

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 634400	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 3/13/2025
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NAME OF PROVIDER OR SUPPLIER WEST HICKORY HAVEN	STREET ADDRESS, CITY, STATE, ZIP CODE 3310 W COMMERCE RD MILFORD, MI 48380
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(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 March 13, 2025, an Emergency Preparedness Survey was conducted by the Michigan Department of Licensing and Regulatory Affairs, Bureau of Survey and Certification. At the survey West Hickory Haven was found to be not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.73, Emergency Preparedness.	E0000		
E0004 SS= F	Develop EP Plan, Review and Update Annually §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, State, 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. *	E0004		

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>[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:</p> <p>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 70 out of 70 occupants in the event of a facility wide disaster.</p> <p>Findings Include:</p> <p>On march 13, 2025, at approximately 8:30 AM. record review revealed the facility failed to update their emergency preparedness plans and polices on at least a annual basis.</p> <p>The Facility Maintenance Director and Administrator confirmed these findings during interview at the time of record review.</p>			

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K0000 SS=	<p>INITIAL COMMENTS</p> <p>On March 13, 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, West Hickory Haven 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 1 story building of type II (222) construction with a partial basement built in 1960. The building is fully sprinklered and has supervised smoke detection in the corridors and spaces open to the corridors.</p> <p>The facility has 101 certified beds. At the time of the survey the census was 70.</p>	K0000			

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K0291 SS= F	<p>Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to ensure automatic emergency lighting is provided in accordance with 7.9. This deficient practice could affect 70 out of 70 occupants in the event of a fire emergency.</p> <p>Findings Include:</p> <p>On March 13, 2025, at approximately 10:00 AM. record review revealed the facility failed to provide documentation on the 30 second test, inspection and maintenance of the battery powered emergency light located in the facility.</p> <p>The Facility Maintenance Director and Administrator confirmed these findings during the exit interview and at the time of record review.</p>	K0291			

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K0712 SS= F	<p>Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to conduct fire drills as required by 19.7.1.4 through 19.7.1.7. This deficient practice could affect 70 out of 70 occupants in the event of a fire emergency.</p> <p>Findings Include:</p> <p>On March 13, 2025, at approximately 9:00 AM. record review revealed the facility failed to document the required quarterly fire drill for the first shift, fourth quarter of 2024.</p> <p>The Facility Maintenance Director and Administrator confirmed these findings during the exit interview and at the time of record review.</p>	K0712			
K0761 SS= F	<p>Maintenance, Inspection & Testing - Doors Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part</p>	K0761			

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	<p>of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to inspect and test annually in accordance with NFPA 101, 19.7.6, 8.3.3.1 and NFPA 80, Standard for Fire Doors and Other Opening Protectives 5.2, 5.2.3. This deficient practice could affect 70 out of 70 occupants in the event of a fire emergency.</p> <p>Findings Include:</p> <p>On March 13, 2025, at approximately 9:30 AM, record review revealed the facility failed to provide documentation for the annual inspection, testing, and maintenance on the building's fire door assemblies in compliance with NFPA 80, 2010 edition. The last fire door inspection available at the time of survey was dated February 11, 2024.</p> <p>The Facility Maintenance Director and Administrator confirmed these findings during the exit interview and at the time of record review.</p>			