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	614010	A. BUILDING ______ B. WING ______	4/20/2023

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CHRISTIAN CARE NURSING CENTER	**2053 S SHERIDAN DRIVE MUSKEGON, MI 49442**

(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 April 20, 2023, an Emergency Preparedness Survey was conducted by the Michigan Department of Licensing and Regulatory Affairs, Bureau of Survey and Certification. At the survey Christian Care Nursing Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.73, Emergency Preparedness.	E0000		
E0006 SS= F	Plan Based on All Hazards Risk Assessment §403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2), §441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §483.475(a)(1)-(2), §484.102(a)(1)-(2), §485.68(a)(1)-(2), §485.542(a)(1)-(2), §485.625(a)(1)-(2), §485.727(a)(1)-(2), §485.920(a)(1)-(2), §486.360(a)(1)-(2), §491.12(a)(1)-(2), §494.62(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach. (2) Include strategies for addressing emergency events	E0006		

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

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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	identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment. *[For ICF/IIDs at §483.475(a):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to maintain an Emergency Preparedness plan that must be reviewed and updated annually and be based on and include a documented, facility-based and community based risk assessment, utilizing an all-hazards approach, including missing residents, and include strategies for addressing emergency events identified by the risk assessment by failing to conduct a facility-based and			

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	community based risk assessment resulting in the potential for failure to identify hazards associated with the facility and less than optimal outcomes for all facility occupants in the event of an emergency. Findings include: On 4/20/2023 at 11:45 am, onsite health surveyors #1 and #2 observed a loud warning alarm coming from outside the facility in the direction of the nearby correctional facility which was determined to be and verified as a prison escapee alarm. An interview was conducted with staff AM and the DON as to what action should be taken inside the facility during a prison escapee alarm notification. The DON stated they should lock the doors and remove key code access. The Administrator stated he was not aware of a procedure under their current emergency preparedness plan for a prison break. This surveyor and health surveyor #1 and #2 did not witness any announcement or procedures taken inside the facility during the prison escapee alarm. On 4/20/2023 between 1:00 pm and 2:00 pm, a review of the facility emergency preparedness plan revealed the LTC's facility's close proximity to the correctional facility was not listed or considered within the hazard vulnerability assessment of the emergency plan nor was there a documented plan of action to secure the facility in case of a prison escapee alarm notification warning was given in the area. This finding was confirmed by interview with Administrator and Maintenance Director at the time of observation.			

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K0000 SS=	INITIAL COMMENTS On April 20, 2023, a Life Safety Recertification Survey was conducted by the Michigan Department of Licensing and Regulatory Affairs, Bureau of Survey and Certification. At the survey, Christian Care Nursing Center 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 building of type V (111) construction, built in 2011. The building is fully sprinklered and has supervised smoke detection in the corridors and spaces open to the corridors. The facility has 49 certified beds. At the time of the survey the census was 30. The requirement at 42 CFR, subpart 483.90 (a) is NOT MET as evidenced by:	K0000		
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	K0353		

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	______________________________ 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, 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 potentially affect all occupants and staff in the event sprinklers are not identified and available at the time of a system malfunction that requires repair or replacement of certain sprinklers on the fire protection system. Findings Include: On 4/20/23 at approximately 12:45 PM observation revealed there was no list of spare sprinklers at the spare sprinkler cabinet located at the sprinkler riser within the mechanical room. This finding was confirmed by interview with the facility Maintenance Director at the time of observation. As required by NFPA 13 6.2.9.7 2010 edition.			
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	K0372		

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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 potentially affect **30** occupants within the smoke compartment in the event the transfer of smoke penetrates the resident corridor at the time of a fire..

Findings Include:

1. On 4/20/23 at approximately 11:05 AM observation revealed penetrations surrounding a 2 inch electrical conduit and wire bundles above the ceiling at the cross corridor doors located off the main hall leading to faith and hope hall. This finding was confirmed by interview with the facility Maintenance Director at the time of observation. As required by 8.5.6.2

2. On 4/20/23 at approximately 11:08 AM observation revealed open penetrations above the ceiling at the cross corridor doors located at faith hall near the linens room. This finding was confirmed by interview with the facility Maintenance director at the time of observation.

3. On 4/20/23 at approximately 11:11 AM observation revealed open penetrations above the ceiling at the smoke barrier wall within the soiled utility room located at faith hall. This finding was confirmed by interview with the facility Maintenance Director at the time of observation.

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	4. On 4/20/23 at approximately 11:17 AM observation revealed penetrations surrounding electrical conduit above the ceiling at the cross corridor doors near room F15 located at faith hall. This finding was confirmed by interview with the facility Maintenance Director at the time of observation.			
K0754 SS= D	Soiled Linen and Trash Containers Soiled Linen and Trash Containers Soiled linen or trash collection receptacles shall not exceed 32 gallons in capacity. The average density of container capacity in a room or space shall not exceed 0.5 gallons/square feet. A total container capacity of 32 gallons shall not be exceeded within any 64 square feet area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gallons shall be located in a room protected as a hazardous area when not attended. Containers used solely for recycling are permitted to be excluded from the above requirements where each container is less than or equal to 96 gallons unless attended, and containers for combustibles are labeled and listed as meeting FM Approval Standard 6921 or equivalent. 18.7.5.7, 19.7.5.7 This REQUIREMENT is not met as evidenced by: Based on observation, and interview, the facility failed to ensure that soiled linen or trash containers did not exceed 32 gallons in capacity or an average density of .5 gal/sq. ft. as required by 19.7.5.7. This deficient practice could potentially affect 15 occupants within the nearest smoke compartment in the event a fire occurs at or within the soiled utility trash container that exceeds 32 gallons.	K0754		

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	Findings Include: On 4/20/23 at approximately 11:44 observation revealed the soiled utility room located at faith hall contained a non approved trash container of 45 gallons unattended. This finding was confirmed by interview with the facility Maintenance Director at the time of observation. As required by 19.7.5.7			
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, 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	K0761		

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	available for review. This deficient practice could potentially affect occupants within the smoke compartment in the event of a fire within the faith hall small kitchen and the fire door separting the kitchen from dining hall fails to operate as designed. Findings Include: On 4/20/23, at approximately 11:40 AM observation revaled the fire shutter door separating the faith hall serving kitchen from the dining was passed due for the required annual service inspection. A tag on the door titled "Total Fire Protection door inspection" revealed a last date of inspection of 3/11/22. This finding was confirmed by interview with the facility Maintenance Director at the time of observation As rquired by NFPA 80 5.2			
K0918 SS= F	Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored	K0918		

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	energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure generators or other alternative power sources and associated equipment is capable of supplying service within 10 seconds, is maintained, inspected, tested and exercised in accordance with NFPA 110, and records are readily available as required by 6.4.4, 6.5.4 and 6.6.4 of NFPA 99, NFPA 110, NFPA 111 and 700.10 of NFPA 70. This deficient practice could potentially affect all occupants and staff in the event the generator fails to start as a result of defective batteries. Findings Include: On 4/20/23 between 8:45am and 10:30am record review revealed the facility failed to provide documentation of specific gravity testing or conductivity testing on the batteries of the diesel fuel generator. This finding was confirmed by interview with the facility Maintenance Director at the time of observation. As required by NFPA 99 6.4.4.1.3 2012 edition.			

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K0923 SS= D	Gas Equipment - Cylinder and Container Storag Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited-combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by:	K0923		

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	Based on observation, and interview, the facility failed to ensure storage of nonflammable gasses meet all requirements of 11.3.1 through 11.3.4 and 11.6.5 of NFPA 99. This deficient practice could potentially affect occupants in the event an empty oxygen cylinder was provided to a occupant by accident for failure to distinguish full from empty cylinders.. Findings Include: 1. On 4/20/23 at approximately 11:42 AM observation revealed the facility failed to post full and empty signs within the oxygen cylinder storage closet located off the main corridor near faith hall. This finding was confirmed by interview with the facility Maintenance Director at the time of observation. As required by NFPA 99 11.6.3 2. On 4/20/23 at approximately 11:42 AM observation revealed combustible storage within 5 feet of the oxygen storage. Card board boxes ,paper and plastics were observed stored within the oxygen storage closet.			