STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	414290	A. BUILDING _____ B. WING _____	**5/8/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000 SS=	Initial Comments On May 8, 2023, a complaint intake MI00135257, Emergency Preparedness Survey was conducted by the Michigan Department of Licensing and Regulatory Affairs, Bureau of Survey and Certification. At the survey, SKLD Beltline was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.73, Emergency Preparedness. The complaint alleges the facility failed to respond appropriately to a facility fire. Allegations are substantiated with deficiencies.	E0000		
E0031 SS= F	Emergency Officials Contact Information §403.748(c)(2), §416.54(c)(2), §418.113(c)(2), §441.184(c)(2), §460.84(c)(2), §482.15(c)(2), §483.73(c)(2), §483.475(c)(2), §484.102(c)(2), §485.68(c)(2), §485.542(c)(2), §485.625(c)(2), §485.727(c)(2), §485.920(c)(2), §486.360(c)(2), §491.12(c)(2), §494.62(c)(2). [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following: (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. *[For LTC Facilities at §483.73(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) The State Licensing and Certification Agency. (iii) The Office of the State Long-Term Care Ombudsman. (iv)	E0031		

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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	414290	A. BUILDING _____ B. WING _____	**5/8/2023**

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	Other sources of assistance. *[For ICF/IIDs at §483.475(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. (iii) The State Licensing and Certification Agency. (iv) The State Protection and Advocacy Agency. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to develop emergency officials contact information for Federal, State, tribal, regional, or local emergency preparedness staff including: the state licensing and certification agency, the office of the state long-term care ombudsman and other sources of assistance. This deficient practice could affect all occupants in the event of staff not following written procedures during an emergency event. Findings Include: On 5/8/23 during the review of facility records between 3:00pm and 4:00pm, the procedures for reporting a fire were stated in the facility's Emergency Preparedness Manual with the correct LARA contact information for the event. The facility received an alarm activation in the Activities room, resulting in a Grand Rapids Fire Department response, while making popcorn which occurred at approximately 2:15pm on 3/23/23. The incident was not reported to the State Agency. The Administrator in an exit interview stated she did not realize it was a fire because the popcorn was not even burnt. The Maintenance Director added that the popcorn machine was unknowingly placed under a smoke detector in			

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	the Activities room before use.			
K0000 SS=	INITIAL COMMENTS On May 8, 2023, a complaint intake MI00135648, Life Safety Code Survey was conducted by the Michigan Department of Licensing and Regulatory Affairs, Bureau of Survey and Certification. At the survey SKLD Beltline was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, subpart 483.90(a), Life Safety from Fire and the applicable provisions of the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety code and the 2012 Edition of NFPA 99, Health Care Facilities Code. The complaint alleges the facility failed to respond appropriately to a facility fire. The facility is a single story building of type II (000) construction built in 1961, with additions in 1968, 1971 and 1993. The building is fully sprinklered and has supervised smoke detection in the corridors and spaces open to the corridors. The facility has 182 certified beds. At the time of the survey the census was 121. An exit conference was held at the conclusion of the survey. The results of the inspection were discussed with the Administrator, Assistant Administrator, and the Maintenance Director. The requirement at 42 CFR, subpart 483.90(a) is met as evidenced by:	K0000		