

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235376	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/28/2025
NAME OF PROVIDER OR SUPPLIER Belle Fountain Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 18591 Quarry Rd Riverview, MI 48192	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.</p> <p>41423</p> <p>This citation pertains to intake MI00148212, MI00149641, and MI00149668.</p> <p>Based on interview and record review, the facility failed to ensure a Registered Nurse (RN) was on duty for eight consecutive hours a day, seven days a week; resulting in the potential for inadequate coordination of emergency or routine care and unmet care needs. This deficient practice had the potential to affect all residents who resided in the facility.</p> <p>Findings include:</p> <p>On 1/27/2025 at 12:30 P.M., the Master Schedule for Nurses during the period of 01/01/2025 - 1/26/25, was reviewed for RN coverage for the facility. The following dates revealed there was no consecutive 8 hour scheduled RN coverage:</p> <p>January 12, 2025, Census 72</p> <p>January 19, 2025, Census 77</p> <p>January 25, 2025, Census 71</p> <p>On 1/28/2025 at 2:25 P.M. the Director of Nursing (DON) was interviewed and the schedules dated (1/12/25, 1/19/25, and 1/25/25) were reviewed. The DON confirmed that RNs did not work of those days. When asked how the facility ensured there was daily 8-hour RN coverage the DON replied, We just hired RNs to assist with coverage. The DON agreed there needs to be daily eight consecutive hours of RN coverage and acknowledged there was a problem with staffing.</p> <p>A review of the facility's policy titled, Staffing dated 11/3/2023, was reviewed. However, the policy provided did not address RN coverage for at least 8 consecutive hours a day, 7 days a week.</p>

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.

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