STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344020	A. BUILDING _____ B. WING _____	**3/5/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKLD IONIA	**814 E LINCOLN AVE IONIA, MI 48846**

(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 March 5, 2025 an Emergency Preparedness Survey was conducted by the Michigan Department of Licensing and Regulatory Affairs, Bureau of Survey and Certification. At the survey SKLD Ionia was found to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.73, Emergency Preparedness.	E0000		
K0000 SS=	INITIAL COMMENTS On March 5, 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, SKLD Ionia 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 one story building of type II (000) construction, built in 1962, with C and D wings added in 1964. The building is fully sprinklered and has supervised smoke detection in the corridors and spaces open to the corridors. The facility has 107 certified beds. At the time of the survey the census was 63.	K0000		

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

Electronically Signed | 03/24/2025

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 AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344020	A. BUILDING _____ B. WING _____	**3/5/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKLD IONIA	**814 E LINCOLN AVE IONIA, MI 48846**

(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
K0355 SS= F	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: Based on record review and interview, the facility failed to ensure portable fire extinguishers are selected, installed, inspected and maintained in accordance with NFPA 10. This deficient practice could potentially affect all occupants and staff in the event of a fire within the facility. Findings Include: On March 5, 2025 between 12:00 pm and 1:30 pm, record review revealed the facility failed to maintain fire extinguishers. The annual service report dated 2/28/25, indicated eight fire extinguishers failed and one extinguisher leaked down. The failed extinguishers were past due on hydrostatic testing. This finding was confirmed by interview with the facility Maintenance Director and Administrator at the time of record review. As required by NFPA 10, 8.3.1	K0355	1. No residents were affected by the deficient practice. 2. The deficient practice could affect all residents, staff and visitors in the event of a fire. 3. Kingdom Fire Protection was at the facility on 3/18/25 and performed hydrostatic testing on ABC fire extinguishers and replacement of fire extinguishers due to leak down. All fire extinguishers have passed inspection and are functioning property therefore putting facility in compliance with state and local regulations. 4. The Administrator/designee will be responsible for maintaining and sustaining compliance. This plan of correction will be monitored at the monthly Quality Assurance meeting until such time consistent substantial compliance has been met. Corrective action completion date:3/18/25	3/18/2025
K0918 SS= F	Electrical Systems - Essential Electric Syste 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	K0918	1. No residents were affected by the deficient practice. 2. The deficient practice could affect all residents, staff and visitors in the event of a power outage. 3. Kohler was out on 1/29/25 and took fuel sample testing on the emergency generator. The report indicates Kohler received the sample on 2/24/25 and completed the results on 3/6/25. The facility did not receive report until 3/10/25 from Kohler. The overall results	3/10/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344020	A. BUILDING _____ B. WING _____	**3/5/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKLD IONIA	**814 E LINCOLN AVE IONIA, MI 48846**

(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
	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, NFPA 99, NFPA 111 and NFPA 70. This deficient practice could potentially affect all occupants in the event of a failure of the emergency power systems. Findings Include: On March 5, 2025 between 12:00 pm and 1:30 pm, record review revealed the facility failed to provide documentation of the required annual		are satisfactory therefore putting facility in compliance with state and local regulations. 4. The Administrator/designee will be responsible for maintaining and sustaining compliance. This plan of correction will be monitored at the monthly Quality Assurance meeting until such time consistent substantial compliance has been met. Corrective action completion date: 3/10/25	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344020	A. BUILDING _____ B. WING _____	**3/5/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKLD IONIA	**814 E LINCOLN AVE IONIA, MI 48846**

(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
	fuel sample testing on the diesel emergency generator. A report dated 1/29/25, indicated a lubricant oil analysis was completed not fuel sample testing. This finding was confirmed by interview with the facility Maintenance Director and Administrator at the time of record review. As required by NFPA 110, 8.3.7			