| PRINTED: 03/11/2024 |
|---------------------|
| FORM APPROVED |
| OMP NO 0038 0301 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | A. B | MULTIPLE CONSTRUCTION UILDING | (X3) DATE SURV COMPLETE | | | |
|--|---|--|---|---|---|----------|----------|--------------------------|
| | | 235728 | B. W | /ING | 01/30/ | 2023 | | |
| NAME OF PROVIDER OR SUPPLIER MICHIGAN VETERANS HOME OF CHESTERFIELD TOWNSHIP | | | STREET ADDRESS, CITY, STATE, ZIP CC 47901 SUGARBUSH RD CHESTERFIELD TOWNSHI, MI | | | | | |
| (X4) ID PREFIX TAG | FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | ID PREFI TAG | | HOULD BE | (X5) COMPLETE DATE |
| E000 | Initial Comments | 3 | E000 | • | | | | |
| | Preparedness Su Michigan Depart Regulatory Affair Certification. At Home Of Cheste in substantial con for participation i | 2023, an Emergency urvey was conducted by the ment of Licensing and rs, Bureau of Survey and the survey, Michigan Veterans erfield Township was found not mpliance with the requirements in Medicare/Medicaid at 42 CFR ncy Preparedness. | | | | | | |
| E004 SS=F | CFR(s): 483.73(a 403.748(a), 416. 460.84(a), 482.1 484.102(a), 485. 485.727(a), 485. 494.62(a). The [facility] mus Federal, State ar preparedness re develop establish comprehensive e program that me section. The eme must include, bu elements: (a) Emergency F and maintain an that must be [rev every 2 years. T following: * [For hospitals a 485.625(a):] Eme | h, Review and Update Annually a) 54(a), 418.113(a), 441.184(a), 5(a), 483.73(a), 483.475(a), 68(a), 485.542(a), 485.625(a), 920(a), 486.360(a), 491.12(a), st comply with all applicable nd local emergency quirements. The [facility] must h and maintain a emergency preparedness sets the requirements of this ergency preparedness program t not be limited to, the following Plan. The [facility] must develop emergency preparedness plan viewed], and updated at least The plan must do all of the at 482.15 and CAHs at ergency Plan. The [hospital or by with all applicable Federal, | E004 | On January 31, 2023, EP mathree neighborhoods- Crossin and Sunrise were reviewed a Administrator, Director of Num Maintenance Director for the year. Manuals were placed at nursing stations for accessibil staff in the event of an emerg All members residing in the h potential to be affected by the practice. The Homes Administrator, Dir Nursing (DON) and Maintena will annually review the Home Plan and amend as necessar The Homes Administrator or a audit quarterly for placement on all neighborhood/nursing s accessibility for staff in the event of an emergency. This task will be Homes TELS/work order softwith on-going compliance. | ag, Heritage and signed by sing and 2023-Annual ceach of the ity for nursing ency. ome have the deficient rector of ace Director es Emergency y. designee will of manuals stations for ent of an blaced in the | 1/31/23 | | |
| | | DER/SUPPLIER REPRESENTATIVE'S SIGNA | TURF | TITLE | () | K6) DATE | | |

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 the 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.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

Electronically Signed

02/10/2023

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED | |
|--|---|---|--------------------|---|--|--|------|
| | | 235728 | | | | 01/30/ | 2023 |
| NAME OF PROVIDER OR SUPPLIER MICHIGAN VETERANS HOME OF CHESTERFIELD TOWNSHIP | | - | | STREET ADDRESS, CITY, STATE, ZIP COD 47901 SUGARBUSH RD CHESTERFIELD TOWNSHI, MI 48 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY) | N SHOULD BE COMPLETE E APPROPRIATE DATE | |
| E004 | requirements. T develop and mai emergency prepa- the requirements hazards approad * [For LTC Facilit Plan. The LTC fa- maintain an eme must be reviewe annually. * [For ESRD Fac Plan. The ESRD maintain an eme must be [evaluat 2 years. This REQUIREM by: Based on record facility failed to d Emergency Prep reviewed and up deficient practice occupants in the emergency situa Findings Include On January 30, 2 PM, record revie conduct the requ distributed "Disa: "Sunrise" and "C last documented | ency preparedness he [hospital or CAH] must ntain a comprehensive aredness program that meets a of this section, utilizing an all- th. ties at 483.73(a):] Emergency acility must develop and rgency preparedness plan that d, and updated at least tilities at 494.62(a):] Emergency facility must develop and rgency preparedness plan that ed], and updated at least every IENT is not met as evidenced review and interview, the evelop and maintain an varedness plan that must be dated at least annually. This e could affect all facility event of a fire or other tion. | E004 | ŀ | Date of Alleged Compliance: Ja 2023 | anuary 31, | |

PRINTED: 03/11/2024

FORM APPROVED

OMB NO. 0938-0391

| | | | | | | 0938-039 | |
|---|---|---|--|--|---|------------------------------|--------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | A. B | MULTIPLE CONSTRUCTION UILDING | (X3) DATE SURV COMPLETE | | |
| | | 235728 | B. W | /ING | 01/30/2023 | | |
| | OVIDER OR SUPPLIER | OF CHESTERFIELD TOWNSHIP | 1 | STREET ADDRESS, CITY, STATE, ZI 47901 SUGARBUSH RD CHESTERFIELD TOWNSHI, | | | |
| (X4) ID PREFIX TAG | IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX | | PROVIDER'S PLAN OF CO X (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY | N SHOULD BE E APPROPRIATE | (X5) COMPLETE DATE |
| E004 | Continued From | page 2 | E004 | | | | |
| | | vere confirmed in interview with tenance Director at the time of | | | | | |
| E015 SS=F | CFR(s): 483.73(403.748(b)(1), 4 460.84(b)(1), 48 483.475(b)(1), 48 (b) Policies and develop and imp preparedness po on the emergend of this section, ri (a)(1) of this sec plan at paragrap policies and prod updated every 2 facilities]. At a n procedures mus (1) The provision and patients who place, include, b following: (i) Food, water, n supplies (ii) Alternate sou following: (A) Temperature safety and for th provisions. (B) Emergency I | 18.113(b)(6)(iii), 441.184(b)(1), 2.15(b)(1), 483.73(b)(1), 85.542(b)(1), 485.625(b)(1) procedures. [Facilities] must element emergency plicies and procedures, based cy plan set forth in paragraph (a) sk assessment at paragraph tion, and the communication h (c) of this section. The cedures must be reviewed and years [annually for LTC hinimum, the policies and t address the following: n of subsistence needs for staff ether they evacuate or shelter in ut are not limited to the medical and pharmaceutical rcces of energy to maintain the es to protect patient health and e safe and sanitary storage of ighting. n, extinguishing, and alarm | | No single member has be be affected by the deficient Storage room C-115 has he to identify the location of E and Water supply. All members residing in the potential to be affected by practice in the event of em- requires the Home to utiliz food and/or water supply. The Homes policy for Eme Planning was reviewed by Director and Administrator appropriate. The Homes Director of Nu- will audit the Emergency F supply room (C-115) monto only emergency items are and available in the event emergency. | et practice. been label clearly mergency Food e home have the the deficient hergency which the emergency ergency Supplies Maintenance and deem trition Services Food and Water thy to ensure properly stored | 2/17/23 | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|---|---|--|---------------------|---|-------------------------------|--------------------------|
| | | 235728 | B. W | /ING | 01/30/ | 2023 |
| | | OF CHESTERFIELD TOWNSHIP | · | STREET ADDRESS, CITY, STATE, ZIP CO 47901 SUGARBUSH RD CHESTERFIELD TOWNSHI, MI | | |
| AND PLAN OF CORRECTION NAME OF PROVIDER OR SUPPLIEF MICHIGAN VETERANS HO (X4) ID SUMMAR PREFIX (EACH DEFIC TAG SUMMAR E015 Continued From E015 Continued From (iii) The policies and performation Policies and performation PREFIX Continued From TAG Continued From E015 Continued From Image: Content of the performation of the per | | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORR X (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY) | HOULD BE | (X5) COMPLETE DATE |
| | Policies and proc (6) The following hospice-operated The policies and following: (iii) The provision hospice employe evacuate or shel limited to the following: (A) Food, water, supplies. (B) Alternate sou following: (1) Temperatures safety and for the provisions. (2) Emergency lii (3) Fire detection systems. (C) Sewage and This REQUIREM by: Based on observe failed to develop procedures that a subsistence need they evacuate or not limited to: Fo pharmaceutical s energy to mainta patient health an sanitary storage lighting, fire dete occupants in the or evacuation or | bospice at 418.113(b)(6)(iii):] cedures. are additional requirements for d inpatient care facilities only. procedures must address the n of subsistence needs for ees and patients, whether they ter in place, include, but are not owing: medical, and pharmaceutical arces of energy to maintain the s to protect patient health and e safe and sanitary storage of ghting. n, extinguishing, and alarm waste disposal. IENT is not met as evidenced vation and interview, the facility , at a minimum, policies and address; the provision of ds for staff and patients whether shelter in place, including, but od, water, medical and supplies, alternate sources of in temperatures to protect d safety and for the safe and of provisions, emergency ction, extinguishing and alarm wage and waste disposal. This e could affect all facility event of a fire, shelter-in-place | E015 | | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

PRINTED: 03/11/2024 FORM APPROVED

OMB NO. 0938-0391

| DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES | | | | | | | | |
|---|------------------------------|--------|-------------------------------------|--------------|--|--|--|--|
| STATEMENT OF | F DEFICIENCIES CORRECTION | A. B | MULTIPLE CONSTRUCTION UILDING //ING | | | | | |
| | DVIDER OR SUPPLIER | 235728 | | | | | | |
| (X4) ID | SUMMARY S | ID | | PROVIDER'S I | | | | |

| NAME OF PRO | OVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
|--------------------------|--|---------------------------------------|--|--------------------------|
| MICHIGAN | N 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 |
| 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 | | |

PRINTED: 03/11/2024 FORM APPROVED OMB NO. 0938-0391

01/30/2023

(X3) DATE SURVEY COMPLETED

| | E & MEDICAID SERVICES | | | | M APPROVED 10. 0938-0391 |
|---|--|---------------------|--|---|-----------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | A. B | MULTIPLE CONSTRUCTION JILDING 01 - BUILDING ING | (X3) DATE SU COMPLE | RVEY TED |
| | 235728 | | | 01/3 | 0/2023 |
| NAME OF PROVIDER OR SUPPLIER | E OF CHESTERFIELD TOWNSHIP | | STREET ADDRESS, CITY, STATE, ZI 47901 SUGARBUSH RD CHESTERFIELD TOWNSHI, | | |
| PRÉFIX (EACH DEFICIE | STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL NR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF C | ORRECTION ON SHOULD BE IE APPROPRIATE | (X5) COMPLETE DATE |
| K000 INITIAL COMM | ENTS | K000 | | | |
| Recertification S Michigan Depar Regulatory Affa Certification. A Home Of Chest substantial com participation in I 483.90(a), Life applicable provi National Fire Pr Life Safety Cod 99, Health Care The facility is a construction, wi The building is a supervised smo spaces open to The facility has the survey the c | 123 certified beds. At the time of | | | | |
| LABORATORY DIRECTOR'S OR PROV | /IDER/SUPPLIER REPRESENTATIVE'S SIGNA | TURE | TITLE | | (X6) DATE 02/10/2023 |

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 the 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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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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