STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235728	A. BUILDING _____ B. WING _____	01/30/2023

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) COMPLETE DATE
E000	Initial Comments On January 30, 2023, an Emergency Preparedness Survey was conducted by the Michigan Department of Licensing and Regulatory Affairs, Bureau of Survey and Certification. At the survey, Michigan Veterans Home Of Chesterfield Township was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.73, Emergency Preparedness.	E000		
E004 SS=F	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) 403.748(a), 416.54(a), 418.113(a), 441.184(a), 460.84(a), 482.15(a), 483.73(a), 483.475(a), 484.102(a), 485.68(a), 485.542(a), 485.625(a), 485.727(a), 485.920(a), 486.360(a), 491.12(a), 494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at 482.15 and CAHs at 485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal,	E004	On January 31, 2023, EP manuals for three neighborhoods- Crossing, Heritage and Sunrise were reviewed and signed by Administrator, Director of Nursing and Maintenance Director for the 2023-Annual year. Manuals were placed at each of the nursing stations for accessibility for nursing staff in the event of an emergency. All members residing in the home have the potential to be affected by the deficient practice. The Homes Administrator, Director of Nursing (DON) and Maintenance Director will annually review the Homes Emergency Plan and amend as necessary. The Homes Administrator or designee will audit quarterly for placement of manuals on all neighborhood/nursing stations for accessibility for staff in the event of an emergency. This task will be placed in the Homes TELS/work order software to assist with on-going compliance.	1/31/23

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	235728	A. BUILDING _____ B. WING _____	01/30/2023

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E004	Continued From page 1 and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at 483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at 494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. . This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to develop and maintain an Emergency Preparedness plan that must be reviewed and updated at least annually. This deficient practice could affect all facility occupants in the event of a fire or other emergency situation. Findings Include: On January 30, 2023 between 2:00 PM and 3:20 PM, record review revealed the facility failed to conduct the required annual update to their distributed "Disaster Plan" at the "Heritage", "Sunrise" and "Crossings" Nurse Stations. The last documented update was 2021.	E004	Date of Alleged Compliance: January 31, 2023	

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E004	Continued From page 2 These findings were confirmed in interview with the Facility Maintenance Director at the time of record review.	E004		
E015 SS=F	Subsistence Needs for Staff and Patients CFR(s): 483.73(b)(1) 403.748(b)(1), 418.113(b)(6)(iii), 441.184(b)(1), 460.84(b)(1), 482.15(b)(1), 483.73(b)(1), 483.475(b)(1), 485.542(b)(1), 485.625(b)(1) [(b) Policies and procedures. [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 every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal.	E015	No single member has been identified to be affected by the deficient practice. Storage room C-115 has been label clearly to identify the location of Emergency Food and Water supply. All members residing in the home have the potential to be affected by the deficient practice in the event of emergency which requires the Home to utilize emergency food and/or water supply. The Homes policy for Emergency Supplies Planning was reviewed by Maintenance Director and Administrator and deem appropriate. The Homes Director of Nutrition Services will audit the Emergency Food and Water supply room (C-115) monthly to ensure only emergency items are properly stored and available in the event of an emergency.	2/17/23

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E015	Continued From page 3 *[For Inpatient Hospice at 418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to develop, at a minimum, policies and procedures that address; the provision of subsistence needs for staff and patients whether they evacuate or shelter in place, including, but not limited to: Food, water, medical and pharmaceutical supplies, alternate sources of energy to maintain temperatures to protect patient health and safety and for the safe and sanitary storage of provisions, emergency lighting, fire detection, extinguishing and alarm systems, and sewage and waste disposal. This deficient practice could affect all facility occupants in the event of a fire, shelter-in-place or evacuation order.	E015		

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E015	Continued From page 4 Findings Include: On January 30, 2023, at 3:15 PM, observation revealed the facility's emergency food supplies were not adequately identified and segregated from their "non-emergency stock" in the Kitchen Dry Storage Room. This could cause confusion for the Dietary Staff in maintaining the required level of reserve of food for the facility occupants. Theses findings were confirmed in interview with the Facility Maintenance Director at the time of observation.	E015		

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K000	INITIAL COMMENTS On January 30, 2023, a Life Safety Recertification Survey was conducted by the Michigan Department of Licensing and Regulatory Affairs, Bureau of Survey and Certification. At the survey, Michigan Veterans Home Of Chesterfield Township was found 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, with no basement, 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 92. The requirement at 42 CFR, subpart 483.90(a) is MET.	K000		

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