STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	134140	A. BUILDING _____ B. WING _____	**12/15/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOMENTOUS HEALTH AT BATTLE CREEK	**675 WAGNER DR BATTLE CREEK, MI 49017**

(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 December 15, 2022, an Emergency Preparedness Survey was conducted by the Michigan Department of Licensing and Regulatory Affairs, Bureau of Survey and Certification. At the survey Momentous Health at Battle Creek was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.73, Emergency Preparedness.	E0000		

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

Electronically Signed | 01/26/2023

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	134140	A. BUILDING _____ B. WING _____	12/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOMENTOUS HEALTH AT BATTLE CREEK	675 WAGNER DR BATTLE CREEK, MI 49017

(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
K0000 SS=	INITIAL COMMENTS On December 15, 2022, a Life Safety Recertification Survey was conducted by the Michigan Department of Licensing and Regulatory Affairs, Bureau of Survey and Certification. At the survey, Momentous Health At Battle Creek 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 one story with partial basement building of Type I (332) construction, built in 1968. There were two addition added to the original facility one in 1985, of Type I (111) and one in 1993, of Type I (332) construction. The building is fully sprinklered and has supervised smoke detection in the corridors and spaces open to the corridors. The facility has 82 certified beds. At the time of the survey the census was 59. The requirement at 42 CFR, subpart 483.90 (a) is NOT MET as evidenced by:	K0000		
K0222 SS= E	Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only	K0222	1. The South Unit fire exit door that failed to open after 15 seconds was promptly repaired to ensure this fire exit was viable for all residents. 2. All residents currently at the facility have the potential to be affected by this deficient practice. 3. All Fire Exit Doors Checked for Egress Weekly will be added to the TELS system.	1/31/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	134140	A. BUILDING _____ B. WING _____	12/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOMENTOUS HEALTH AT BATTLE CREEK	675 WAGNER DR BATTLE CREEK, MI 49017

(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
	one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected		The policy for door monitoring was updated on 1-12-2023 by the QAPI Team to include weekly checks and documentation of those door checks. 4. All door checks will be verified weekly by the Director of Maintenance x4 and monthly thereafter. Results will be reported to QAPI Committee for compliance and process improvement. 5. The Administrator is responsible for this plan of correction.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	134140	A. BUILDING _____ B. WING _____	12/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOMENTOUS HEALTH AT BATTLE CREEK	675 WAGNER DR BATTLE CREEK, MI 49017

(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
	throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure doors in a required means of egress are not equipped with a latch or lock that requires the use of a tool or key from the egress side unless meeting the special locking arrangements for clinical needs in accordance with 19.2.2.2.5.1 and 19.2.2.2.6, special needs locking arrangements in accordance with 19.2.2.2.5.2, delayed egress locking in accordance with 19.2.2.2.4, access-controlled egress doors in accordance with 19.2.2.2.4, or elevator lobby exit access in accordance with 19.2.2.2.4. This deficient practice could affect 30 occupants in the event of a fire emergency. Findings Include: On 06/08/22 at approximately 3:31 PM observation revealed the facility failed to maintain emergency exit door located at the end of the hall of South Wing in between Laundry and HR office. The 15 second delayed egress door failed to activate and open upon testing. This finding was confirmed with Facility Maintenance at the time of observation			
K0324 SS= F	Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used	K0324	1. The vent hood was cleaned on 12/27/2022. 2. All residents have the potential to be affected. 3. The cleaning of the vent a hood every six months was added to the preventive maintenance schedule in TELS by the Director of Environmental Services/Designee	1/31/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	134140	A. BUILDING _____ B. WING _____	12/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOMENTOUS HEALTH AT BATTLE CREEK	675 WAGNER DR BATTLE CREEK, MI 49017

(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
	for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure cooking facilities are protected in accordance with NFPA 96, unless meeting the requirements of 19.3.2.5.2, 19.3.2.5.3 or 19.3.2.4.4, as required by 19.3.2.5.1 through 19.3.2.5.5, 9.2.3 and TIA 12-2. This deficient practice could affect all occupants in the event of a fire emergency. Findings Include: On 12/15/22, between the hours of 9:30 AM & 1:30 PM, record review revealed the semi-annual cleaning service for the Kitchen Hood is past due. Systems serving moderate-volume cooking operations are required to have semi-annual cleanings per NFPA 96-11.4. Last recorded service on the Kitchen Hood cleaning was February 2022. This finding was confirmed by interview with Facility Maintenance at the time of record review.		to ensure the completion of the cleaning every six months. 4. All TELS preventive maintenance logs and schedule logs will be brought to monthly QAPI Meeting for trending and ongoing process improvement. 5. The Administrator is responsible for this plan of correction.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	134140	A. BUILDING _____ B. WING _____	12/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOMENTOUS HEALTH AT BATTLE CREEK	675 WAGNER DR BATTLE CREEK, MI 49017

(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
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 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 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, and records are readily available as required by 19.6.1.3, 9.6.1.5, NFPA 70 and NFPA 72. This deficient practice could affect all occupants in the event of a fire emergency Findings Include: On 12/15/22 between the hours of 9:30 AM and 1:30 PM record review revealed the facility failed to provide documentation of the required bi-annual Sensitivity Test for the installed fire alarm system. No documentation of the requested document was provided by the exit of the survey. This finding was confirmed by interview with Facility Maintenance at the time of record review.	K0345	1. The sensitivity test was completed on 1/10/2023. 2. This has the potential to affect all residents. 3. A quarterly check on sensitivity testing was added to the TELS preventive maintenance system to remind maintenance personnel of the need to verify a current sensitivity test is on record at all times. Maintenance was educated on this new process. 4. All TELS logs related to sensitivity testing verification will be brought to monthly QA and trended for accuracy and process improvement. 5. The Administrator is responsible for this plan of correction.	1/31/2023
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	K0353	1. On 1/11/2023 the Sprinkler vendor came in and did the 5 year internal inspection, the 5 year check valve inspection, the 5 year pressure gage checks and replaced the sprinklers in the North Oxygen room and	1/31/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	134140	A. BUILDING _____ B. WING _____	12/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOMENTOUS HEALTH AT BATTLE CREEK	675 WAGNER DR BATTLE CREEK, MI 49017

(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
	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 ensure the automatic sprinkler and standpipe systems are inspected, tested and maintained in accordance with NFPA 25, and records are readily available as required by 9.7.5, 9.7.7, 9.7.8 and NFPA 25. This deficient practice could affect all occupants in the event of fire emergency. Findings Include: 1. On 12/15/22 between the hours of 9:30 am & 1:30 PM, record review revealed the facility failed to provide documentation of the 5-year internal inspection of piping for the sprinkler system as required in NFPA 25. No documents were provided for review by the exit of the survey. 2. On 12/15/22 between the hours of 9:30 am & 1:30 PM, record review revealed the facility failed to provide documentation of the 5-year inspection of the check valve for the sprinkler system as required in NFPA 25. No documents		North Storage room. 2. All residents have the potential to be affected. 3. A quarterly audit of all sprinkler heads will be added to the TELS system for preventive maintenance tracking and an audit completed every quarter. All Maintenance staff were educated on 1/24/2023 on the revised process. 4. All audits will be brought to QAPI each quarter for trending and process improvement for the next 12 months and then re-evaluated for extension. 5. The Administrator is responsible for this plan of correction.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	134140	A. BUILDING _____ B. WING _____	12/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOMENTOUS HEALTH AT BATTLE CREEK	675 WAGNER DR BATTLE CREEK, MI 49017

(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
	were provided for review by the exit of the survey. 3. On 12/15/22 between the hours of 9:30 am & 1:30 PM, record review revealed the facility failed to provide documentation of the 5-year replacement or recalibrating of the pressure gages for the sprinkler system as required in NFPA 25. No documents were provided for review by the exit of the survey. 4. On 12/15/22 between the hours of 9:30 am & 1:30 PM, record review revealed the facility failed to provide documentation for the third quarter sprinkler flow test. No documentation was provided for the quarterly sprinkler flow test listed by the exit of survey. 5. On 12/15/22 at approximately 3:05 PM, observation revealed the in the North oxygen storage room and dining activities North storage room has sprinkler heads dated 1967. Sprinkler heads over 50 years old are required to be replaced or tested. These findings were confirmed by interview with Facility Maintenance at the time of record review and observation.			
K0362 SS= D	Corridors - Construction of Walls Corridors - Construction of Walls 2012 EXISTING Corridors are separated from use areas by walls constructed with at least 1/2-hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the transfer of smoke. In nonsprinklered buildings, walls extend to the underside of the floor or roof deck above the ceiling. Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Fixed fire window assemblies in corridor walls are in	K0362	1. The fire penetration was fixed on 1/5/2023. 2. All residents have the potential to be affected by this. 3. The monthly audit of all facility firewalls for any penetrations was added to TELS for monthly preventive maintenance. Maintenance was educated on 1/24/2023 on the revised process. 4. All audits will be reviewed for trends and brought to monthly QAPI Meeting for trending and process improvement for the next 12 months and longer, if indicated. 5. The Administrator is responsible for this	1/31/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	134140	A. BUILDING _____ B. WING _____	12/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOMENTOUS HEALTH AT BATTLE CREEK	675 WAGNER DR BATTLE CREEK, MI 49017

(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
	accordance with Section 8.3, but in sprinklered compartments there are no restrictions in area or fire resistance of glass or frames. If the walls have a fire resistance rating, give the rating _____ if the walls terminate at the underside of the ceiling, give brief description in REMARKS, describing the ceiling throughout the floor area. 19.3.6.2, 19.3.6.2.7 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure corridors are separated from use areas by walls of at least 1/2-hour fire resistance rating or meet the requirements of smoke partitions in smoke compartments protected throughout by a supervised, automatic sprinkler system as required by 19.3.6.2 and 19.3.6.2.7. This deficient practice could affect 8 occupants in the event of fire emergency. Findings Include: On 12/15/22 at approximately 3:17 PM, observation revealed the corridor wall starting at room 117 to room 118 in the North Unit has an unsealed penetration crack along the wall above and below the suspended ceiling approximately 1/2" wide and 12' long. This was confirmed by interview with Facility Maintenance at the time of observation.		plan of correction.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	134140	A. BUILDING _____ B. WING _____	12/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOMENTOUS HEALTH AT BATTLE CREEK	675 WAGNER DR BATTLE CREEK, MI 49017

(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
K0371 SS= F	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 record review 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 all occupants in the event of a fire emergency. Findings Include: On 12/15/22 between the hours of 09:30 AM and 1:30 PM record review revealed the facility failed provide proper documentation of a floor plan that identified smoke barrier walls. No documentation of the smoke barrier walls was provided by the exit of the survey. This was confirmed by interview with the Facility Maintenance at the time of record review.	K0371	1. The floor plan was updated on 12/28/2022 and now includes the smoke barriers. 2. All residents have the potential to be affected. 3. A review of the disaster plan to include the review of the disaster plan map to include smoke barriers was added to TELS for ongoing preventive maintenance. Maintenance was educated on 1/24/2023. 4. The disaster plan review, including the disaster plan map, will be brought to QAPI Meeting monthly for review and process improvement. 5. The Administrator is responsible for this plan of correction.	1/31/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	134140	A. BUILDING _____ B. WING _____	12/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOMENTOUS HEALTH AT BATTLE CREEK	675 WAGNER DR BATTLE CREEK, MI 49017

(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
K0372 SS= E	Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure smoke barriers were constructed to a minimum 1/2-hour fire resistance rating in accordance with 8.5, as required by 19.3.7.3 and 8.6.7.1(1). This deficient practice could affect 30 occupants in the event of a fire emergency. Findings Include: 1. On 12/15/22 at approximately 2:35 PM, observation revealed above the suspended ceiling at the smoke barrier doors located at the entrance North Double doors is an unsealed penetration approximately 2"x 2" along the sprinkler piping. 2. On 12/15/22 at approximately 2:46 PM, observation revealed above the suspended ceiling at the smoke barrier doors #9 located in the North Unit is an unsealed penetration approximately 1"x 1" along the data wires. These findings were confirmed by interview with facility maintenance at the time of observation.	K0372	1. The penetrations for the North Double Doors and North Unit #9 were fixed on 1/5/2023. 2. All residents have the potential to be affected. 3. The monthly audit of all facility firewalls for any penetrations was added to TELS for monthly preventive maintenance. Maintenance was educated on 1/24/2023 on the revised process. 4. All audits will be reviewed for trends and brought to monthly QAPI Meeting for trending and process improvement for the next 12 months and longer, if indicated. 5. The Administrator is responsible for this plan of correction.	1/31/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	134140	A. BUILDING _____ B. WING _____	12/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOMENTOUS HEALTH AT BATTLE CREEK	675 WAGNER DR BATTLE CREEK, MI 49017

(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
K0761 SS= D	Maintenance, Inspection & Testing - Doors Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, 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 observation, record review and interview, the facility failed to inspect and test annually in accordance with NFPA 101, 19.7.6, 8.3.3.1 and NFPA 80, Standard for Fire Doors and Other Opening Protectives 5.2, 5.2.3. 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. This deficient practice could affect 30 occupants in the event of a fire emergency. Findings Include: On 12/15/22 between the hours of 9:30 AM and 1:30 PM, record review revealed the facility failed to correct the deficiency from the fire door inspection report dated 11/2021. The updated	K0761	1. The door was repaired by the outside vendor on 1/26/2023. 2. All residents have the potential to be affected. 3. The Policy for Preventive Maintenance checks for the fire doors was reviewed by the QAPI Team and updated. Monthly Preventive Maintenance checks were added to TELS that include verification of the safety of the fire doors. Maintenance was educated on 1/24/2023. 4. Preventive Checks of the Fire Doors will be completed monthlyx3. Results will be brought to QAPI for trending and process improvement. 5. The Administrator is responsible for this plan of correction.	1/31/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	134140	A. BUILDING _____ B. WING _____	**12/15/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOMENTOUS HEALTH AT BATTLE CREEK	**675 WAGNER DR BATTLE CREEK, MI 49017**

(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
	annual from 11/2022 reveals the same deficiency noted of an open hole on edge of door. Observation revealed at approximately 3:20 PM, and confirmed an open hole on the edge of the door #8 was not covered with like materials. This was confirmed by interview with Facility Maintenance at the time of record review and observation.			