STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	394090	A. BUILDING _____ B. WING _____	**4/30/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAROLD AND GRACE UPJOHN COMMUNITY CARE CENTER	**2400 PORTAGE ST KALAMAZOO, MI 49001**

(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
E0000 SS=	Initial Comments On April 30, 2025, an Emergency Preparedness Revisit Survey was conducted by the Michigan Department of Licensing and Regulatory Affairs, Bureau of Survey and Certification. At the survey, Harold and Grace Upjohn Community Care Center was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.73, Emergency Preparedness.	E0000		

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

Electronically Signed | 05/06/2025

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	394090	A. BUILDING _____ B. WING _____	**4/30/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAROLD AND GRACE UPJOHN COMMUNITY CARE CENTER	**2400 PORTAGE ST KALAMAZOO, MI 49001**

(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
K0000 SS=	INITIAL COMMENTS On April 30, 2025, a Life Safety Recertification revisit Survey was conducted by the Michigan Department of Licensing and Regulatory Affairs, Bureau of Survey and Certification. At the survey, Harold and Grace Upjohn Community 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 Association (NFPA) 101, Life Safety Code (LSC) and the 2012 Edition of NFPA 99, Health Care Facilities Code. The facility is a one-story building with partial basement of type II(000) construction built in 1964 with a major modification of Therapy, Dining and Offices in 2016. The building is fully sprinklered except the attic which is constructed with non-combustible materials. The facility has supervised smoke detection in the corridors and spaces open to the corridors. The requirement at 42 CFR, subpart 483.90 (a) is not met as evidenced by:	K0000		
K0211 SS= F	Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by:	K0211	1. All exit access corridors were cleared of all obstructions, including construction equipment/materials and resident furniture, in accordance with LSC 19.2.2 and chapter 7. 2. Actively scheduled staff requiring education will be identified to receive education on keeping exit corridors clear of obstructions. 3. The Director of Plant Operations and/ or designee will conduct a weekly audit, and results of the audits will be brought to the Quality Assurance Performance Improvement	4/21/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	394090	A. BUILDING _____ B. WING _____	**4/30/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAROLD AND GRACE UPJOHN COMMUNITY CARE CENTER	**2400 PORTAGE ST KALAMAZOO, MI 49001**

(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
	Based on observation and interview, the facility failed to ensure that exit access corridors were clear of all obstructions in accordance with LSC 19.2.2 and Chapter 7. This deficient practice could potentially affect the occupants of the smoke compartment in the event of delayed egress because of obstructions during an emergency evacuation. Findings include: On 4/30/25 between 12:00 PM and 1:00 PM, observation revealed construction equipment, construction materials, and resident room furniture being stored in the 100 corridor and spaces open to that corridor which is a violation of LSC 7.1.10.2.1. At the time of this survey there was an ongoing floor renovation of the residents' rooms. There were residents occupying the rooms in the 100 corridor that were not presently under renovation. There was no separation from the construction work area and the corridor as the construction room door was blocked open. There was a presence of glue vapors in the corridor which indicated improper ventilation. On 4/30/25 at approximately 12:30 PM, interview with the Administrator, Facilities Supervisor, Director of Facilities Plant Operations, and Chief Operating Officer, it was stated the project for each room is completed within the same day. The furniture is replaced back into the room and equipment is picked up. There was construction materials allowed to be stored in a resident day area open to the corridor.		Committee monthly for review. Any changes to the auditing process will be made by the QA Committee. The Administrator is responsible for attaining and maintaining compliance. 4. The completion date for compliance will be 05/1/2025	