STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	414090	A. BUILDING _____ B. WING _____	**7/11/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPECTRUM HEALTH REHAB AND NURSING CENTER	**4118 KALAMAZOO AVE S E GRAND RAPIDS, MI 49508**

(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 July 11, 2023, an Emergency Preparedness Survey was conducted by the Michigan Department of Licensing and Regulatory Affairs, Bureau of Survey and Certification. At the survey, Spectrum Health Rehab and Nursing Center was found to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.73, Emergency Preparedness. The facility has 165 certified beds. At the time of the survey the census was 127. An exit conference was held at the conclusion of the survey. The results of the inspection were discussed with the Administrator, Plant Operations Supervisor, and the Maintenance Director. The requirement at 42 CFR, subpart 483.73 was determined to be met at the time of this survey.	E0000		

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

Electronically Signed | 07/25/2023

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
	414090	A. BUILDING _____ B. WING _____	**7/11/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPECTRUM HEALTH REHAB AND NURSING CENTER	**4118 KALAMAZOO AVE S E GRAND RAPIDS, MI 49508**

(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 July 11, 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, Spectrum Health Rehab and 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 Association (NFPA) 101, Life Safety Code (LSC) and the 2012 Edition of NFPA 99, Health Care Facilities Code. The facility is a two story building of type II(111) construction, with partial basement, built in 2016. The building is fully sprinklered and has supervised smoke detection in the corridors and spaces open to the corridors. The facility has 165 certified beds. At the time of the survey the census was 127. An exit conference was held at the conclusion of the survey. The results of the inspection were discussed with the Administrator, Plant Operations Supervisor, and the Maintenance Director. The requirement at 42 CFR, subpart 483.90(a) is not met as evidenced by:	K0000		
K0321 SS= E	Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire	K0321	This plan of correction does not constitute an admission or agreement by the provider of truth of the facts alleged or conclusion set forth on this statement of deficiencies. This plan of correction is prepared solely because it is required by State and Federal law. Spectrum Health Rehab and Nursing Center	8/7/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	414090	A. BUILDING _____ B. WING _____	7/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPECTRUM HEALTH REHAB AND NURSING CENTER	4118 KALAMAZOO AVE S E GRAND RAPIDS, MI 49508

(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
	extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide Hazardous areas protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. This deficient practice could affect occupants, staff and visitors in the event the storage room door fails to close and positive latch to prevent the transfer of smoke and heat into the residents corridor in case of a fire in the converted respiratory storage room..		wishes to have this plan of correction stand as its written statement of compliance. K321 Hazardous Area - Enclosure LSC 8.4, 8.7.1, 8.7.1.3, and 19.3.5.9 Element #1 Storage Room #s 2354 and 2181 were without a door closer and failed to automatically close and positive latch. Storage Room #s 2179 and 1362 were without a door closer. Storage Room #1618 failed to positive latch. Element #2 All storage doors have the potential to be affected. A facility wide audit was conducted of all facility storage doors and Storage Room #2433 was additionally noted without a door closer. Element #3 Work Order # 241560 Fire Marshal □ Storage Rooms missing automatic door closer in rooms 1362, 1618, 2179, 2181, 2354 The facility has reviewed the LSC 8.4, 8.7.1, 8.7.1.3, and 19.3.5.9 and has determined that the completed Work Order meets current standards according to regulatory guidelines for K321. Element #4 Self or automatic-closing and positive latch mechanisms have been installed properly. Element #5 The facility is confident that this corrective measure will be successfully implemented by August 7, 2023.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	414090	A. BUILDING _____ B. WING _____	**7/11/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPECTRUM HEALTH REHAB AND NURSING CENTER	**4118 KALAMAZOO AVE S E GRAND RAPIDS, MI 49508**

(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
	Findings Include: 1. On 7/11/23 at approximately 9:56 AM, observation revealed the converted respiratory storage room #2354 located on the 2nd floor that was previous designated a lab room was without a door closer and failed to automatically close and positive latch upon testing. This finding was confirmed by interview with Maintenance # 1 and # 2 at the time of observation as required by 8.7.1.3. 2. On 7/11/23 at approximately 10:20 AM, observation revealed the converted respiratory storage room # 2181 located on the 2nd floor that was previous designated a lab room was without a door closer and failed to automatically close and positive latch upon testing. This finding was confirmed by interview with Maintenance #1 and #2 at the time of observation. 3. On 7/11/23 at approximately 10:23 AM, observation revealed the Covid storage room #2179 located on the second floor was without a door closer. This finding was confirmed by interview with facility Maintenance #1 and #2 at the time of observation. 4. On 7/11/23 at approximately 10:40 AM, observation revealed the storage room # 1362 located on the 1st floor south was without a door closer. This finding was confirmed by interview with facility Maintenance #1 and #2 at the time of observation. 5. On 7/11/23 at approximately 11:24 AM, observation revealed the wheel chair storage room door #1618 located on the 1st floor failed to positive latch.			
K0923	Gas Equipment - Cylinder and Container	K0923	This plan of correction does not constitute an	8/7/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	414090	A. BUILDING _____ B. WING _____	7/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPECTRUM HEALTH REHAB AND NURSING CENTER	4118 KALAMAZOO AVE S E GRAND RAPIDS, MI 49508

(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
SS= D	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:		admission or agreement by the provider of truth of the facts alleged or conclusion set forth on this statement of deficiencies. This plan of correction is prepared solely because it is required by State and Federal law. Spectrum Health Rehab and Nursing Center wishes to have this plan of correction stand as its written statement of compliance. K923 Gas Equipment □ Cylinder and Container Storage LSC 11.3.1 through 11.3.4 and 11.6.5 of NFPA 99 Element #1 2nd floor oxygen storage room (#2505G) contained 3 partially empty tanks mixed in with the full tanks. Element #2 All oxygen storage rooms have the potential to be affected. All oxygen storage rooms were audited with no identified concerns. Element #3 Oxygen storage rooms will be standardized to allow for storage of oxygen cylinders which clearly designate FULLEMPTY, and PARTIAL cylinders. Work Order # 241967 Standardize O2 Storage Labeling The facility has reviewed the LSC 11.3.1 through 11.3.4 and 11.6.5 of NFPA 99 and has determined that the completed Work Order meets current standards according to regulatory guidelines for K923. All Spectrum Health Rehab and Nursing Center team members will be re-educated on proper storage of oxygen tanks in oxygen	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	414090	A. BUILDING _____ B. WING _____	**7/11/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPECTRUM HEALTH REHAB AND NURSING CENTER	**4118 KALAMAZOO AVE S E GRAND RAPIDS, MI 49508**

(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
	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 case of an emergency and the available oxygen supply cylinders is insufficient. to provide to a resident in need. Findings Include: On 7/11/23 at approximately 10:00 AM, observation revealed the 2nd floor oxygen storage room contained three partially empty tanks mixed in with the full tanks. This finding was confirmed by interview with the facility Maintenance #1 and #2 at the time of observation as required by NFPA 99, 11.6.5.2.		storage rooms. Elements #4 Clear labeling for designated storage areas of oxygen cylinders in all oxygen storage rooms has been completed. Element #5 The facility is confident that this corrective measure will be successfully implemented by August 7, 2023.	