STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	138520	A. BUILDING _____ B. WING _____	**2/21/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALHOUN COUNTY MEDICAL CARE FACILITY	**1150 E MICHIGAN AVE BATTLE CREEK, MI 49014**

(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 February 19th through 21st, 2025, an Emergency Preparedness Survey was conducted by the Michigan Department of Licensing and Regulatory Affairs, Bureau of Survey and Certification. At the survey Calhoun County Medical Care Facility was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.73, Emergency Preparedness.	E0000		

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

Electronically Signed | 03/15/2025

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.

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K0000 SS=	INITIAL COMMENTS On February 19th though 21st, 2025, a Life Safety Recertification Survey was conducted by the Michigan Department of Licensing and Regulatory Affairs, Bureau of Survey and Certification. At the survey, Calhoun County Medical Care Facility 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 two story building, with a partial basement, built at two different times. The original building built in 1977, was determined to be Type II (222) construction. The addition built in 2007, was determined to be Type II (000) construction. The buildings were surveyed as one building. The building is fully sprinklered and has supervised smoke detection in the corridors and spaces open to the corridors. The facility has 120 certified beds. At the time of the survey the census was 96.	K0000		
K0324 SS= D	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	K0324	K324 was cited at a D level deficiency. The plan of correction is as follows: At the direction of the Administrator, upon identification of the concern, the gas line for the kitchen tilt skillet burner was corrected on 2/27/2025. At the direction of the Administrator, on 3/7/2025, all other gas appliances in the building were checked and there were no	3/21/2025

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	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 and interview, the facility failed to ensure cooking facilities are protected in accordance with NFPA 96. This deficient practice could affect 10 occupants in the event of a fire emergency. Findings Include: On 02/20/2025, at approximately 12:09 PM, observation revealed the gas line for the kitchen tilt skillet burner had a non-commercial grade piping as required in NFPA 54-9.6.1. This finding was confirmed by interview with Facility Maintenance at the time of observation.		other corrections needed. On 3/11/25, maintenance staff were educated on the correction made and the expectation that with any new appliances that may be installed, we will ensure that proper gas lines are installed. Additionally, at the direction of the Administrator, a QAPI study was developed to ensure that the identified concerns are monitored for compliance. Findings will be discussed with the Facility□s QAPI committee until such time consistent substantial compliance has been met. The Administrator is responsible for attaining and sustaining overall compliance with this Plan of Correction.	
K0341 SS= E	Fire Alarm System - Installation Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is	K0341	K341 was cited at an E level deficiency. The plan of correction is as follows: At the direction of the Administrator, upon identification of the concern, the cited smoke detectors were moved to comply with requirements on 2/26/2025. At the direction of the Administrator, on or before 3/14/2025, a building-wide audit was	3/21/2025

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	also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure a fire alarm system is installed in accordance with NFPA 70 and NFPA 72-29.8.3.4 (6) This deficient practice could affect 45 occupants in the event of a fire emergency. Findings Include: 1. On 02/20/2025, at approximately 1:46 PM, observation revealed a smoke and heat detector within 3 feet of direct airflow to a air return/supply on the ceiling located in the Willow Court kitchen. 2. On 02/20/2025. at approximately 2:01 PM, observation revealed the smoke detector was within 3 feet of direct airflow to a diffuser on the ceiling located in the Blue Spruce Nurse Manager Office. These findings were confirmed by interview with Facility Maintenance at the time of observation.		done to identify other related smoke detector concerns and make corrections as needed. On 3/11/25, maintenance staff were educated on the corrections made and the expectation that with any new smoke detectors that may be installed, we will ensure that proper distance is maintained from a direct airflow. Additionally, at the direction of the Administrator, a QAPI study was developed to ensure that the identified concerns are monitored for compliance. Findings will be discussed with the Facility□s QAPI committee until such time consistent substantial compliance has been met. The Administrator is responsible for attaining and sustaining overall compliance with this Plan of Correction.	
K0372 SS= E	Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC	K0372	K372 was cited at an E level deficiency. The plan of correction is as follows: At the direction of the Administrator, Maintenance staff used fire-rated caulk to seal the identified wall penetrations 2/24/2025. On or before 3/14/25, Maintenance staff	3/21/2025

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	systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure smoke barriers were constructed to a minimum 1/2-hour fire resistance rating in accordance with 8.5, as required by 19.3.7.3 and 8.6.7.1(1). This deficient practice could affect 45 occupants in the event of a fire emergency. Findings Include: 1. On 02/20/2025, at approximately 10:06 AM, observation revealed above the suspended ceiling at the smoke barrier doors located at Beechwood Hill next to the elevator is a unsealed penetration approximately 3"x 4" with data lines running through. 2. On 02/20/2025, at approximately 10:06 AM, observation revealed above the suspended ceiling at the smoke barrier doors located at Willow Court Dining is a unsealed penetration at the fire suppression pipe with data lines and cable running through. These findings were confirmed by interview with Facility Maintenance at the time of observation.		checked all smoke-barriers for any unsealed penetrations and no areas of concern were identified. On 3/12/2025, the Facility revised the Contractor Firewall/Ceiling/Floor penetrations log that is used when contractors are completing work in the building to ensure any new penetrations are caulked appropriately. The Maintenance Team Leader or Facility Operations Manager will complete random checks of recent contractor or maintenance staff work that has the potential for penetrating smoke compartments to ensure proper caulking was completed. Any issues will be resolved immediately once identified. On 3/11/25, the Facility□s policy titled Sealing of Through Penetrations in Floors, Decking, Walls, and Ceilings was reviewed to ensure it remains appropriate. On 3/11/25, all Facility staff who coordinate with contractors in the building were educated on the Facility□s plan of correction related to ensuring wall penetrations are sealed appropriately. Additionally, at the direction of the Administrator, a QAPI study was developed to ensure that the identified concerns are monitored for compliance. Findings will be discussed with the Facility□s QAPI committee until such time consistent substantial compliance has been met. The Administrator is responsible for attaining and sustaining overall compliance with this Plan of Correction.	
	Electrical Systems - Essential Electric Syste	K0918	K918 was cited at an F level deficiency. The	3/21/2025

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K0918 SS= F	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 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 record review and interview, the facility failed to ensure generators or other alternative power source are in accordance with NFPA 110,		plan of correction is as follows: At the direction of the Administrator, both Facility generators will have a fuel sample collected for testing on or before 3/21/2025. If any concerns are identified from the sample, corrective action will be taken. On 3/11/2025, the Facility signed an updated contract with its routine maintenance provider for the generators to ensure a fuel quality test is performed annually as part of routine preventative maintenance checks. On 3/11/2025 the Facility□s Emergency Generator Operations and Testing policy was revised to include annual fuel sample tests being completed. On 3/11/25, maintenance staff were educated on the problem identified and that Facility□s plan for correction going forward. Additionally, at the direction of the Administrator, a QAPI study was developed to ensure that the identified concerns are monitored for compliance. Findings will be discussed with the Facility□s QAPI committee until such time consistent substantial compliance has been met. The Administrator is responsible for attaining and sustaining overall compliance with this Plan of Correction.	

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	NFPA 99, NFPA 111 and NFPA 70. This deficient practice could affect all occupants in the event of generator failure. Findings Include: On 02/19/2025, at approximately 11:09 AM, record review revealed the facility failed to provide documentation for a fuel quality test has been performed during the last 12 months, per NFPA 110, 8.3.8, fuel quality test performed at least annually using tests approved by ASTM standards. No fuel quality test was provided to this surveyor by the exit of the survey. This finding was confirmed by interview with Facility Maintenance at the time of record review.			
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	K923 was cited at an F level deficiency. The plan of correction is as follows: At the direction of the Administrator, upon identification of the concern, signage was replaced on the cited door to ensure proper size on 3/4/2025. The Facility checked all other oxygen storage areas to ensure proper signage size on or before 3/14/2025. Maintenance routinely checks for oxygen storage signs during routine rounds and will continue to do so with the new signage. On 3/11/25, maintenance staff were educated on the problem identified and that Facility□s plan for correction going forward. Additionally, at the direction of the Administrator, a QAPI study was developed to ensure that the identified concerns are monitored for compliance. Findings will be	3/21/2025

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	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 20 occupants in the event of a fire emergency. Findings Include: On 02/21/2025 at approximately 11:25 AM, observation revealed the Beechwood Med room is storing oxygen and is missing proper signage on the door. This signage must read "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING" as required by NFPA 99 2012 edition 11.3.4.2. This finding was confirmed by interview with Facility Maintenance at the time of observation.		discussed with the Facility□s QAPI committee until such time consistent substantial compliance has been met. The Administrator is responsible for attaining and sustaining overall compliance with this Plan of Correction.	