STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	824350	A. BUILDING _____ B. WING _____	**12/7/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUR SEASONS NURSING CENTER OF WESTLAND	**8365 NEWBURGH RD WESTLAND, MI 48185**

(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 7, 2023, an Emergency Preparedness Survey was conducted by the Michigan Department of Licensing and Regulatory Affairs, Bureau of Survey and Certification. At the survey, Four Seasons Nursing Center Of Westland was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.73, Emergency Preparedness.	E0000		
E0039 SS= F	EP Testing Requirements §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is	E0039	Element #1 The required EP testing Requirement drill took place on 6/1/23 related to Active Shooter, documents were not given at time of survey. On 12/27/23 facility will complete EP Table top exercise on Active Shooter. Element #2 The Administrator and Maintenance Director have been educated on EP testing requirements for E039 and facility policy for Emergency Preparedness. Element #3 The Maintenance Director will audit monthly required drills to ensure yearly EP Testing Requirement is met. Deficiencies will be immediately corrected. Findings will be submitted to the facility Quality Assurance Performance Committee for review and further recommendation until substantial compliance is achieved and maintained. Element #4 The Maintenance Director is responsible for continued monitoring. The Administrator is responsible for continued regulatory compliance. Date of compliance: 1/12/23	1/12/2024

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

Electronically Signed | 12/21/2023

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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	not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a			

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	group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise			

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	that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. * [For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the			

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	emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based			

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	functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency			

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	events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d) (2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a			

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	facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The facility must participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the facility based experiences an			

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	actual natural or man-made emergency that requires activation of the emergency plan, the facility is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event. The facility must conduct an additional exercise that may include, but is not limited to a second full-scale exercise that is community-based or individual, facility-based. A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. The facility must analyze the response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the facility's emergency plan, as needed. This deficient practice could affect all 151 facility residents in the event of a fire or other facility or community-wide incident. Findings Include: On December 7, 2023 at 2:10 PM, record review revealed the facility failed to provide documentation the their required table-top exercise for calendar year 2023. No supporting documentation was presented to surveyor by the time of surveyor exit. These findings were confirmed interview with the facility Maintenance Assistance and Director at the time of record review.			

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K0000 SS=	INITIAL COMMENTS On December 7, 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, Four Seasons Nursing Center of Westland was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 482.90(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 1 story building of Type II (222) construction, built in 1961. The building is fully sprinklered and has supervised smoke detection in the corridors and spaces open to the corridors. The facility has 180 certified beds. At the time of the survey the census was 151.	K0000		
K0211 SS= E	Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure aisles, passageways, corridors, exit discharges, exit locations and accesses are in accordance with Chapter 7, and continuously	K0211	Element #1 The Summer wing exit door has been repaired to open with reasonable force. The padlock was removed from the patio exit gate by Autumn wing. The Physical Therapy Room exit door has been repaired to open with reasonable force. The Autumn wing day room single door top hinge has been corrected to allow door to close to a tight smoke tight fit. Element #2 The maintenance staff have been educated on K 211 requirements. The Maintenance Director has conducted rounds to ensure the means of egress is continuously free of all obstruction to full use in case of an emergency.	1/12/2024

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	maintained free of all obstructions to full use in case of an emergency as required by 19.2.1 and 7.1.10.1. This deficient practice could affect 30 of the 151 residents in the event of a fire. Findings Include: 1) On December 7, 2023, at approximately 11:40 AM observation revealed the exit door for the Summer wing did not open with reasonable force as required by NFPA 101 2012 edition, 7.2.1.4.5.1. 2) On December 7, 2023, at approximately 1:06 PM observation revealed the patio gate exit by the Autumn Wing had a posted exit sign and the gate was padlocked. This deficient practice could result in residents unable to exit in an emergency. 3) On December 7, 2023, at approximately 12:47 PM observation revealed the Physical Therapy Room exit door to the outside did not open with a reasonable amount of force as required by NFPA 101 2012 edition, 7.2.1.4.5. 4) On December 7, 2023, at approximately 1:16 PM observation revealed the Autumn Wing Dayroom single door top hinge was installed on the front side of the door. This deficient practice could potentially result in the door not closing to a smoke-tight fit. These findings were confirmed by the Maintenance Director at the time of observation and interview.		Element #3 The Maintenance Director or designee will audit Means of Egress daily to ensure the means of egress is continuously free of all obstruction to full use in case of an emergency. Deficiencies will be immediately corrected. Findings will be submitted to the facility Quality Assurance Performance Committee for review and further recommendation until substantial compliance is achieved and maintained. Element #4 The Maintenance Director is responsible for continued monitoring. The Administrator is responsible for continued regulatory compliance.	
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	K0222	Element #1 a. Signage was placed on the Autumn door stating Pull until alarm sounds door can be opened in 15 seconds b. The audible alarm by the gate has been	1/12/2024

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	locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only 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		repaired to produce sound. Element #2 All residents residing in the facility have the potential to be affected by citied practice. The Maintenance Director has completed rounds to ensure egress doors have proper signage and those with audible alarms have sound. Element #3 The maintenance staff has been educated on K 222 requirements. The Maintenance Director or designee will conduct daily audits to ensure proper signage is posted, and those alarms with audible sound have proper volume. Deficiencies will be immediately corrected. Findings will be submitted monthly to the facility Quality Assurance Performance Committee for review and further recommendation until substantial compliance is achieved and maintained. Element #4 The Maintenance Director is responsible for continued monitoring. The Administrator is responsible for continued regulatory compliance.	

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	824350	A. BUILDING _____ B. WING _____	**12/7/2023**

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	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 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 of the 151 residents in the event of a fire. Findings Include: 1) On December 7, 2023, at approximately 11:52 AM observation revealed the Autumn clinical needs wing 15 second delayed egress door does not have approved signage "PULL UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS" for door operation as required by NFPA 101 2012 edition, 7.2.1.6.1.1 (4). 2) On December 7, 2023, at approximately 1:04 PM observation revealed the fence gate for the patio area has delayed egress with signage stating, "PUSH UNTIL ALARM SOUNDS, DOOR WILL OPEN IN 15 SECONDS." No required			

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	audible alarm by the gate sounded when the gate was tested. These findings were confirmed by the Maintenance Director at the time of observation and interview.			
K0223 SS= E	Doors with Self-Closing Devices Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure doors in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area are self-closing and kept in the closed position unless held open in accordance with 7.2.1.8.2, as required by 19.2.2.2.7 and 19.2.2.2.8. This deficient practice could affect 12 of the 151 residents in the event of a fire. Findings Include: On December 7, 2023, at approximately 11:45 AM observation revealed the Central Supply Office fire rated door was held open with a	K0223	Element #1 The door to the Central Supply room was closed and the wedge was removed. Element #2 Facility staff has been educated to ensure that all doors are kept in closed position and not propped open. Element #3 The Maintenance Director or designee will audit doors daily to ensure Doors with Self-Closing Devices are in closed position and not propped open. Deficiencies will be immediately corrected. Findings will be submitted to the facility Quality Assurance Performance Committee for review and further recommendation until substantial compliance is achieved and maintained. Element #4 The Maintenance Director is responsible for continued monitoring. The Administrator is responsible for continued regulatory compliance.	1/12/2024

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	wedge. This deficient practice does not allow the door to be self-closing as required by NFPA 80 2010 edition, 6.1.4.2. These findings were confirmed by the Maintenance Director at the time of observation and interview.			

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K0291 SS= E	Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure automatic emergency lighting of 1-1/2 hour duration is provided in accordance with 7.9, as required by 19.2.9.1. This deficient practice could affect 12 of the 151 residents in the event of an emergency. Findings Include: 1) On December 7, 2023, approximately 10:35 AM observation revealed the emergency light for the Front Office was not illuminated when tested. NFPA 101 2012 edition, 7.9.2.6 requires emergency lighting to be maintained. 2) On December 7, 2023, approximately 11:15 AM observation revealed the emergency light in the kitchen above Dry Storage the right bulb was not illuminated when tested. NFPA 101 20112 Edition, 7.9.2.6 requires emergency lighting to be maintained. These findings were confirmed by the Maintenance Director at the time of observation and interview.	K0291	Element #1 The emergency light for the front office has been repaired to illuminate. The right bulb on the emergency light above Dry Storage has been replaced. Element #2 Maintenance Director has conducted audits on all emergency lights to ensure they illuminate. Element #3 The maintenance staff has been educated on requirements of K 291 Emergency Lighting. The Maintenance Director or designee will audit Emergency lights monthly to ensure Emergency lights are illuminating properly. Deficiencies will be immediately corrected. Findings will be submitted to the facility Quality Assurance Performance Committee for review and further recommendation until substantial compliance is achieved and maintained. Element #4 The Maintenance Director is responsible for continued monitoring. The Administrator is responsible for continued regulatory compliance.	1/12/2024

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K0293 SS= E	Exit Signage Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure exit and directional signs are displayed in accordance with 7.10, continuously illuminated and served by the emergency lighting system as required by 19.2.10.1. This deficient practice could affect 10 of the 151 residents in the event of a fire. Findings Include: On December 7, 2023, at approximately 1:35 PM observation revealed the exit sign by the maintenance room had bulbs that were not illuminated. NFPA 101 2012 edition, 7.10.5.2.1 requires continuous illumination for lighted signs. These findings were confirmed by the Maintenance Director at the time of observation and interview.	K0293	Element #1 The exit sign bulbs were replaced by the Maintenance Room Door. Element #2 Maintenance Director has conducted audits on all exit signs to ensure they illuminate. Element #3 The maintenance staff has been educated on requirements of K 293. The Maintenance Director or designee will audit Exit Signs weekly to ensure Exit Signs are illuminating properly. . Deficiencies will be immediately corrected. Findings will be submitted to the facility Quality Assurance Performance Committee for review and further recommendation until substantial compliance is achieved and maintained. Element #4 The Maintenance Director is responsible for continued monitoring. The Administrator is responsible for continued regulatory compliance.	1/12/2024
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 extinguishing system option is used, the areas shall be separated from other spaces	K0321	Element #1 The lint screens on the 3 commercial dryers have been cleaned. Mop heads are no longer placed in the dryers. Element #2 Laundry and Housekeeping were educated on the process of cleaning the lint screens are the dryers and not putting mop heads in the dryers.	1/12/2024

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	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 6 occupants in the event of a fire. Findings Include: 1) On December 7, 2023, at approximately 12:20 PM observation revealed the three commercial		Element #3 The maintenance staff and laundry and housekeeping staff has been educated on requirements of K 321. The Housekeeping Director or designee will audit lint screens daily to ensure lint screens are free from lint and mop heads are not placed in dryers. Deficiencies will be immediately corrected. Findings will be submitted to the facility Quality Assurance Performance Committee for review and further recommendation until substantial compliance is achieved and maintained. Element #4 The Maintenance Director is responsible for continued monitoring. The Administrator is responsible for continued regulatory compliance.	

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	dryers in the Laundry Room had uncleaned lint screens. This could potentially cause a fire with the combustible lint and heat from the dryers. 2) On December 7, 2023, at approximately 12:25 PM interview revealed, when asked how washed mop heads are dried a laundry staff replied, "put in dryer." Mop heads exposed to heat could potentially result in a dryer fire. These findings were confirmed by the Maintenance Director at the time of observation and interview.			
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 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 observation, record review and	K0324	Element #1 Facility has obtained the “Owners Monthly Hood Inspection” documentation for 2023. The stove in the Activities room has had a 60-minute timer device installed. The baffle to the right on the kitchen hood above the steamer has been repaired to ensure no spaces are between the baffle plates. Element #2 The maintenance staff, Dietary Manager, and Activity Director have been educated on requirements of K 324 Cooking Facilities. Element #3 The Maintenance Director or designee will audit monthly for required documentation on “Owners Monthly Hood Inspection” and will audit weekly the baffle plates on kitchen hood above steamer, the 60-minute timer on the Activity Stove will be audited monthly to ensure it remain in proper working condition. Deficiencies will be immediately corrected. Findings will be submitted to the facility Quality Assurance Performance Committee for review and further recommendation until substantial compliance is achieved and maintained. Element #4 The Maintenance Director is responsible for	1/12/2024

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	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 151 facility residents in the event of a fire. Findings Include: 1) On December 7, 2023 at 12:40 PM, record review revealed the facility failed to provide evidence of the required "Owners Monthly Hood Inspection" for their installed range hood suppression system for calendar year 2023. No supporting documentation was presented to surveyor by the time of surveyor exit. These findings were confirmed interview with the facility Maintenance Assistance and Director at the time of record review. Findings Include: 2) On December 7, 2023, at approximately 12:45 PM, observation revealed the facility failed to provide the stove in the Activities Room with the required lock-out switch and timer device as required by NFPA 101 2012 edition, 19.3.2.5.3 (9). 3) On December 7, 2023, at approximately 11:10 AM, observation revealed the baffle to the right on the kitchen hood system above the steamer had a space in between the baffle plates. This deficient practice could possibly result in grease build-up in the kitchen hood duct system. These findings were confirmed by the Maintenance Director at the time of observation and interview.		continued monitoring. The Administrator is responsible for continued regulatory compliance.	

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K0331 SS= E	Interior Wall and Ceiling Finish Interior Wall and Ceiling Finish 2012 EXISTING Interior wall and ceiling finishes, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and have a flame spread rating of Class A or Class B. The reduction in class of interior finish for a sprinkler system as prescribed in 10.2.8.1 is permitted. 10.2, 19.3.3.1, 19.3.3.2 Indicate flame spread rating(s). _____ This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure interior wall and ceiling finishes have a flame spread rating of Class A or B, unless permitted to be reduced by 10.2.8.1, as required by 19.3.3.1 and 19.3.3.2. This deficient practice could affect 12 occupants in the event of a fire. Findings Include: On December 7, 2023, at approximately 2:45 PM observation revealed wood paneling in the Conference Room. The facility did not present approved flame spread rating documentation as required by NFPA 101 2012 edition, 10.2.8.1. No documentation was available by survey exit. These findings were confirmed by the Maintenance Director at the time of observation and interview.	K0331	Element #1 The facility has identified that paneling was installed in approximately the 1970□s, the approved flame spread rating documentation is not available. The facility will apply a Flame Control Class A Varnish Basecoat followed by a Flame Control Class A Varnish Fire Retardant Topcoat, base coat and top coat are a Class A with a flame spread rating of 20 and smoked developed 160-240. Element #2 Maintenance Director has audited the remainder of the building to ensure there are no other paneled areas within the facility. The Maintenance Director has been educated on K331. Element #3 The Maintenance Director or designee will conduct monthly audit of paneling to ensure Flame Control Class A Varnish Basecoat followed by a Flame Control Class A Varnish Fire Retardant Topcoat does not wear off. Deficiencies will be immediately corrected. Findings will be submitted to the facility Quality Assurance Performance Committee for review and further recommendation until substantial compliance is achieved and maintained. Element #4 The Maintenance Director is responsible for continued monitoring. The Administrator is responsible for continued regulatory compliance.	1/12/2024

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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 observation 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 151 residents in the event of a fire. Findings Include: On December 7, 2023, at approximately 12:06 PM observation revealed the facility failed to have the date of manufacture in the month/year format visible on the fire alarm panel batteries as required by NFPA 72 2010 edition, 10.5.9.1. The date installed 3/8/21 was labeled on the top of the two batteries. These findings were confirmed by the Maintenance Director at the time of observation and interview.	K0345	Element #1 The facility has had Eagle Security correct the citied practice and the fire panel alarm batteries now have the manufacture month/year date on them. Element #2 The Fire Alarm Testing and maintenance policy has been reviewed and deemed appropriate. Maintenance staff have been educated on the requirements of K 345. Element #3 The Maintenance Director or designee will audit monthly for required manufacture month/year on Fire Alarm Panel batteries. Deficiencies will be immediately corrected. Findings will be submitted to the facility Quality Assurance Performance Committee for review and further recommendation until substantial compliance is achieved and maintained. Element #4 The Maintenance Director is responsible for continued monitoring. The Administrator is responsible for continued regulatory compliance.	1/12/2024
K0351 SS= E	Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where	K0351	Element #1 The facility has had Dynamic Fire Protection repair the door closer to ensure it is more than	1/12/2024

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	required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure hospitals where required by construction type are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, as required by 19.3.5.1 through 19.3.5.5, 19.4.2, 19.3.5.10, 9.7 and 9.7.1.1(1). This deficient practice could affect 12 of the 151 residents in the event of a fire. Findings Include: 1) On December 7, 2023, at approximately 10:52 AM observation revealed a door closer less than 18 inches from the pendent sprinkler head inside and above the Spring nurse station Med Room door. NFPA 25 2011 edition, 5.2.1.2 requires clearance to be maintained by the minimum installation standards. 2) On December 7, 2023, at approximately 1:05		18 inches from the pendent sprinkler head in the Spring Nurse Medication Room. The gas grill has been removed from the covered patio area. Element #2 Maintenance Director has conducted audits on all door closers. Element #3 The maintenance staff has been educated on requirements of K 351 requirements. The Maintenance Director or designee will audit monthly that no door closers are within the allowed clearance from the pendent sprinkler head and that no gas grill is stored on the patio. Deficiencies will be immediately corrected. Findings will be submitted to the facility Quality Assurance Performance Committee for review and further recommendation until substantial compliance is achieved and maintained. Element #4 The Maintenance Director is responsible for continued monitoring. The Administrator is responsible for continued regulatory compliance.	

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	824350	A. BUILDING _____ B. WING _____	12/7/2023

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	PM observation revealed a propane gas fueled grill under a non-sprinklered combustible wooden roof on the patio. This deficient practice could potentially result in a fire event due to a fire source operated under a combustible structure. These findings were confirmed by the Maintenance Director at the time of observation and interview.			
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 _____ 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 affect all 151 residents in the event of a fire. Findings Include:	K0353	Element #1 The 3x6 inch ceiling drywall and 6x6 drywall wall penetration areas have been repaired. The escutcheon cover for the ceiling sprinkler head in room 205-2 has been replaced and the recessed sprinkler head has been repaired by Dynamic Fire Protection. The cable wire penetrating the ceiling tile above the clock in the Activity Room has been replaced. The sprinkler drains in the Dietician Office and Autumn Wing Janitor closet have been labeled. The items in the closet in the Administrator office and Front Office have now been removed to ensure there is nothing stored less than 18 inches from the sprinkler head. Element #2 Maintenance Director has conducted audits on closets, sprinkler drains, ceiling tiles, and walls. Element #3 The maintenance staff, administrator, and front office staff have been educated on requirements of K 353 requirements. The Maintenance Director or designee will audit monthly to ensure sprinkler system is maintained properly. Deficiencies will be immediately corrected. Findings will be submitted to the facility Quality Assurance Performance Committee for review and further recommendation until substantial compliance is achieved and maintained.	1/12/2024

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	1) On December 7, 2023, at approximately 11:19 AM observation revealed a 3x6 inch ceiling drywall penetration above the kitchen disposal and a 6x6 inch drywall penetration in the wall above the door. This deficient practice could potentially allow heat to spread beyond the protection of the drywall and delay the activation of the sprinkler system. 2) On December 7, 2023, at approximately 12:25 PM observation revealed the escutcheon cover for the ceiling sprinkler head was missing above Bed 2 in Room 205. This deficient practice resulted in an unprotected area around the sprinkler head. 3) On December 7, 2023, at approximately 12:37 PM observation revealed the ceiling sprinkler head was recessed above Bed 2 in Room 205. This deficient practice could potentially affect the spray pattern of the sprinkler head. 4) On December 7, 2023, at approximately 11:55 AM observation revealed the facility failed to maintain the ceiling tile above the clock in the Activities Room. A cable wire was penetrating the ceiling tile. 5) On December 7, 2023, at approximately 11:27 AM observation revealed the Dietician Office sprinkler drain was not labeled. NFPA 25 2011 edition, 13.3.2.2 (6) requires inspections to verify valves are identified with signs. 6) On December 7, 2023, at approximately 1;13 PM observation revealed the Autumn Wing janitor room sprinkler drain was not labeled. NFPA 25 2011 edition, 13.3.2.2 (6) requires inspections to verify valves are identified with signs. 7) On December 7, 2023, at approximately 10:30		Element #4 The Maintenance Director is responsible for continued monitoring. The Administrator is responsible for continued regulatory compliance.	

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	AM observation revealed the Administrator storage closet has shelf storage less than 18 inches from the sprinkler head. This deficient practice could obstruct the spray pattern of the sprinkler head. 8) On December 7, 2023, at approximately 10:32 AM observation revealed the Front Office storage closet has shelf storage less than 18 inches from the sprinkler head. This deficient practice could obstruct the spray pattern of the sprinkler head. These findings were confirmed by the Maintenance Director at the time of observation and interview.			

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K0374 SS= E	Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure doors in smoke barriers are 1-3/4 inch solid bonded wood-core doors or construction that resists fire for 20 minutes, are self-closing or automatic-closing and provide a minimum width of 32 inches as required by 19.3.7.6, 18.3.7.8 and 19.3.7.9. This deficient practice could affect 25 of the 151 residents in the event of a fire. Findings Include: On December 7, 2023, at approximately 10:45 AM observation revealed the cross-corridor doors for the Spring wing did not close to a smoke tight fit. The coordinator does not allow the door with the astragal to close first. These findings were confirmed by the Maintenance Director at the time of observation and interview.	K0374	Element #1 The cross-corridor on Spring Unit have been repaired to ensure the door closes to a smoke tight fit. Element #2 Maintenance Director has conducted audits on all doors to ensure a smoke tight fit. Element #3 The maintenance staff has been educated on requirements of K 374. The Maintenance Director or designee will audit weekly of cross-corridor doors to ensure Smoke Barrie Doors have a smoke tight fit. Deficiencies will be immediately corrected. Findings will be submitted to the facility Quality Assurance Performance Committee for review and further recommendation until substantial compliance is achieved and maintained. Element #4 The Maintenance Director is responsible for continued monitoring. The Administrator is responsible for continued regulatory compliance.	1/12/2024

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K0711 SS= F	Evacuation and Relocation Plan Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure there is a written plan for the protection of all residents and for their evacuation in the event of an emergency, employees are periodically instructed in their duties under the plan, the plan is readily available, addresses the basic response required by staff and provides all components as required by 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2 and 19.7.2.3. This deficient practice could affect all 151 residents in the event of an emergency. Findings Include: On December 7, 2023, at approximately 10:30 AM observation revealed the evacuation plan map provided for survey and those in the emergency preparedness books did not identify the smoke barriers. Staff cannot evacuate residents to an area of refuge without knowledge of the smoke barrier locations. These findings were confirmed by the	K0711	Element #1 The evacuation floor plan maps have been updated to identify smoke barriers. New maps have been placed in the Emergency Preparedness books. Element #2 Facility staff has been educated on the facility evacuation floor plan maps and identified smoke barriers. Element #3 The maintenance staff has been educated on requirements of K 711. The Maintenance Director or designee will audit monthly Emergency Preparedness books for proper documentation. Deficiencies will be immediately corrected. Findings will be submitted to the facility Quality Assurance Performance Committee for review and further recommendation until substantial compliance is achieved and maintained. Element #4 The Maintenance Director is responsible for continued monitoring. The Administrator is responsible for continued regulatory compliance.	1/12/2024

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	Maintenance Director at the time of observation and interview.			
K0712 SS= F	Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions, are held at unexpected times under varying circumstances, conducted at least quarterly on each shift and responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership as required by 19.7.1.4 through 19.7.1.7. This deficient practice could affect all 151 facility residents in the event of a fire. Findings Include: On December 7, 2023 at 10:41 AM, record review revealed the facility failed to conduct their required fire drills at "...unexpected time...". The fire drills for the 1st Shift, 3rd and 4th Quarter of 2023, were held at 10:05 AM for both quarters. The fire drills for the 2nd Shift, 1st and 2nd Quarter of 2023, were held at 3:23 PM and 3:40 PM, respectfully. The fire drills for the 3rd Shift, 2nd and 3rd Quarter of 2023, were held at 5:06 AM and 5:05 AM, respectfully.	K0712	Element #1 All future fire drills will be held at unexpected times under varying circumstances, conducted at least quarterly on each shift. Element #2 The maintenance staff has been educated on requirements for the fire drills to be conducted at varied times and with varied circumstances. Element #3 The Maintenance Director or designee will audit monthly fire drill times and circumstances. Deficiencies will be immediately corrected. Findings will be submitted to the facility Quality Assurance Performance Committee for review and further recommendation until substantial compliance is achieved and maintained. Element #4 The Maintenance Director is responsible for continued monitoring. The Administrator is responsible for continued regulatory compliance.	1/12/2024

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	These findings were confirmed interview with the facility Maintenance Assistance at the time of record review.			
K0741 SS= E	Smoking Regulations Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure smoking regulations were adopted and meet all provisions as required by 19.7.4. This deficient practice could affect 5 of the 151 residents in the event of a fire. Findings Include:	K0741	Element #1 The cigarette butts on the ground around the fence for the outdoor medical gas equipment have been removed and more signs for No Smoking in Area have been put up on fence. Element #2 Facility staff have been educated that they may not smoke near or dispose of cigarette butts on the ground near the medical gas equipment. Element #3 The Maintenance Director or designee will audit ground around outdoor medical gas equipment for cigarette butts 3x's weekly. Deficiencies will be immediately corrected. Findings will be submitted to the facility Quality Assurance Performance Committee for review and further recommendation until substantial compliance is achieved and maintained. Element #4 The Maintenance Director is responsible for continued monitoring. The Administrator is responsible for continued regulatory compliance.	1/12/2024

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	On December 7, 2023, at approximately 12:15 PM observation revealed cigarette butts on the ground by the fence for the outdoor medical gas equipment that has posted no smoking signs. This deficient practice could potentially ignite a fire. These findings were confirmed by the Maintenance Director at the time of observation and interview.			

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K0912 SS= D	Electrical Systems - Receptacles Electrical Systems - Receptacles Power receptacles have at least one, separate, highly dependable grounding pole capable of maintaining low-contact resistance with its mating plug. In pediatric locations, receptacles in patient rooms, bathrooms, play rooms, and activity rooms, other than nurseries, are listed tamper-resistant or employ a listed cover. If used in patient care room, ground-fault circuit interrupters (GFCI) are listed. 6.3.2.2.6.2 (F), 6.3.2.2.4.2 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure power receptacles comply with the requirements of 6.3.2.2.6.2(F) and 6.3.2.4.2 of NFPA 99. This deficient practice could affect 1 occupant in the event of an electrical shock. Findings Include: On December 7, 2023, at approximately 10:34 AM observation revealed the facility failed to have the Front Office water cooler plugged into a GFCI outlet. Ground fault protection is required by NFPA 99-2012 and NFPA 70-2011 210.8 (B) (6) within 6 feet of a water source. This deficient practice creates an electrocution risk in a wet location. These findings were confirmed by the Maintenance Director at the time of observation and interview.	K0912	Element #4 The Maintenance Director is responsible for continued monitoring. The Element #1 A GFCI outlet has been installed to outlet where Front Office water cooler is plugged into. Element #2 Front office staff has been educated on Ground Fault protection being required within 6 feet of water source. Element #3 The Maintenance Director or designee will audit monthly to ensure GFCI plugs are within 6 feet of water source. Deficiencies will be immediately corrected. Deficiencies will be immediately corrected. Findings will be submitted to the facility Quality Assurance Performance Committee for review and further recommendation until substantial compliance is achieved and maintained. Administrator is responsible for continued regulatory compliance.	1/12/2024
K0918 SS= F	Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The	K0918	Element #1 The facility has installed a 90-minute battery-operated light in the Transfer Switch room.	1/12/2024

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	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 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 observation 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		Element #2 Maintenance staff was educated on requirements of K 918. Element #3 The Maintenance Director or designee will audit monthly to ensure the battery-operated light in the Transfer Switch room is fully operational. . Deficiencies will be immediately corrected. Findings will be submitted to the facility Quality Assurance Performance Committee for review and further recommendation until substantial compliance is achieved and maintained. Element #4 The Maintenance Director is responsible for continued monitoring. The Administrator is responsible for continued regulatory compliance.	

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	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 affect all 151 residents in the event of an emergency. Findings Include: On December 7, 2023, at approximately 12:05 PM observation revealed the facility failed to have a battery-operated emergency light installed in the Transfer Switch Room. These findings were confirmed by the Maintenance Director at the time of observation and interview.			
K0923 SS= E	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	K0923	Element #1 The facility has placed signage on the Oxygen Room door that reads “Caution: Oxidizing Gas (es) Sored Within No Smoking”. Oxygen concentrator were removed from the area. Element #2 Facility staff was educated on having proper Oxygen Signage on door and not storing oxygen concentrators in Oxygen room. Element #3 The Maintenance Director, Respiratory Therapist, or designee will audit weekly to ensure the proper signage is on door of Oxygen room and that oxygen concentrator are not stored in Oxygen Room. Deficiencies will be immediately corrected. Findings will be submitted to the facility Quality Assurance Performance Committee for review and further recommendation until substantial compliance is achieved and maintained. Element #4 The Maintenance Director is responsible for continued monitoring. The Administrator is responsible for continued regulatory	1/12/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	824350	A. BUILDING _____ B. WING _____	**12/7/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUR SEASONS NURSING CENTER OF WESTLAND	**8365 NEWBURGH RD WESTLAND, MI 48185**

(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
	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: 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 affect 20 of the 151 residents in the event of a fire. Findings Include: 1) On December 7, 2023, at approximately 12:26 PM observation revealed the Oxygen Room does not have signage on the door that reads" CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING" as required by NFPA 99 2012 edition, 11.3.4.2. 2) On December 7, 2023, at approximately 12:27 PM observation revealed 2 oxygen concentrators less than 5 feet from the oxygen cylinders in the Oxygen Room. NFPA 99 11.3.2.3(2) requires at least a 5-foot separation of combustibles or materials being housed in the same area.		compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	824350	A. BUILDING _____ B. WING _____	**12/7/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUR SEASONS NURSING CENTER OF WESTLAND	**8365 NEWBURGH RD WESTLAND, MI 48185**

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	These findings were confirmed by the Maintenance Director at the time of observation and interview.			