PRINTED: 1/30/2025 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER:		A (X2) MULT A. BUILDIN	IPLE CON IG		(X3) DATE SURVEY COMPLETED	
		238510	B. WING		1	2/18/2024
	VIDER OR SUPPLIE				STREET ADDRESS, CITY, STATE, ZI 530 W BEECH ST	P CODE
					CHARLOTTE, MI 48813	
(X4) ID PREFIX TAG	(EACH DEFICIENT FULL REGULATION	TEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	/IDER'S PLAN OF CORRECTION (EAC RECTIVE ACTION SHOULD BE CROS FERENCED TO THE APPROPRIATE DEFICIENCY)	
E0000	Initial Comments	3	E0000			
SS=	Preparedness S Michigan Depart Regulatory Affair Certification. At t Medical Care Fa substantial comp for participation i	3, 2024, an Emergency urvey was conducted by the ment of Licensing and rs, Bureau of Survey and the survey Eaton County cility was found in blance with the requirements in Medicare/Medicaid at 42 hergency Preparedness.				
K0000	INITIAL COMME	ENTS	K0000			
SS=	Recertification S Michigan Depart Regulatory Affair Certification. At t Medical Care Fa substantial comp for participation i CFR 482.90(a), applicable provis the National Fire 101, Life Safety of NFPA 99, Hea	3, 2024, a Life Safety urvey was conducted by the ment of Licensing and rs, Bureau of Survey and the survey, Eaton County cility was found not in obliance with the requirements in Medicare/Medicaid at 42 Life Safety from Fire and the sions of the 2012 Edition of Protection Agency (NFPA) Code and the 2012 Edition alth Care Facilities Code.				
	(111) construction is fully sprinklere	single story building of type II on, built in 1966. The building ed and has supervised in the corridors and spaces dors.				
		42 certified beds. At the by the census was 127.				
K0222 SS= F	required means	gress Doors Doors in a of egress shall not be latch or a lock that requires	K0222		NT I: the facility failed to ensure do uired means of egress are not	1/27/2025 pors

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

Electronically Signed

01/17/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER:		A (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		238510	B. WING		12/18/	2024	
EATON COU	NTY MEDICAL CA	ARE FACI		DRO	STREET ADDRESS, CITY, STA 530 W BEECH ST CHARLOTTE, MI 48813		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES		PREFIX TAG Equip use of unless arrang with 1 needs with 1 according elevating 19.2.2 all occ. The fathe from The fathe from The fathe from ELEM Egres check opera				(X5) COMPLETION DATE
	egress locking staccordance with on door assembly hazard contents throughout by ar automatic fire de approved, super system. 18.2.2.2 CONTROLLED I ARRANGEMENT	TS Approved, listed delayed- ystems installed in 7.2.1.6.1 shall be permitted ies serving low and ordinary in buildings protected approved, supervised tection system or an vised automatic sprinkler .4, 19.2.2.2.4 ACCESS- EGRESS LOCKING TS Access-Controlled emblies installed in		Admini: ELEME	strator.		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIAND PLAN OF CORRECTION IDENTIFICATION NUMBER:				ISTRUCTION	(X3) DATE SURVEY COMPLETED		
		238510	B. WING		12/18/2024		
NAME OF PRO	VIDER OR SUPPLIE	R	•		STREET ADDRESS, CITY, STATE	, ZIP CO	DE
EATON COU	NTY MEDICAL CA	ARE FACI			530 W BEECH ST CHARLOTTE, MI 48813		
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULAT	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	VIDER'S PLAN OF CORRECTION (RECTIVE ACTION SHOULD BE CF FERENCED TO THE APPROPRIA DEFICIENCY)	ROSS-	(X5) COMPLETION DATE
	18.2.2.2.4, 19.2 EXIT ACCESS L Elevator lobby est accordance with on door assembly throughout by an automatic fire de approved, supersystem. 18.2.2.2 This REQUIREM evidenced by: Based on observat failed to ensure do egress are not equirequires the use of side unless meetin arrangements for c with 19.2.2.2.5.1 a locking arrangements for cwith 19.2.2.2.5.2, delay accordance with 19 egress doors in accelevator lobby exit 19.2.2.2.4. This de occupants in the exit of the properties of the proper	ion and interview, the facility ors in a required means of ipped with a latch or lock that a tool or key from the egress g the special locking clinical needs in accordance and 19.2.2.2.6, special needs ents in accordance with red egress locking in 9.2.2.2.4, access-controlled cordance with 19.2.2.2.4, or a access in accordance with efficient practice could affect all went of a fire emergency. at approximately 11:47 AM, ed the front entrance/exit at the equired special knowledge to at approximately 3:00 PM, ed the emergency exit to the at the entrance of 400 Hall was at egress and needed special					

		(X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER:				STRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER						STREET ADDRESS, CITY, STATE,	ZIP CO	DE
EATON COUNTY MEDICAL CARE FACI						530 W BEECH ST CHARLOTTE, MI 48813		
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	observation reveal outside courtyard i Hall was mag lock special knowledge These findings wer	at approximately 3:06 PM, ed the emergency exit to the near resident room 418 in 400 ed against egress and needed to exit the facility.						

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	VIDER OR SUPPLIE		•		STREET ADDRESS, CITY, STATE 530 W BEECH ST CHARLOTTE, MI 48813	, ZIP CO	DE
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA)	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECTION (E RECTIVE ACTION SHOULD BE CRI FERENCED TO THE APPROPRIAT DEFICIENCY)	OSS-	(X5) COMPLETION DATE
K0232 SS= F	Corridor or Ramwidth of aisles or unobstructed) se at least 4 feet an convenient remo patients on strete 19.2.3.4, excepti This REQUIREM evidenced by: Based on observat failed to ensure the was maintained cle accordance with 1 deficient practice event of in the every findings Include: On 12/18/2024 bet 4:05 PM, observat receptacles stored corridors without of from 100 hall thro items that are permoderidor as long al a) Equipment in use b) Medical Emergence of Patient lift and the These findings we	or Ramp Width Aisle, by Width 2012 EXISTING The corridors (clear or string as exit access shall be distributed to provide the val of nonambulatory chers, except as modified by ons 1-5. 19.2.3.4, 19.2.3.5 IENT is not met as distributed in the valid of aisles or corridors ear and unobstructed in 9.2.3.4 and 19.2.3.5. This could affect all occupants in the nt of a fire emergency. It ween the hours of 11:35 AM to ion revealed several trash on both sides of the residents wheels throughout the facility ugh 600 hall. The only wheeled nitted on one side of the lither one of the lither of the lither of observation.	K0232	or corricunobstr 19.2.3.9 occupa emerge The fac contain ELEME The Bu will more a log. Staff wi width or clear ar ELEME The Bu will com complia noncom and dur complia The Bu for ensu	illity failed to ensure the width of dors was maintained clear and ructed in accordance with 19.2.3 b. This deficient practice could a nts in the event of in the event of in the event of ency. illity will remove all non-wheeled ers from halls/corridors. INT II: ilding Services Director or designitor the halls on a monthly basis compliance. Findings will be pla II be educated regarding to ensure faisles or corridors are maintained unobstructed. INT III: ilding Services Director or designitely and the port any including services of the monthly ance logs and report any including QAPI to ensure ongoing ance. ilding Services Director is respondence sustained compliance.	.4 and ffect all f a fire Trash Trash nee s to ced on ure the ed rator	1/27/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER:		A (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		238510	B. WING			12/18/	2/18/2024	
EATON COUNTY MEDICAL CARE FACI (X4) ID SLIMMARY STATEMENT OF DESICIENCIES			,		STREET ADDRESS, CITY, STATE 530 W BEECH ST CHARLOTTE, MI 48813		DE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG				(X5) COMPLETION DATE	
K0251 SS= F	Travel Dead-Enc Path of Travel 20 corridors shall no dead-end corrido be permitted to be is impractical and 19.2.5.2 This REQUIREM evidenced by: Based upon observation facility failed to en not exceed 30 feet unfeasible to alter This deficient praction the event of a fill Findings Include: On 12/18/2024 at a observation reveal located in the pine hall are mag locke greater than 30 ft. opened with specific badge to unlock the This finding was controlled.	lors and Common Path of a Corridors and Common D12 EXISTING Dead-end of exceed 30 feet. Existing ors greater than 30 feet shall be continued to be used if it did unfeasible to alter them. IENT is not met as Vation and interview, the asure that dead-end corridors do unless it is impractical or them as required by 19.2.5.2. The could affect all occupants re emergency. Approximately 12:37 PM, ed the cross-corridor doors hall leading out to the service did creating a dead-end corridor. These mag locks can only be all knowledge key code or ese cross-corridor doors. Onfirmed by interview with the at the time of observation.	K0251	corridor impract require could a emerge The Fa door at ELEME The dorplaced ensure docume ELEME The Bu will concomplianon and duracomplianon the Bu for ensure ELEME The Bu ELEME The Bu ELEME The Bu ELEME The Bu ELEME	cility failed to ensure that dead-ens do not exceed 30 feet unless ical or unfeasible to alter them at dby 19.2.5.2. This deficient prauffect all occupants in the event of ency. cility will remove key pad securithe end of the 100 hall. ENT II: ors at the end of the 100 hall will on monthly checks by maintenathe doors are not secured and ented on a log. ENT III: ilding Services Director or designated and audit of the monthly ance logs and report any appliance findings to the Administring QAPI to ensure ongoing ance. ilding Services Director is responding sustained compliance.	it is as ctice of a fire o	1/27/2025	

STATEMENT O AND PLAN OF (F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER:	A (X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
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EATON COU	NTY MEDICAL CA	ARE FACI			530 W BEECH ST CHARLOTTE, MI 48813			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PREFIX CORRECTIVE ACTION SHOULD BE CROSS				
K0300 SS= E	the REMARKS s and 19.3 Protect not addressed by are deficient. This applicable Life S standard citation Form CMS-2567 This REQUIREM evidenced by: Based on observatialed to ensure prostorage, as required deficient practice devent of a fire emergency of the standard residents 100 hall. Unnecessary combidevelopment to a femergency.	ion and interview, the facility oper storage of combustible d by 18.3 and 19.3. This could affect 40 occupants in the	K0300	combus 19.3. Toccupa The Fa puzzles ensure and/or ELEME The Bu will mon puzzles floor on complia Activitie proper ELEME The Bu will concomplia noncon and durcomplia The Bu for ensure ELEME ELEME	cility failed to ensure proper statible storage, as required by his deficient practice could affints in the event of a fire emer cility immediately removed the from the 100 hall corridor and that puzzles will not be stored on the floor of any other corrider. ENT II: ilding Services Director or definitor the corridors to ensure the are not stored in totes and/on a monthly basis to ensure ance. Findings will be placed on a staff will be educated regar storage of activity items. ENT III: ilding Services Director or definition of a monthly basis to ensure ance. Findings will be placed on the placed of the monthly ance logs and report any inpliance findings to the Admirring QAPI to ensure ongoing ance. ilding Services Director is resuring sustained compliance	18.3 and ect 40 gency. e stored d will in totes ors. signee at on the on a log. ding the signee	1/27/2025	

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		238510	B. WING			12/18/	2024
	/IDER OR SUPPLIE		'		STREET ADDRESS, CITY, ST 530 W BEECH ST CHARLOTTE, MI 48813	TATE, ZIP CO	DE
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULAT	TEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY 'ORY OR LSC IDENTIFYING IFORMATION)	ID PREFIX TAG	COR	VIDER'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE FERENCED TO THE APPROP DEFICIENCY)	E CROSS-	(X5) COMPLETION DATE
K0379 SS= E	Door Glazing 20'smoke barrier do glazing or wired (19.3.7.6, 19.3.7.6. This REQUIREM evidenced by: Based on observatifailed to ensure op were fire-rated glasteel frames as req 19.3.7.6, 19.3.7.6. 2 practice could affe a fire emergency. Findings Include: 1. On 12/18/2024 a observation reveal vision panel are coin and out of the 6d door vision panel vision panels are coin and out of the 6d oor and had foam between the vision cross corridor door the 600 Hall between the vision the 600 Hall between the vision cross corridor door the 600 Hall between the vision cross corridor door the following the first panel are coin and out of the halls rated glazing requirent firmed by interview of the confirmed by interview of the same confirmed by interv	ENT is not met as Ion and interview, the facility enings in smoke barrier doors zing or wired glass panels in uired by NFPA 7.1.10.2, 2 and 8.5. This deficient et 30 occupants in the event of at approximately 12:54 PM, ed the cross corridor door evered obstructing clear vision 00 Hall. This cross corridor was located in the 600 Hall near at approximately 1:08 PM, ed the cross corridor door overed on the inside of the type insulation stuffed panels and the cover. These evision panels are located in the nursing station and actices obstruct a clear vision in and does not meet the fire- red. These findings were	K0379	smoke wired g by NFP 8.5. The factoross colear vi (Memoroom 6 vision p the nurrinsulating and the ELEME The croplaced ensure docume ELEME will concomplian to mand duromplian the But for ensure the But the But will concomplian the But the	cility failed to ensure opening barrier doors were fire-rated lass panels in steel frames at A 7.1.10.2, 19.3.7.6, 19.3.7 cility removed the mural covered orridor door vision panels of sion in and out of the 600 Hay Care Neighborhood) near 04 and from the cross corridorated in the 600 Hay Care Neighborhood) near 04 and from the cross corridoranels located in the 600 Hay on stuffed between the vision of stuffed between the vision of cover were removed as we see that II: See corridor doors on 600 Hay on monthly checks by mainty vision panels are not obstruented on a log. ENT III: SINT III: SINT III: SINT III: SINT IIII: SINT IIII: SINT IIII: SINT IIII: SINT IIII: SINT IIII: SINT IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII	d glazing or as required .6.2 and .6.3 and .6.3 and .6.3 and .6.3 and .6.4	1/27/2025

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	VIDER OR SUPPLIE				STREET ADDRESS, CITY, STATE 530 W BEECH ST CHARLOTTE, MI 48813	, ZIP COI	DE
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K0753 SS= F	Decorations Conbe prohibited unlimet: o Flame ret approved fire-ret and labeled for pNFPA 701. o De release less thar accordance with such as photograre attached to tifire-rated doors i 18.7.5.6(4) or 19 in existing occup quantities that a or spread is not prohibited except requirements of 19 could affect all ocemergency. Findings Include: 1. On 12/18/2024 observation reveal doors including stadining room doors wrapping paper. 2. On 12/18/2024 observation reveal corridor door near door. This disguisi	corations Combustible inbustible decorations shall less one of the following is ardant or treated with ardant coating that is listed broduct. o Decorations meet corations exhibit heat in 100 kilowatts in NFPA 289. o Decorations, aphs, paintings and other art the walls, ceilings and non- in accordance with 1.7.5.6(4). o The decorations ancies are in such limited hazard of fire development bresent. 19.7.5.6 IENT is not met as ion and interview, the facility imbustible decorations were as permitted by the 1.7.5.6. This deficient practice cupants in the event of a at approximately 12:15 PM, ed wrapping paper on several aff and guest restrooms, and decorated in Christmas at approximately 12:54 PM, ed a decorative mural on cross room 604 covering the whole ing of a door creates confusion act of where an emergency exit	K0753	decorat permitti This de occupa Decora ELEME The Bu will morare not All staff combus ELEME The Bu will concomplianoncon and duracomplia The Bu for ensite ELEME ELEME	illity failed to ensure combustible ions were prohibited except as ed by the requirements of 19.7.5 ficient practice could affect all nts in the event of a emergency. It is in the event of a emergency. It is were removed. ENT II: ilding Services Director or designitor to ensure combustible decoused. Findings will be placed or will be educated regarding stible decorations. ENT III: ilding Services Director or designitor to ensure combustible decorations. ENT III: ilding Services Director or designitor and audit of the monthly ance logs and report any appliance findings to the Administring QAPI to ensure ongoing ance. Ilding Services Director is respondering sustained compliance	nee orations n a log.	1/27/2025

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K0754	observation reveal both cross corrido station and office decorative mural in doors creating corn where the emerge These findings we Facility Maintena observations.	at approximately 12:54 PM, led a decorative mural covering r doors between the nursing #8 located in 600 Hall. This s disguising the cross corridor aftusion during an emergency of next exist is located. The confirmed by interview with nee at the time of the	1075 4				4/07/0005	
SS= F	Linen and Trash trash collection in 32 gallons in cap of container cap not exceed 0.5 gc container capacities container capacities container capacities with gallons shall be as a hazardous Containers used permitted to be containers with an or equal to and containers frand listed as me 6921 or equivaled This REQUIREN evidenced by: Based on observatifailed to ensure the containers did not or an average deniby 19.7.5.7. This containers deniby 19.7.5.7. This containers deniby 19.7.5.7.	d Trash Containers Soiled Containers Soiled linen or eceptacles shall not exceed acity. The average density acity in a room or space shall pallons/square feet. A total ty of 32 gallons shall not be any 64 square feet area. en or trash collection capacities greater than 32 located in a room protected area when not attended. It is solely for recycling are excluded from the above here each container is less 96 gallons unless attended, or combustibles are labeled enting FM Approval Standard ent. 18.7.5.7, 19.7.5.7 MENT is not met as It ion and interview, the facility at soiled linen or trash exceed 32 gallons in capacity sity of .5 gal/sq. ft. as required deficient practice could affect the event of a fire emergency.	K0754	trash cocapacitias required to the factor of	cility failed to ensure that soiled I containers did not exceed 32 galling or an average density of .5 galling or an average density of .5 galling by or an average density of .5 galling by or an average density of .5 galling or an average density of .5 galling or an average density of .5 galling fleet all occupants in the event of ency. Cility will remove all non-wheeled ers from halls/corridors. ENT II illiding Services Director or designitor the halls on a monthly basic compliance. Findings will be placed by the educated regarding the use containers, including size and square illiding Services Director or designificance an audit of the monthly ance logs and report any appliance findings to the Administring QAPI to ensure ongoing	ons in I/sq. ft. oractice of a fire I Trash I	1/27/2025	

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K0920	4:05 PM, observat receptacles with at throughout the fac through 600. Trast stored in a rated ha These findings we Facility Maintenar observations.	tween the hours of 11:35 AM to ion revealed several trash accumulation of trash illity in resident corridors 100 a receptacles and refuse must be azard room. The confirmed by interview with the at the time of the interview with the action of the interview of t	K0920	for ens	ilding Services Director is responding Sustained compliance. ENT IV: cility will be in compliance by 1.2		1/27/2025	
SS= E	Extens Electrical and Extension C patient care vicin components of n electrical equipm that have been a personnel and m 10.2.3.6. Power vicinity may not be term care resided PCREE. Power 1363A or UL 7000 power strandards. All power strandards. All power structure. Extensive tructure. Extensive tremoved immitted purpose for weets the conditi (NFPA 99), 10.2.70), 590.3(D) (NI	Equipment - Power Cords ords Power strips in a aity are only used for novable patient-care-related tent (PCREE) assembles assembled by qualified teet the conditions of strips in the patient care be used for non-PCREE tectronics), except in long-nt rooms that do not use strips for PCREE meet UL 501-1. Power strips for non-titent care rooms (outside of 1363. In non-patient care rips meet other UL over strips are used with ons. Extension cords are not tute for fixed wiring of a sion cords used temporarily nediately upon completion of which it was installed and ions of 10.2.4. 10.2.3.6. 4 (NFPA 99), 400-8 (NFPA FPA 70), TIA 12-5 IENT is not met as		ELEME The fac complia deficier the eve The fac strips fr ensure use. ELEME The Bu will mor complia All staff power s ELEME The Bu will con logs an the Adr	cility failed to ensure power strips ance with NFPA 99, and NFPA 7 nt practice could affect 47 occupant of a fire emergency. cility removed the unapproved power that Therapy gym and will authat only approved power strips. ENT II: cilding Services Director or designitor on a monthly basis to ensurance. Findings will be placed on fail will be educated regarding the estrips.	70. This ants in ower adit to are in nee re a log. use of nee pliance lings to		

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(X4) ID PREFIX TAG	(EACH DEFICIENT FULL REGULA	TEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	PREFIX CORRECTIVE ACTION SHOULD BE CRO TAG REFERENCED TO THE APPROPRIAT DEFICIENCY)			(X5) COMPLETION DATE	
K0923 SS= F	failed to ensure powith NFPA 99, an practice could affe a fire emergency. Findings Include: On 12/18/2024 at observation reveal cords located in the patient care did not 60601-1 rating. These findings we Facility Maintenal observations. Gas Equipment Storag Gas Equi Container Storag 3,000 cubic feet designed, constitutions.	ion and interview, the facility over strips are in compliance d NFPA 70. This deficient ect 47 occupants in the event of approximately 12:50 PM, led 6 multi-plug power strip the therapy gym that service at meet the UL 1362A or UL are confirmed by interview with the at the time of the confirmed to the confirmed	K0923	K923 ELEME The fact K921 ELEME The fact K923 ELEME The fact The fact of NFP affect a	The Building Services Director is responsible for ensuring sustained compliance ELEMENT IV: The facility will be in compliance by 1.27.25 K923 ELEMENT I: The facility failed to ensure storage of nonflammable gasses meet all requirements of NFPA 99. This deficient practice could affect all occupants in the event of the			
	are outdoors in a enclosed interior combustible con outdoors) that ca gases are not st are separated frr (5 feet if sprinkle of noncombustib minimum 1/2 hr. than or equal to smoke compartr available for impareas with an ag	cubic feet Storage locations an enclosure or within an a space of non- or limited-struction, with door (or gates an be secured. Oxidizing ored with flammables, and om combustibles by 20 feet ared) or enclosed in a cabinet alle construction having a fire protection rating. Less 300 cubic feet In a single ment, individual cylinders nediate use in patient care gregate volume of less than subic feet are not required to		The fact doors to (ES) So require combustorage between ELEME The Bu will more	ent need of oxygen. Sility will post laminated signage of that reads "CAUTION: OXIDIZING TORED WITHIN NO SMOKING" d. The facility will ensure no stibles are stored within 5 ft. of oxide located in the oxygen storage roun 100 and 200 Hall. ENT II: Siliding Services Director or designance. Findings will be placed on a silicity will provide the storage will be placed on a silicity will be p	G GAS as xygen com		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLI. IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		238510	B. WING _			12/18/	2024
NAME OF PROV			STREET ADDRESS, CITY, STATE, ZIP C 530 W BEECH ST CHARLOTTE, MI 48813			DE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure storage of nonflammable gasses meet all requirements of NFPA 99. This deficient practice could affect all occupants in the event of the emergent need of oxygen.		ID PREFIX TAG	All staff of oxyg ELEME The Bu will con logs an the Adr ongoing The Bu for ensi			(X5) COMPLETION DATE
	observation reveal between 100 and 2 on the door that re GAS(ES) STORE required. 2. On 12/18/2024 observation reveal within 5 ft. of oxy	at approximately 12:12 PM, ed the oxygen storage room 200 Hall did not have signage ads "CAUTION: OXIDIZING D WITHIN NO SMOKING" as at approximately 12:13 PM, ed combustibles are stored gen storage located in the tom between 100 and 200 Hall.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		238510		B. WING			12/18/2024	
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE			, ZIP CODE	
EATON COUNTY MEDICAL CARE FACI						530 W BEECH ST CHARLOTTE, MI 48813		
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULAT	TEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY 'ORY OR LSC IDENTIFYING IFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EA CORRECTIVE ACTION SHOULD BE CROS REFERENCED TO THE APPROPRIATE DEFICIENCY)		SS-	(X5) COMPLETION DATE
		re confirmed by interview with ce at the time of the						