. Sults will be presented to the QAA tee for review and consideration corrective actions.	times ance sure icy of		
K0324 SS= F		s Cooking Facilities Cooking stected in accordance with	K0324	Elemer The she	nt One elf on the range oven obstructing	the	12/19/2022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					(X3) DATE SURVEY COMPLETED	
		414290	B. WING _		11/18/2022			
NAME OF PRO	VIDER OR SUPPLIE	ER			STREET ADDRESS, CITY, STATE	ZIP CO	DE	
SKLD BELTLINE					2320 E BELTLINE SE GRAND RAPIDS, MI 49546			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	CORI	VIDER'S PLAN OF CORRECTION (E RECTIVE ACTION SHOULD BE CR FERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE		
	and Fire Protecti 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 compa patients comply 18.3.2.5.4, 19.3. protected accorr are not required hazardous areas corridor. 18.3.2.5 19.3.2.5.1 throug This REQUIREM evidenced by: Based on observat interview, the faci facilities in accord and NFPA 96. Thi potentially affect t practice could affect a gas leak and/or f Findings include: 1. On 11/18/22, dt records between 1 no current docume monthly "owners" NFPA 17A, 7.2. L 2. On 11/18/22 at	ard for Ventilation Control ion of Commercial Cooking iss: * residential cooking small appliances such as plates, toasters) are used gor 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 fling to NFPA 96 per 9.2.3 to be enclosed as 5, but shall not be open to the 5.1 through 18.3.2.5.4, gh 19.3.2.5.5, 9.2.3, TIA 12-2 MENT is not met as Lion, records review and lity failed to protect cooking lance with LSC Section 19.3.2.5 is deficient practice could the in the event of This deficient ext all occupants in the event of This deficient ext all occu		12/13/2 grade g ovens v line on Elemen All resic by this Elemen The Pla the Mai hood in hence l 12/12/2 Elemen The Ad random monthly months been at these ir correctl The res commit further of Elemen The Ad complia	dents have the potential to be after practice. In the practice and Operations Manager re-educe the name of Director to ensure ran spections were completed montogged for record keeping on 1022. In the process of the logs being kept of a record in audits of the logs being kept of a record in a record in a process of the logs being kept of a record in a r	rected ated ge hly, t the ree has that		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER: 414290	Α	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED		
NAME OF PROVIDER OR SUPPLIER SKLD BELTLINE						STREET ADDRESS, CITY, STATE, ZIP CODE 2320 E BELTLINE SE GRAND RAPIDS, MI 49546			
(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) cause an obstruction to the suppression nozzles if activated which violates NFPA 96, 10.2.7.3. 3. On 11/18/22 at 3:30pm, observation revealed the gas supply line for the Kitchen Vulcan Convection Oven was not commercial grade piping as required in NFPA 54, 9.6.1. These findings were confirmed during an interview with Maintenance #1 at the time observed and reviewed.				ID PREFIX TAG	COR	/IDER'S PLAN OF CORRECTION (E RECTIVE ACTION SHOULD BE CRO FERENCED TO THE APPROPRIAT DEFICIENCY)	DSS-	(X5) COMPLETION DATE	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN		(X3) DATE SURVEY COMPLETED			
		414290	B. WING		11	11/18/2022		
NAME OF PRO	VIDER OR SUPPLIE	R		STREET ADDRESS, CITY, STATE, ZIP CODE				
SKLD BELTLINE					2320 E BELTLINE SE GRAND RAPIDS, MI 49546			
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA)	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	PROV CORI RE				
K0712 SS= F	transmission of a simulation of emdrills are held at times under vary quarterly on each with procedures part of establishe conducted betwee coded announce of audible alarms. This REQUIREM evidenced by: Based on records a failed to provide with fire drills in according to the fattained in approversible. On 11/18/22 durin between 11:00am documentation proconducted on the sor on the third shift were also not conducted varying conducted. These findings we	rills Fire drills include the a fire alarm signal and bergency fire conditions. Fire expected and unexpected ing conditions, at least in shift. The staff is familiar and is aware that drills are der routine. Where drills are seen 9:00 PM and 6:00 AM, a ment may be used instead in 19.7.1.4 through 19.7.1.7 IENT is not met as seview and interview the facility written documentation regarding lance with LSC Section 19.7.1. tice could potentially affect all acility if staff are not properly demergency procedures. If the review of facility records and 2:30pm,, there was no wided for fire drills being second shift in the first quarter in the third quarter. The drills fucted throughout the shifts ditions as required in LSC are confirmed during an Maintenance #1 at the time the wed.	K0712	DEFICIENCY)		l ff		
K0761 SS= F	Maintenance, Ins Fire doors assen	spection & Testing - Doors spection & Testing - Doors ablies are inspected and accordance with NFPA 80,	K0761		door inspections were completed on 022 and recorded on the proper for			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN				DATE SURVEY PLETED	
		414290	B. WING			11/18/2022		
NAME OF PRO	I ER			STREET ADDRESS, CITY, STATE, 2320 E BELTLINE SE GRAND RAPIDS, MI 49546	DE			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on records review and interview, it was		ID PREFIX TAG	All reside by this Elemer	VIDER'S PLAN OF CORRECTION (EARECTIVE ACTION SHOULD BE CROSFERENCED TO THE APPROPRIATE DEFICIENCY) dents have the potential to be affer practice. It Three	(X5) COMPLETION DATE		
				The Plant Operations Manager re-educated the Maintenance Director to ensure monthly fire door inspections are completed. Element Four The Administrator/designee will conduct random audits of the inspection logs until substantial compliance has been attained and maintained to ensure that these drills are performed correctly and on time. The results will be presented to the QAA committee for review and consideration of further corrective actions. Element Five				
	determined that the required annual in doors assemblies in 8.3.3.1 and NFPA could potentially a facility. A delay in	e facility did not conduct the spection and testing of fire in accordance with LSC Section 80. This deficient practice affect all occupants of the in exiting the facility could exposure to a hazardous		assurin through	ministrator will be responsible for g substantial compliance is attain this plan of correction by 12/19/2 sustained compliance after that.	ed		
	between 11:00am current documenta testing of fire door 5.2.1. Last record	ere confirmed during an						
K0918 SS= F	records were revie	Maintenance #1 at the time the swed. ns - Essential Electric Syste ns - Essential Electric ance and Testing The	K0918		nt One enerators had fuel samples drawr o the lab for testing on 12/13/202:		12/19/2022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	(X3) DATE SURVEY COMPLETED			
		414290	B. WING _			11/18/	/2022
NAME OF PRO	ER	-	STREET ADDRESS, CITY, STATE, ZIP CODE				
SKLD BELTL	INE				2320 E BELTLINE SE GRAND RAPIDS, MI 49546		
(X4) ID PREFIX TAG	(EACH DEFICIENT FULL REGULATION	TEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	/IDER'S PLAN OF CORRECTION (E RECTIVE ACTION SHOULD BE CR FERENCED TO THE APPROPRIAT DEFICIENCY)	OSS-	(X5) COMPLETION DATE
	and associated a supplying service 10-second criter monthly test, a pannually confirm safety and critica and testing of the switches are per NFPA 110. Geneweekly, exercised times a year in 2 exercised once a continuous hours conditions include start and automa EES loads, and a personnel. Maintenergy power so accordance with circuit breakers a a program for personnel to the components is a manufacturer recomponents is a manufacturer recomponent is a manufacturer recomponent is a personnel for maintenance and separate from Minimizing the personnel for	er alternate power source equipment is capable of e within 10 seconds. If the ion is not met during the rocess shall be provided to this capability for the life al branches. Maintenance e generator and transfer formed in accordance with erator sets are inspected dunder load 30 minutes 12 0-40 day intervals, and every 36 months for 4 s. Scheduled test under load let a complete simulated cold accomplete simulated cold are conducted by competent tenance and testing of stored eurces (Type 3 EES) are in NFPA 111. Main and feeder are inspected annually, and triodically 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 row installations. 6.4.4, PA 99), NFPA 110, NFPA PA 70) MENT is not met as		Manual Elemen All resid by this Elemen The Plate educati ensure conduct Elemen The Adrandom test unt attained drills ar The residue Consider Elemen The Adrandom test unt attained drills ar The residue Consider Elemen The Adrandom test content attained consider Elemen The Adrandom The Adrandom Elemen El	at Two dents have the potential to be after practice. In Three ant Operations Manager complet on with the Maintenance Director the fuel sampling of the generat ted annually. It Four ministrator/designee will conduct a audits of the logs being kept of ill substantial compliance has been a dand maintained to ensure that e performed correctly and on time sults of the audits will be present a Committee for review and eration of further corrective actions.	fected red re- or to ors is t the en these ne. ed to ns.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

AND PLAN OF CORRECTION IDENTIF		(X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER: 414290		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 11/18/2022		
NAME OF PROVIDER OR SUPPLIER						STREET ADDRESS, CITY, STATE,	ZIP CO	DE	
SKLD BELTLINE						2320 E BELTLINE SE GRAND RAPIDS, MI 49546			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	COR	VIDER'S PLAN OF CORRECTION (E RECTIVE ACTION SHOULD BE CRO FERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE		
generator failure due to a lack of maintenance.									
Findings include:									
On 11/18/22 during the review of facility records between 11:00 am and 2:30pm, there was no documentation available for the annual emergency generator fuel sample testing per ASTM standards as required in NFPA 110, 8.3.8. These findings were confirmed during an interview with the Maintenance #1 at the time the records were reviewed.									