Department of Veterans Affairs State Veterans Home Survey Report

This survey report and the information contained herein, resulted from the State Veterans Home (SVH) Survey as a Summary Statement of Deficiencies. (Each Deficiency Must be Preceded by Full Regulatory or applicable Life Safety Code Identifying Information.) Title 38 Code of Federal Regulations Part 51 is applied for SVHs applicable by level of care.

General Information:

Facility Name: Michigan Veteran Homes at Chesterfield Township

Location: 47901 Sugarbush Road, Chesterfield Township, MI 48047

Onsite / Virtual: Onsite

Dates of Survey: 8/26/25 – 8/29/25

NH / DOM / ADHC: Nursing Home

Survey Class: Annual

Total Available Beds: 128

Census on First Day of Survey: 121

Surveyed By: Adewale Balogun, Generalist**;** Dawna Nygaard, RN; Wylona Coleman, RN; Stephen Fryar, RCP; David Walker (LSC); Kathryn Scott, VACO.

VA Regulation Deficiency	Findings
	Initial Comments: A VA Annual Survey was conducted from August 26, 2025, through August 29, 2025, at the Michigan Veteran Homes at Chesterfield Township. The survey revealed the facility was not in compliance with Title 38 CFR Part 51 Federal Requirements for State Veterans Homes.
§ 51.120 (i) Accidents. The facility management must ensure that— (1) The resident environment remains as free of accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. **Rating** – Not Met **Scope and Severity** – F **Residents Affected** – Many	Based on observation, staff interviews, and facility policy review, the facility failed to ensure the resident environment remained as free of accident hazards as possible. Specifically, the facility failed to equip the public male and female restrooms, located in the main lobby, with an emergency call system to allow residents to summon aid in case of an emergency. This failure affected all residents who were independently mobile or participated in recreational and faith-related activities in the main lobby, placing them at risk for delayed assistance in the event of a fall or other medical emergency while using the restroom. The findings include: The facility's policy titled, "ACCIDENTS/INCIDENTS, INVESTIGATION AND REPORTING v3," last revised on 9/18/25, documented that an "Accident" referred to “any

	unexpected or unintentional incident which results or may result in injury or illness to a member." The policy stipulated that in the event of an incident or accident, immediate assistance would be provided. The policy did not address a call light system or other system to request assistance while in the identified restrooms. During the survey from 8/26/25, through 8/29/25, it was observed that the facility utilized its front lobby area for various activities, including but not limited to family visitation, recreational, and faith-related gatherings. Residents from all eight (8) of the facility's units who were independent with mobility and/or utilized wheelchairs for mobility had access to and utilized the public restrooms in the lobby. The restrooms were observed to be unlocked and were not monitored by staff. On 8/27/25, at 1:13 p.m., a tour of the public restrooms was conducted with the Director of Maintenance. The male public restroom contained two (2) urinals and two (2) stalls, one (1) of which was designated as handicap accessible. A thorough observation of this area confirmed the complete absence of any emergency call capability, such as an emergency pull cord, at either the urinals or within the stalls. Similarly, the female public restroom, which contained four (4) stalls with one (1) designated as handicap accessible, was also found to be lacking any form of emergency call system that would aid a resident in getting staff assistance in the event of an emergency. During an interview, on 8/27/25, at approximately 1:20 p.m., the Director of Maintenance confirmed the restrooms were part of the original building design and were not equipped with emergency pull cords like those found in the resident rooms. The Director of Maintenance stated that the facility had not previously identified this as a necessary safety feature. During an interview, on 8/27/25, at 3:30 p.m., the Director of Nurses stated that while the facility encouraged resident independence and participation in activities, the potential hazard of not having call lights in the lobby restrooms had been overlooked. During an interview, on 8/27/25, at 3:37 p.m., the facility Administrator stated that he/she agreed with the findings and described the situation (the complete absence of any emergency call capability in the public restroom) as a valid concern and an oversight. The Administrator explained that as the facility worked to make the lobby a more active space for residents, they had failed to re-evaluate the safety features of the surrounding environment.