STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	506014	A. BUILDING 01 B. WING _____	08/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICHIGAN VETERANS HOME OF CHESTERFIELD TOWNSHIP	47901 SUGARBUSH RD CHESTERFIELD TOWNSHI, MI 48047

(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
E 000	Initial Comments On August 4, 2021, an initial Emergency Preparedness Survey was conducted by the Michigan Department of Licensing and Regulatory Affairs. At the survey, Michigan Veterans Home of Chesterfield Twp was found not to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.73, Emergency Preparedness.	E 000		
E 025 SS=F	Arrangement with Other Facilities CFR(s): 483.73(b)(7) §403.748(b)(7), §418.113(b)(5), §441.184(b)(7), §460.84(b)(8), §482.15(b)(7), §483.73(b)(7), §483.475(b)(7), §485.625(b)(7), §485.920(b)(6), §494.62(b)(6). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] *[For Hospices at §418.113(b), PRFTs at §441.184,(b) Hospitals at §482.15(b), and LTC Facilities at §483.73(b):] Policies and procedures. (7) [or (5)] The development of arrangements with other [facilities] [and] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients.	E 025	On August 11, 2021, entered into a MOU with Martha T. Berry MCF with developed an arrangement to receive members in the event of limitations or cessations of operations to maintain the continuity of service to Home's members. All members residing in the home have the potential to be affected by the deficient practice. The Home's Administrator, Director of Nursing (DON) and Maintenance Director will annually review the Home's Emergency Plan, review and amend MOU as necessary to maintain the continuity of service for Home's members. Home's Administrator, DON and Maintenance Director will sign annually and as necessary with updates. The Home's Administrator will audit and maintain compliance with the Home's Emergency Plan to ensure MOU is in place and active. Date of Alleged Compliance: September 6, 2021	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 8/25/21

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E 025	Continued From page 1 *[For PACE at §460.84(b), ICF/IIDs at §483.475(b), CAHs at §486.625(b), CMHCs at §485.920(b) and ESRD Facilities at §494.62(b):] Policies and procedures. (7) [or (6), (8)] The development of arrangements with other [facilities] [or] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. *[For RNHCIs at §403.748(b):] Policies and procedures. (7) The development of arrangements with other RNHCIs and other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of non-medical services to RNHCI patients. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to develop arrangements with other LTC facilities and other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. This deficient practice could affect all facility occupants in the event of an emergency requiring evacuation and/or relocation of residents. Findings Include: On August 4, 2021 at 4:30 PM, record review revealed the facility failed to include in their Emergency Plan (EP) copies of the arrangements and/or any agreements the facility has with other facilities to receive patients (residents) in the event the facility is not able to care for them during an emergency.	E 025		

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E 025	Continued From page 2 These findings were confirmed in interview with the Director of Maintenance and Facility Administrator at the time of record review.	E 025		
K 000	INITIAL COMMENTS On August 4, 2021, an initial Life Safety Recertification Survey was conducted by the Michigan Department of Licensing and Regulatory Affairs, Bureau of Community and Health Systems. At the survey, Michigan Veterans Home of Chesterfield Twp was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire and the applicable provisions of the 2012 Edition of the National Fire Protection Agency (NFPA) 101, Life Safety Code and the 2012 Edition of NFPA 99, Health Care Facilities Code. The facility is a 1 story building of Type II (000) construction, built in 2020. The building is fully sprinklered and has supervised smoke detection in the corridors and spaces open to the corridors. The facility has 123 certified beds. At the time of the survey the census was 24. The requirement at 42 CFR, subpart 483.90(a) is NOT MET as evidenced by:	K 000		
K 291 SS=D	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2 hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1	K 291	No single member has been identified to be affected by the deficient practice. All members residing in the home have the potential to be affected by the deficient practice in the event of power	

		loss. Maintenance Director has testing Emergency Light to establish baseline. The Home's procedure for Emergency Control of Utilities was reviewed by Maintenance Director. Emergency Lighting inspection schedule was attached to the lighting for monthly checks The Home's Maintenance Director will audit for Emergency Lighting to be tested monthly for 30 seconds and annually for 90 minutes. Date of Compliance: September 6, 2021	

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K 291	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based upon records review and interview, the facility failed to ensure that automatic emergency lighting of 1-1/2 hour duration is provided in accordance with 7.9 as required by 18.2.9.1. This deficient practice could affect an isolated number of facility occupants in the event of loss of commercial power. Findings Include: On August 4, 2021 at 11:10 PM, record review revealed the facility failed to provide documentation of the required "Monthly 30 Second Testing" of their installed emergency lighting system for the months of May and June of 2021. These findings were confirmed in interview with the facility Director of Maintenance at the time of record review.	K 291	
K 324 SS=E	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: *residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2. *cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3,	K 324	No single member has been identified to be affected by the deficient practice. All members residing in the home have the potential to be affected by the deficient practice in the event of emergency in the Freshwater kitchenette and the misaligned suppression system nozzles are unable to provide coverage to the affected area to extinguish fire. All members residing in the home have the potential to be affected by the deficient practice in the event of emergency in Freshwater and Heritage kitchenette and the warming shelve prohibits the suppression system nozzles to provide coverage to the affected area to extinguish the fire. The Maintenance Director will realign the suppression system nozzle in the Freshwater kitchenette to ensure complete coverage of affected stove top

	in the event of an emergency. The Maintenance Director will remove all warming shelves from the stove top units in efforts to ensure complete coverage of the stove top unit from the suppression system in the event of an emergency. The Maintenance Director or designee will audit for proper alignment of the suppression system nozzle in Freshwater once a week for 4 weeks and then monthly for three months. Date of Compliance: September 6, 2021	

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K 324	Continued From page 4 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 upon observation and interview, the facility failed to ensure that cooking facilities are protected in accordance with NFPA 96 unless meeting the requirements of 18.3.2.5.2, 18.3.2.5.3, or 18.3.2.4.4 as required by 18.3.2.5.1 through 18.3.2.5.4, 9.2.3, and TIA 12-2. This deficient practice could affect more than a limited number of facility occupants in the event of fire on the protected cooking equipment. Findings Include: 1) On August 4, 2021 at 1:30 PM, observation revealed 1 of 3 hood suppression system nozzles located in the Freshwater Kitchenette was misaligned and did not provide the adequate coverage for its specific portion of the range top. 2) On August 4, 2021 at 1:33 PM, observation revealed a prohibited warming shelf installed at the rear of the range top stove in the Freshwater Kitchenette. The shelf partially obstructs the hood suppression system nozzles coverage area. 3) On August 4, 2021 at 4:41 PM, observation revealed a a prohibited warming shelf installed at the rear of the range top stove in the Heritage	K 324	

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K 324	Continued From page 5 Kitchenette. The shelf partially obstructs the hood suppression system nozzles coverage area. These findings were confirmed in interview with the facility Director of Maintenance at the time of discovery.	K 324	
K 353 SS=E	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked b) Who provided system test c) Water system supply source Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based upon observation and interview, the ~~facility failed to ensure that~~ 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 more than a limited number of facility	K 353	No single member has been identified to be affected by the deficient practice. All members residing in the home have the potential to be affected by the deficient practice in the event of emergency in the Home. The Maintenance Director has located the affected areas and will fire caulk the ceiling tile to create heat barrier to facilitate proper functioning of installed sprinkler heads. The items in the walk-in cooler/refrigerator have been removed in efforts to create the 18" clearing for the sprinkler head. The Maintenance Director will audit the home for any additional affected areas and fire the ceiling tile to create heat barrier to facilitate proper functioning of installed sprinkler heads. The Maintenance Director or designee will audit once a week for 4 weeks and then monthly for three months. Date of Compliance: September 6, 2021

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K 353	Continued From page 6 occupants in the event of a fire by preventing ceiling tiles to act as heat barriers to facilitate proper functioning of installed sprinkler heads. Findings Include: On August 4, 2021 the following deficiencies were observed at the times and locations indicated: 1) At 1:25 PM, ceiling tile penetrations at the Ansel Hood Suppression System piping above door to the Freshwater Kitchenette. 2) At 1:37 PM, ceiling tile penetration above the linen rack in the Freshwater Clean Linen Room. 3) At 1:57 PM, ceiling tile penetration around the electrical conduit in Room #130 Housekeeping in Anchor Bay. 4) At 2:33 PM, ceiling tile penetration at the wire bundle in Room #350 Equipment Storage Room. 5) At 2:40 PM, ceiling tile penetrations at the Ansel Hood Suppression System piping above the door to the Crossings Kitchenette. 6) At 3:29 PM, stock items stored within 18" of sprinkler heads in the main kitchen walk-in refrigerator and freezer. 8) At 3:30 PM, ceiling tile penetrations at the gas valve piping to the hood suppression subsystem in the main kitchen. 9) At 4:03 PM, ceiling tile penetration above the electrical box in Storage Room #839. 10) At 4:40 PM, ceiling tile penetrations at the	K 353		

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K 353	Continued From page 7 Ansel Hood Suppression System piping above the range top in the Heritage Kitchenette. These findings were confirmed in interview with the facility Director of Maintenance at the time of observation.	K 353		
K 372 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 NEW Smoke barriers shall be constructed to provide at least a one hour fire resistance rating and constructed in accordance with 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations of fully ducted HVAC systems. 18.3.7.3, 18.3.7.4, 18.3.7.5, 8.3 Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based upon observation and interview, the facility failed to ensure that smoke barriers were constructed to a minimum 1-hour fire resistance rating in accordance with 8.5 as required by 18.3.7.3 and 8.6.7.1(1). This deficient practice could affect more than a limited number of occupants in the event of a fire producing toxic gases and smoke. Findings Include: On August 4, 2021 the following deficiencies were observed at the times and locations indicated:	K 372	No single member has been identified to be affected by the deficient practice. All members residing in the home have the potential to be affected by the deficient practice in the event of emergency in the Home. The Maintenance Director has located the affected areas and will fire caulk the smoke barriers ceiling tiles. The Maintenance Director will audit the home for any additional affected areas and fire the ceiling tile to create heat barrier to facilitate proper functioning of installed sprinkler heads. Date of Compliance: September 6, 2021	

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K 372	Continued From page 8 1) At 1:10 PM, penetrations in the fire barrier at the electrical conduit and low-voltage conduit in the Freshwater IT Room. 2) At 2:16 PM, fire barrier penetrations above the ceiling tiles at the cross corridor doors by the N107 Conference Room. 3) At 2:30 PM, fire barrier penetrations above the ceiling tiles at the cross corridor HVAC ducts, at 3 eletrical conduits and a 3"penetration in the cinder block at the M117 cross corridor door set. 4) At 3:55 PM, fire barrier penetration above the ceiling tiles approximate 3" x 5" above the cross corridor door set by the Meditation Room. 5) At 4:00 PM, fire barrier penetration in the Selfridge IT Room above the IDF Rack. These findings were confirmed in interview with the facility Director of Maintenance at the time of observation.	K 372		