

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 734050	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 5/22/2025
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NAME OF PROVIDER OR SUPPLIER HOYT NURSING & REHAB CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 1202 WEISS ST SAGINAW, MI 48602
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E0000 SS=	Initial Comments On May 22, 2025, an Emergency Preparedness Survey was conducted by the Michigan Department of Licensing and Regulatory Affairs, Bureau of Survey and Certification. At the survey Hoyt Nursing & Rehab Centre was found not to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.73, Emergency Preparedness.	E0000		
E0013 SS= F	Development of EP Policies and Procedures §403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.102(b), §485.68(b), §485.542(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b). (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 at least every 2 years. *[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility 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 at least annually. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization	E0013		

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

TITLE

(X6) 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 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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	<p>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 address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least every 2 years. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility 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 at least every 2 years. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to develop Emergency Preparedness policies and procedures, based on the emergency plan, risk assessment and communication plan. The policies and procedures must be reviewed and updated at least annually. This deficient</p>				

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	<p>practice could affect all occupants in the event of a power outage.</p> <p>Findings Include:</p> <p>On May 22, 2025 at approximately 3:30 PM record review revealed the facility has upgraded the emergency backup generator to cover the power load of the entire facility. The facility has not updated the utility power loss policy. The policy still indicates staff must use extension cords and red outlets to provide backup power to certain resident rooms and treatment areas. This may confuse staff and limit capabilities during a power outage emergency.</p> <p>These findings were confirmed through interview with the maintenance director at the time of observation.</p>			

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K0000 SS=	<p>INITIAL COMMENTS</p> <p>On May 22, 2025, a Life Safety Recertification Survey was conducted by the Michigan Department of Licensing and Regulatory Affairs, Bureau of Survey and Certification. At the survey, Hoyt Nursing & Rehabilitation Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 482.90(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.</p> <p>The facility is a one story building of type II (000) construction, built in 1963, with an addition of type V (111) built in 2002. The building is fully sprinklered and has supervised smoke detection in the corridors and spaces open to the corridors.</p> <p>The facility has 128 certified beds. At the time of the survey the census was 81.</p>	K0000			

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K0293 SS= E	<p>Exit Signage Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and interview, the facility failed to ensure exit and directional signs are displayed in accordance with 7.10, continuously illuminated and served by the emergency lighting system as required by 19.2.10.1. This deficient practice could affect 35 occupants in the event of an emergency evacuation.</p> <p>Findings Include:</p> <p>On May 22, 2025 at approximately 11:30 AM observation revealed the emergency egress configuration for the emergency exit sign outside the Saginaw Room Dining space is incorrect. The current exit configuration leaves the North side of the facility without an emergency exit from the resident spaces. The exit configuration does not match the emergency placards displayed in the corridors.</p> <p>These findings were confirmed through interview with the maintenance director at the time of observation.</p>	K0293			
K0363 SS= E	<p>Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-</p>	K0363			

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	<p>bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review and interview, the facility failed to ensure doors protecting corridor openings are capable of resisting the passage of smoke as required by</p>			

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	<p>NFPA 19.3.6.3. This deficient practice could affect 30 occupants in the event of a fire or smoke event.</p> <p>Findings Include:</p> <p>On May 22, 2025, at approximately 11:25 observation revealed the shower room door across from the 100 nurse station has an open grate door that will allow smoke, heat, fire to transfer from the room into the emergency egress corridor.</p> <p>These findings were confirmed through interview with the maintenance director at the time of observation.</p>				

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K0916 SS= F	<p>Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Alarm Annunciator A remote annunciator that is storage battery powered is provided to operate outside of the generating room in a location readily observed by operating personnel. The annunciator is hard-wired to indicate alarm conditions of the emergency power source. A centralized computer system (e.g., building information system) is not to be substituted for the alarm annunciator. 6.4.1.1.17, 6.4.1.1.17.5 (NFPA 99) This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and interview, the facility failed to ensure a remote annunciator is provided to operate outside of the generating room in a location readily observed by operating personnel as required by 6.4.1.1.17, 6.4.1.1.17.5, NFPA 99. This deficient practice could affect all occupants in the event power is lost to the facility.</p> <p>Findings Include:</p> <p>On May 22, 2025, at approximately 12:30 PM observation revealed the new emergency generator annunciator is installed in the back building electrical room and not in a location readily observed by operating personnel. This will lead to alarms and conditions of the generator going unnoticed by facility staff.</p> <p>These findings were confirmed through interview with the maintenance director at the time of observation.</p>	K0916		