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 _____	**8/23/2023**

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
K0000 SS=	INITIAL COMMENTS On August 23, 2023, a complaint intake MI00138922, Life Safety Code Survey was conducted by the Michigan Department of Licensing and Regulatory Affairs, Bureau of Survey and Certification. The facility is a single story structure determined to be type II(000) construction. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors and is fully sprinklered. The facility has 182 certified beds. The complaint alleges on 08/22/23 at approximately 9:20 am, the housekeeper started to use the microwave in the staff room in the service hallway. She had bread in a covered plastic container. She can't recall how many minutes she had put in to warm up the bread though recalls pushing 77. The smoke triggered the fire alarm, resulting in the fire department coming to the facility between 9:25-9:30 am. When the fire department arrived at the facility, the housekeeper had unplugged the microwave. The event ended at 9:45 am. Based on records review, observation, and interview the facility followed the emergency procedures as required in the event of a fire. The microwave was removed from the facility and replaced by a new one. Inspection of the electrical outlet showed no signs of damage. A new sign was installed in the Breakroom on items that should not be used in the Microwave. There was no odor of smoke in the area. These findings were confirmed during an interview with Maintenance #1 at the time the items were observed and reviewed.	K0000		

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

Electronically Signed | 10/12/2023

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.

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	At the survey SKLD Beltline was found to be 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 was determined to be substantiated with no citations.			