

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>834860</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>7/9/2024</b>
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NAME OF PROVIDER OR SUPPLIER  <b>OMNI CONTINUING CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE  <b>5201 CONNER DETROIT, MI 48213</b>
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(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 9, 2024, an Emergency Preparedness Survey was conducted by the Michigan Department of Licensing and Regulatory Affairs, Bureau of Survey and Certification. At the survey, Omni Continuing Care - Detroit 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	E039  Element 1  Facility will conduct facility-base full scale exercise by date of expected compliance August 22, 2024  Element 2  The facility policy and procedure on Emergency Preparedness with facility tabletop and facility-base full scale exercises was reviewed and deemed appropriate. The Maintenance Director was in-serviced on the timely initiation and facilitating of tabletop and facility-base full scale exercises.  Element 3  The Administrator will in-service the IDT on the importance of participating in a full scale exercise. Monthly during QAPI the team will discuss an emergency situation, then pose it for further discussion during group discussion.  Element 4  Any area of concern will be addressed	8/22/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

08/02/2024

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		immediately, findings will be reported to QAPI committee monthly for further follow up and consideration. Administrator/Maintenance Director is responsible for continued compl		

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	<p>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</p>				

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	<p>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</p>			

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	<p>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</p>			

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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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	<p>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</p>			

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	<p>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.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>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</p>				

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	<p>individual, facility-based. If the facility based experiences an 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 90 facility residents in the event of a natural or man-made emergency situation.</p> <p>Findings Include:</p> <p>On July 9, 2024 at 11:49 AM, record review revealed the facility failed to provide evidence of their required participation in a community-based, individual or facility-base full-scale exercise for 2023. No compliance supporting documentation was presented to the surveyor by the time of surveyor exit.</p> <p>These findings were confirmed in interview with the facility Maintenance Director at the time of record review.</p>				

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K0000 SS=	<p>INITIAL COMMENTS</p> <p>On July 9, 2024, a Life Safety Recertification Survey was conducted by the Michigan Department of Licensing and Regulatory Affairs, Bureau of Survey and Certification. At the survey, Omni Continuing Care - Detroit 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.</p> <p>The facility is a 2 - story building of Type II (222) construction with a full basement, built in 1969. The building is fully sprinklered and has supervised smoke detection in the corridors and spaces open to the corridors.</p> <p>The facility has 136 certified beds. At the time of the survey the census was 90.</p>	K0000			

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K0225 SS= E	<p>Stairways and Smokeproof Enclosures Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2 This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and interview, the facility failed to ensure that stairways and smokeproof enclosures used as exits are in accordance with NFPA 101 - 2012 edition, sections 19.2, 19.2.1, 19.2.2.3, 7.2.2, 7.2.2.4, 7.2.2.4.5 and 7.2.2.4.5.3. This deficient practice could affect 38 of 90 facility residents in the he event of a fire.</p> <p>Findings include:</p> <p>On July 9, 2024 at 4:37 PM and 5:55 PM, observation revealed the guardrails on all floors of all stairway enclosures had openings larger than the maximum allowed four inches. The guardrail openings were approximately 14" by 42".</p> <p>These findings were confirmed in interview with the facility Maintenance Director and Maintenance Lead at the time of observation.</p>	K0225	<p>K225</p> <p>Element 1</p> <p>The guardrails identified on all floors of all stairwells with opening larger than maximum allowance have been augmented to reduce the opening within allotted inches/width.</p> <p>Element 2</p> <p>Rounds has been made to ensure all stairwells guardrails are maintained with four inches of maximum allowed opening on all stair guardrails.</p> <p>Element 3</p> <p>Maintenance Director has been reeducated on environmental rounds policy to ensure guardrails are maintained with four inches opening on all stairs.</p> <p>Maintenance Director or designee will conduct weekly checks X 4 weeks. This will be to ensure continued placement of all newly installed spacing apparatuses.</p> <p>Element 4</p> <p>Any area of concern will be addressed immediately, findings will be reported to QAPI committee monthly for further follow up and consideration. Administrator/Maintenance Director is responsible for continued compliance</p>	8/22/2024	
K0345 SS= F	<p>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</p>	K0345	<p>K345</p> <p>Element 1</p> <p>1. Facility has retrieved evidence of the biennial sensitivity test date for the installed</p>	8/22/2024	

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	<p>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:</p> <p>Based on record review 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 90 facility residents in the event of a fire.</p> <p>Findings Include:</p> <p>1) On July 9, 2024 at 2:45 PM, record review revealed the facility failed to provide evidence of the required biennial (every 2 years) Sensitivity Test Date for their installed automatic smoke detectors.</p> <p>2) On July 9, 2024 at 2:48 PM, record review revealed the facility failed to provide evidence of the required monthly testing of their battery-operated smoke detectors installed in resident rooms for 2023 to present.</p> <p>3) On July 9, 2024 at 3:48 PM, record review revealed the facility failed to provide documentation of the required Quarterly Dialer Test for their installed fire alarm system for the 1st and 2nd Quarter 2024.</p> <p>No compliance supporting documentation</p>		<p>automatic smoke detector.</p> <p>2. Facility has retrieved evidence of required monthly testing of the battery-operated smoke detectors installed in the residents 'room for 2023 through current.</p> <p>3. Facility has the documentation related to the Quarterly Dialer test for the fire alarm system for 1st and 2nd quarter.</p> <p>Element 2</p> <p>The facility policy and procedure were reviewed and deemed appropriate. Audits are completed to ensure all documentation is in place as required.</p> <p>Element 3</p> <p>Maintenance Director has been reeducated on filling and maintain the supporting documents. To ensure continued compliance the Maintenance Director will maintain necessary documentation related to Sensitivity testing, Battery-operated smoke detectors and the quarterly Dialer Testing as required and Administrator will audit x 4 weeks, randomly thereafter.</p> <p>Element 4</p> <p>Any area of concern will be addressed immediately, findings will be reported to QAPI committee monthly for further follow up and consideration. Administrator/Maintenance Director is responsible for continued compliance</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>834860</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>7/9/2024</b>
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K0353 SS= F	<p>was presented to the surveyor by the time of surveyor exit.</p> <p>These findings were confirmed in interview with the facility Maintenance Director at the time of record review.</p> <p>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:</p> <p>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 90 facility residents in the event of a fire.</p> <p>Findings Include:</p>	K0353	<p>K353</p> <p>Element 1</p> <ol style="list-style-type: none"> <li>1. The dirty sprinkler head identified in the vestibule near ceiling vent has been cleaned.</li> <li>2. The two dirty sprinkler heads in the main lobby have been cleaned.</li> <li>3. The opening in the ceiling tile at the air conditioner coolant line has been cleaned.</li> <li>4. The dirty water line at the water line in the Harper Janitor Closet has been cleaned.</li> <li>5. Side-wall sprinkler escutcheon plate has been reattached to the wall.</li> <li>6. The dirty sprinkler head in the Mack Ave Employee Restroom has been cleaned.</li> <li>7. The two (2) dirty sprinkler heads in the Mack Ave dayroom have been cleaned</li> <li>8. The items identified within 18" of the sprinkler head in the Mack Ave PT supply closet have been removed.</li> <li>9. Missing ceiling tiles on Gratiot Nurse Station med room have been replaced.</li> <li>10. Stock items obstructing sprinkler head in the Respiratory Supply room have been removed.</li> </ol>	8/22/2024

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	<p>1) On July 9, 2024 at 10:15 AM, observation revealed dirty sprinkler head in the vestibule near the ceiling vent.</p> <p>2) On July 9, 2024 at 10:16 AM, observation revealed 2 dirty sprinkler heads in the main lobby.</p> <p>3) On July 9, 2024 at 4:23 PM, observation revealed opening in the ceiling tile at the air conditioner coolant lines in the Harper Med Room.</p> <p>4) On July 9, 2024 at 4:39 PM, observation revealed dirty sprinkler head at the water lines in the Harper Janitor's Closet.</p> <p>5) On July 9, 2024 at 4:48 PM, observation revealed the side-wall sprinkler escutcheon plate was separating from the wall in the Motown Cafe.</p> <p>6) On July 9, 2024 at 4:59 PM, observation revealed dirty sprinkler head in the Mack Ave Employee Rest Room.</p> <p>7) On July 9, 2024 at 5:01 PM, observation revealed 2 dirty sprinkler heads in the Mack Ave Day Room.</p> <p>8) On July 9, 2024 at 5:06 PM, observation revealed stock item stored within 18" of the sprinkler head in the Mack Ave Physical Therapy Supply Closet.</p> <p>9) On July 9, 2024 at 5:30 PM, observation revealed ceiling tile missing in the Gratiot Nurse Station Med Room.</p> <p>10) On July 9, 2024 at 5:34 PM, observation revealed stock items obstructing the</p>		<p>11. The dirty sprinkler head in PT room has been cleaned.</p> <p>12. Stock items observed in supply closet in DON's office have been removed</p> <p>13. Missing ceiling tiles in the Jefferson Hall soiled utility have been replaced.</p> <p>14. Dirty sprinkler heads in the kitchen have all been cleaned.</p> <p>Element 2</p> <p>The facility policy and procedure on general maintenance and facility rounding was reviewed and deemed appropriate. The Maintenance Director was in-service on the importance of facility rounding and addressing maintenance concerns timely.</p> <p>Element 3</p> <p>The Maintenance Director or designee will conduct weekly rounds x 4 weeks, general whole house maintenance rounds, address any immediate concerns. The Administrator will audit randomly thereafter.</p> <p>Element 4</p> <p>Any area of concern will be addressed immediately, findings will be reported to QAPI committee monthly for further follow up and consideration. Administrator/Maintenance Director is responsible for continued compliance</p>		

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K0354 SS= F	<p>sprinklers heads in the Respiratory Supply Room.</p> <p>11) On July 2024 at 5:38 PM, observation revealed dirty sprinkler heads in Physical Therapy.</p> <p>12) On July 9, 2024 at 5:44 PM, observation revealed stock items stored within 18" of the sprinkler head in the supply closet in the DON's Office.</p> <p>13) On July 9, 2024 at 5:51 PM, observation revealed missing ceiling tiles in the Jefferson Hall Soiled Utility.</p> <p>14) On July 9, 2024 at 6:37 PM, observation revealed dirty sprinkler heads throughout the Kitchen.</p> <p>These findings were confirmed in interview with the facility Maintenance Director and the Maintenance Lead at the time of observation.</p> <p>Sprinkler System - Out of Service Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25)</p>	K0354	<p>K354</p> <p>Element 1</p> <p>The require BCHS Contact information (1-800-882-6006) has been added to the Fire Watch policy.</p> <p>Element 2</p> <p>The facility Fire Watch policy and procedures were reviewed, updated and deemed appropriate. The Maintenance Director was in-serviced on updating policies and contact information.</p>	8/22/2024

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	<p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review and interview, the facility failed to ensure when the sprinkler system is out of service for more than 10 hours in a 24-hour period, the affected areas are evacuated or an approved Fire Watch is provided until the sprinkler system is returned to service as required by 19.3.5.1 and 9.7.5 of the LSC and 15.5.2 of NFPA 25. This deficient practice could affect all 90 facility residents occupants in the event of a fire.</p> <p>Findings Include:</p> <p>On On July 9, 2024 at 12:05 PM, record review revealed the facility failed to include in their distributed Fire Watch Policy - Sprinkler System, the required BCHS Contact Information Number (1-800-882-6006) for the reporting of fire or other emergent event(s).</p> <p>These findings were confirmed in interview with the facility Maintenance Director at the time of record review.</p>		<p>Element 3</p> <p>The Maintenance Director or designee will conduct monthly audits to ensure items in the Emergency Preparedness manual are current x 4 months, or as needed then yearly thereafter.</p> <p>Element 4</p> <p>Any area of concern will be addressed immediately, findings will be reported to QAPI committee monthly for further follow up and consideration. Administrator/Maintenance Director is responsible for continued compliance</p>		

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K0355 SS= E	<p>Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and interview, the facility failed to ensure portable fire extinguishers are selected, installed, inspected and maintained in accordance with NFPA 10, as required by 19.3.5.12. This deficient practice could affect 48 of 90 facility residents occupants in the event of a fire.</p> <p>Findings Include:</p> <p>On July 9, 2024 at 6:34 PM, observation revealed the facility failed to provide the required ABC portable fire extinguishers in the main kitchen for the extinguishment of other than grease fires.</p> <p>These findings were confirmed in interview with the facility Maintenance Director and Maintenance Lead at the time of observation.</p>	K0355	<p>K355</p> <p>Element 1</p> <p>The required ABC fire extinguisher for the main kitchen for the extinguishment of other than grease fires is in place and properly located. No resident or staff experienced any ill-effects as a result of the deficient practice.</p> <p>Element 2</p> <p>Rounds has been made to ensure all fire extinguisher has been selected, installed and maintained as per NFPA guidelines. The facility policy and procedures were reviewed and deemed appropriate. The Maintenance Director was in-serviced on ensuring general LSC practices are carried out per regulation.</p> <p>Element 3</p> <p>The Maintenance Director or designee will conduct weekly audits x 4 weeks, environmental maintenance rounds, address any immediate concerns. The Administrator will audit randomly thereafter.</p> <p>Element 4</p> <p>Any area of concern will be addressed immediately, findings will be reported to QAPI committee monthly for further follow up and consideration. Administrator/Maintenance Director is responsible for continued compliance</p>	8/22/2024	
K0712 SS= F	<p>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</p>	K0712	<p>K712</p> <p>Element 1</p> <p>Fire drill documentation identified as not being provided for the 1st quarter 2024-2nd and 3rd</p>	8/22/2024	

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K0761	<p>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:</p> <p>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 90 facility resident in the event of a fire.</p> <p>Findings Include:</p> <p>On July 9, 2024 at 3:45 PM, record review revealed the facility failed to provide documentation of the required fire drills for the following timeframe's: 1st Quarter 2024 - 2nd and 3rd Shift, 2nd Quarter 2024 - 3rd Shift, 3rd Quarter 2023 - 2nd and 3rd Shift, and 4th Quarter 2023 - 2nd and 3rd Shift. No compliance supporting documentation was presented to the surveyor by the time of surveyor exit.</p> <p>These findings were confirmed in interview with the facility Maintenance Director at the time of record review.</p>	K0761	<p>shifts, 2nd quarter 2024, 3rd shift, 3rd quarter 2023-2nd and 3rd shift, and 4 quarter 2nd and 3rd shift have been reviewed and determined fire drill scheduling error. Fire Drill schedule will be held at varying times and conditions at least quarterly on each shift. No resident were affected by this deficient practice.</p> <p>Element 2</p> <p>The facility policy and procedures were reviewed and deemed appropriate. Fire Drills are being conducted per regulation. The Maintenance Director was in-serviced on conducting fire drills per LSC regulation, varying schedule of drills</p> <p>Element 3</p> <p>The Maintenance Director or designee will maintain documentation, conduct fire drills per regulation as required. The Administrator will audit for compliance x 4 weeks, randomly thereafter.</p> <p>Element 4</p> <p>Any area of concern will be addressed immediately, findings will be reported to QAPI committee monthly for further follow up and consideration. Administrator/Maintenance Director is responsible for continued compliance</p>	8/22/2024	
	Maintenance, Inspection & Testing - Doors		K761		

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SS= F	<p>Maintenance, Inspection &amp; Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to inspect and test annually in accordance with NFPA 101, 19.7.6, 8.3.3.1 and NFPA 80, Standard for Fire Doors and Other Opening Protectives 5.2, 5.2.3. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. This deficient practice could affect all 90 facility residents in the event of a fire.</p> <p>Findings Include:</p> <p>On July 9, 2024 at 3:15 PM, record review revealed the facility failed to provide evidence of the required Fire Rated Door Annual Inspection of their install fire-rated</p>		<p>Element 1  Facility has retrieved documentation of the Fire Rated Door Annual Inspection for the installed fire-rated doors for 2023 to present. No resident suffered any ill-effects because of this deficient practice.</p> <p>Element 2  The facility policy and procedures were reviewed and deemed appropriate. Fire Rated Door Inspections will be conducted annually per LSC regulation. The Maintenance Director was in-serviced ensuring fire door inspections are carried out as required per policy and regulation.</p> <p>Element 3  The Maintenance Director or designee will maintain documentation of all Fire Rated Door inspections as required. Audits will be conducted by Administrator to ensure compliance monthly</p> <p>Element 4  Any area of concern will be addressed immediately, findings will be reported to QAPI committee monthly for further follow up and consideration. Administrator/Maintenance Director is responsible for continued compliance</p>		

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K0914 SS= F	<p>doors for 2023 to present. No compliance supporting documentation was presented to the surveyor by the time of surveyor exit.</p> <p>These findings were confirmed in interview with the facility Maintenance Director at the time of record review.</p> <p>Electrical Systems - Maintenance and Testing Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to ensure hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia</p>	K0914	<p>K914</p> <p>Element 1</p> <p>The receptacle testing identified as not being conducted per facility per facility record reviewed had last been completed on July 20, 2023. Documentation has been retrieved.</p> <p>Element 2</p> <p>The facility policy and procedures were reviewed and deemed appropriate. The Maintenance Director received a One-on-One In-service education on maintaining pertinent documentation as well as ensuring that all LSC tasks are being completed per policy and regulation.</p> <p>Element 3</p> <p>The Maintenance Director or designee will conduct yearly testing as required per regulation and facility policy. Ensure supporting documentation of receptacle testing is maintained and presented when requested. Administrator will audit weekly x 4, then randomly thereafter.</p> <p>Element 4</p> <p>Any area of concern will be addressed immediately, findings will be reported to QAPI committee monthly for further follow up and</p>	8/22/2024

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K0918 SS= F	<p>is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance date. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Records are maintained of required tests and associated repairs or modifications, contain date, room or area tested and results as required by 6.3.4 of NFPA 99. This deficient practice could affect all 90 facility residents in the event of a fire resulting from improperly maintained electrical receptacles.</p> <p>Findings Include:</p> <p>On July 9, 2024 at 3:17 PM, record review revealed the facility failed to provide evidence of the required annual Electrical System - Maintenance and Testing of the resident rooms wall receptacles for 2023 to present. No compliance supporting documentation was presented to the surveyor by the time of surveyor exit.</p> <p>These findings were confirmed in interview with the facility Maintenance Director at the time of record review.</p> <p>Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer</p>	K0918	<p>consideration. Administrator/Maintenance Director is responsible for continued compliance</p> <p>K918 Element 1</p> <p>1. 300Kw emergency backup power generator weekly inspection documents for the months January, February and March 2024 (missing 2 weeks each), April 2024 (missing 1 weeks) May and June 2024 (missing 3 weeks each) documentation has been located.</p>	8/22/2024

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NAME OF PROVIDER OR SUPPLIER  <b>OMNI CONTINUING CARE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE  <b>5201 CONNER DETROIT, MI 48213</b>		
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	<p>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)</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, 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 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 90 facility residents in the event of a loss of commercial power to the facility.</p>		<p>2. 60Kw emergency backup diesel generator weekly inspection document for 2023 to present have been located.</p> <p>3. Proof of the monthly load test for 60Kw emergency backup generator has been provided/conducted for current month as of</p> <p>4. Both 60Kw and 30Kw Diesel emergency backup generators that were missing the required NFPA 704 Hazard Identification Placards, which inform emergency responders of hazards within an area, have NFPA Hazard Identification signage in place.</p> <p>Element 2</p> <p>The facility policy for Generator Testing was reviewed and deemed appropriate. The Maintenance Director received a One-on One In-service education on maintaining current and accessible generator documentation when requested, as well as ensuring general LSC task are being carried out per policy and regulation.</p> <p>Element 3</p> <p>The Maintenance Director will ensure all generators or other alternative power sources and associated equipment have supporting documentation for record review as evidence of compliance when requested. The Administrator will audit x 4 weeks, the one monthly thereafter.</p> <p>Element 4</p> <p>Any area of concern will be addressed immediately, findings will be reported to QAPI committee monthly for further follow up and consideration. Administrator/Maintenance</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>834860</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>7/9/2024</b>
NAME OF PROVIDER OR SUPPLIER  <b>OMNI CONTINUING CARE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE  <b>5201 CONNER DETROIT, MI 48213</b>	
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	<p>Findings Include:</p> <p>1) On July 9, 2024 at 2:30 PM, record review revealed the facility failed to provide evidence of the required Weekly Inspection of their installed 300Kw emergency backup power generator for the following: January, February and March 2024 (missing 2 weeks each), April 2024 (missing 1 week), May and June 2024 (missing 3 weeks each). No compliance supporting documentation was presented to the surveyor by the time of surveyor exit.</p> <p>2) On July 9, 2024 at 3:51 PM, record review revealed the facility failed to provide evidence of the required Weekly Inspection of their installed 60 kW emergency backup diesel generator for 2023 to present. No compliance supporting documentation was presented tot he surveyor by the time of surveyor exit.</p> <p>3) On July 9, 2024 at 3:57 PM, record review revealed the facility failed to provide evidence of the required Monthly Load Test for their installed 60 kW emergency backup power generator for 2023 to present. No compliance supporting documentation was presented to the surveyor by the time of surveyor exit.</p> <p>These findings were confirmed in interview with the facility Maintenance Director at the time of record review.</p> <p>4) On July 9, 2024 at 5:50 PM, observation revealed both the 60kW and 300kW diesel emergency backup power generators were missing the required NFPA 704 Hazard Identification Placards which informs</p>		<p>Director is responsible for continued compliance</p> <p>The Maintenance Director will be responsible for ongoing compliance.</p>	

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	<p>emergency responders of the hazards within an area.</p> <p>These findings were confirmed in interview with the facility Maintenance Director and Maintenance Lead at the time of observation.</p>				