| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | **294020** | A. BUILDING _____ B. WING _____ | **3/25/2025** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| **RIVERSIDE HEALTHCARE CENTER** | **1149 WEST MONROE RD SAINT LOUIS, MI 48880** |

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| E0000<br>SS= | Initial Comments<br><br>On March 25, 2025, an Emergency Preparedness Survey was conducted by the Michigan Department of Licensing and Regulatory Affairs, Bureau of Survey and Certification. At the survey Riverside Healthcare Center was found to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.73, Emergency Preparedness. | E0000 | | |
| K0000<br>SS= | INITIAL COMMENTS<br><br>On March 25, 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, Riverside Healthcare 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.<br><br>The facility is a one story building of type II (222) construction built in about 1968. The building is fully sprinklered and has supervised smoke detection in the corridors and spaces open to the corridors.<br><br>The facility has 39 certified beds. At the time of the survey the census was 38. | K0000 | | |
| K0222<br>SS= E | Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires | K0222 | Maintenance Director adjusted the cooler door in the kitchen to ensure proper functioning. All other doors were checked and corrected | 4/18/2025 |

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

Electronically Signed | 04/16/2025

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.

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| | the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in | | as identified.<br>Maintenance Director was educated on K222 tag to ensure proper means of egress in the event of an emergency.<br>Maintenance Director will complete facility rounds to ensure concerns observed will be addressed at the time of observation. Results of audits will be reported to QAPI Monthly x3 and PRN.<br>Administrator is responsible for maintaining compliance | |

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| | accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4<br>This REQUIREMENT is not met as evidenced by:<br><br>Based on observation and interview, the facility failed to ensure doors in a required means of egress are not equipped with a latch or lock that requires the use of a tool or key from the egress side unless meeting the special locking arrangements for clinical needs in accordance with 19.2.2.2.5.1 and 19.2.2.2.6. This deficient practice could affect 15 occupants in the event of a egress emergency.<br><br>Findings Include:<br><br>On 03/25/2025, at approximately 12:48 PM, observation revealed the cooler door for kitchen storage had a hasp latching mechanism with a padlock for locking the cooler. This latching hardware arrangement could allow for someone to be locked inside the cooler without a way to exit.<br><br>This finding was confirmed by interview with Facility Maintenance at the time of observation. | | | |
| K0321<br>SS= E | Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated | K0321 | Rounds being conducted during the Annual State Survey the Maintenance director was unable to make entry into the supply closet located between rooms 11 and 12 in the | 4/18/2025 |

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| | doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)<br>This REQUIREMENT is not met as evidenced by:<br><br>Based on observation and interview, the facility failed to provide hazardous areas protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 19.3.5.9. Doors shall be self-closing or automatic-closing. This deficient practice could affect 20 occupants in the event of a fire emergency.<br><br>Findings Include:<br><br>On 03/25/2025, at approximately 12:20 PM, observation revealed staff were unable to provide access the supply storage room located in the service hall between storage rooms 11 & 12. This | | service hallway in turn not being able to ensure the automatic-closing door or the presence of an automatic fire extinguishing system which put 20 occupants at risk.<br>The maintenance director adjusted the door to the supply closet between rooms 11 and 12 to ensure the door would open freely with key access. The Maintenance director confirmed that the door was an automatic-closing door and was functioning properly and there was an automatic fire extinguishing system present inside the closet. The maintenance director did a complete facility round to ensure safe guards were in place.<br>The maintenance director was educated on K321 tag to ensure proper access to the facility to ensure areas are protected with a fire rated door or an automatic fire extinguishing system to ensure all safe guards are in place.<br>The Maintenance director will complete bi-weekly facility rounds to ensure safeguards are in place and that all doors are functioning properly concerns will be addressed at the time of observation. Results of the facility rounds will be reported in QAPI monthly x 3 months.<br>Administrator is responsible for maintaining compliance | |

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| | deficient practice does not allow full observation of the building to ensure proper protection of the area and ensure the hazardous area is safeguarded by an automatic extinguishing system.<br><br>This finding was confirmed by interview with Facility Maintenance at the time of observation. | | | |

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| K0341<br>SS= E | Fire Alarm System - Installation Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8<br>This REQUIREMENT is not met as evidenced by:<br><br>Based on observation and interview, the facility failed to ensure a fire alarm system is installed in accordance with NFPA 70 and NFPA 72. This deficient practice could affect 30 occupants in the event of a fire emergency.<br><br>Findings Include:<br><br>On 03/25/2025, at approximately 12:43 PM, observation revealed a smoke detector within 3 feet of direct airflow to a air return/supply on the ceiling located near Exit Door H.<br><br>This finding was confirmed by interview with Facility Maintenance at the time of observation. | K0341 | Maintenance Director moved the smoke detector to an area more than 3 feet away from the air/return supply on the ceiling.<br>All other areas were reviewed with no concerns noted.<br>Maintenance Director was educated on K341 tag to ensure proper placement of smoke detectors from direct airflow to an air return/supply.<br>Maintenance Director will complete facility rounds to ensure concerns observed will be addressed at the time of observation. Results of audits will be reported to QAPI Monthly x3 and PRN.<br>Administrator is responsible for maintaining compliance of K 345 | 4/18/2025 |

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| K0345<br>SS= F | Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72<br>This REQUIREMENT is not met as evidenced by:<br><br>Based on record review and interview, the facility failed to ensure the fire alarm system was tested and maintained in accordance with an approved program complying with NFPA 70 and NFPA 72. This deficient practice could affect all occupants in the event of a fire emergency.<br><br>Findings Include:<br><br>On 03/25/2025, at approximately 10:31 AM, record review revealed the facility failed to provide documentation of the required bi-annual Sensitivity Test for the installed fire alarm system. No documentation was provided by the exit of the survey.<br><br>This finding was confirmed by interview with Facility Maintenance at the time of record review. | K0345 | K345 - Fire alarm System<br>The Facility failed to have the bi-annual Sensitivity Test for the installed fire system completed, putting the whole facility and all occupants at risk.<br>The maintenance director scheduled the Smoke Detector Sensitivity Test with DeLau Fire services, this was completed on 4-14-25 with all smoker detectors passing inspection no repair or follow up needed, he also scheduled our next bi-annual Sensitivity Test to ensure sustained compliance.<br>The Maintenance Director was educated on the requirements and importance of having the Sensitivity Test completed and other scheduled maintenance.<br>The Maintenance Director will complete facility rounds to ensure concerns observed will be addressed at the time of observation. Results of audits will be reported to QAPI Monthly x3 and PRN.<br>Administrator is responsible for maintaining compliance | 4/18/2025 |
| K0363<br>SS= E | 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-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors | K0363 | K 363<br>The med supply door handle was corrected related to a gap that would allow smoke to pass and addressed to remedy this concern. Like areas were reviewed for areas of concern with no concerns noted at this time<br>Maintenance Director was educated on K363 | 4/18/2025 |

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| | 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.<br>This REQUIREMENT is not met as evidenced by:<br><br>Based on observation and interview, the facility failed to ensure doors protecting corridor openings are capable of resisting the passage of smoke as required by NFPA 19.3.6.3. This deficient practice could affect 20 occupants in the event of a fire emergency. | | tag to ensure corridors openings are capable of resisting the passage of smoke.<br>Maintenance Director will complete facility rounds to ensure concerns observed will be addressed at the time of observation. Results of audits will be reported to QAPI Monthly x3 and PRN.<br>Administrator is responsible for maintaining compliance | |

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| | Findings Include:<br><br>On 03/25/2025, at approximately 12:20 PM, observation revealed the med supply room door handle has an approximately 2" long by 1/4" wide gap in the door at the handle cover.<br><br>This finding was confirmed by interview with Facility Maintenance at the time of observation. | | | |

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| K0371<br>SS= F | Subdivision of Building Spaces - Smoke Compar Subdivision of Building Spaces - Smoke Compartments 2012 EXISTING<br>Smoke barriers shall be provided to form at least two smoke compartments on every sleeping floor with a 30 or more patient bed capacity. Size of compartments cannot exceed 22,500 square feet or a 200-foot travel distance from any point in the compartment to a door in the smoke barrier. 19.3.7.1, 19.3.7.2 Detail in REMARKS zone dimensions including length of zones and dead-end corridors.<br>This REQUIREMENT is not met as evidenced by:<br><br>Based on record review and interview, the facility failed to ensure smoke barriers were provided to form at least 2 smoke compartments on every floor as required by 19.3.7.1 and 19.3.7.2. This deficient practice could affect all occupants in the event of a fire emergency.<br><br>Findings Include:<br><br>On 03/25/2025 at approximately 9:36 AM, record review revealed the facility failed to provide a smoke barrier map that shows the facility compartmentalized by smoke barriers. All smoke barriers shown on the map provided do not show complete compartmentalization from one smoke compartment to another throughout the facility. Compartmentalization must show smoke barriers separating smoke compartments from outside wall through outside wall in each smoke compartment.<br><br>This finding was confirmed by interview with Facility Maintenance at the time of record review. | K0371 | K 371<br>Facility floor plan was reviewed and revised to include smoke compartments.<br>Floor plans in the facility will be replaced to meet requirements<br>Maintenance Director was educated on K371 tag that floor plan must identify smoke barrier walls.<br>Maintenance Director will review floor plans with any changes to ensure compliance with updates. Concerns observed will be addressed at the time of observation. Results of audits will be reported to QAPI Monthly x3 and PRN.<br>Administrator is responsible for maintaining compliance | 4/18/2025 |

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| K0511<br>SS= E | Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2<br>This REQUIREMENT is not met as evidenced by:<br><br>Based on observation and interview, the facility failed to ensure equipment using gas or gas-related piping complies with NFPA 54, and electrical wiring and equipment complies with NFPA 70. This deficient practice could affect 10 occupants in the event of a unintentional exposure to electricity.<br><br>Findings Include:<br><br>On 03/25/2025, at approximately 12:55 PM, observation revealed behind the garbage disposal in the kitchen dish tank is a receptacle box electric tapped hanging off the wall exposing live electric wires to water and potential stock exposure.<br><br>This finding was confirmed by interview with Facility Maintenance at the time of observation. | K0511 | K511<br>Live wires in kitchen were addressed.<br>Like areas were reviewed and no concerns were noted at this time.<br>Maintenance director was educated on K511 electrical equipment complies with NFPA 70 NEC Code for unintentional exposure to electricity.<br>Maintenance Director will complete facility rounds to ensure concerns observed will be addressed at the time of observation. Results of audits will be reported to QAPI Monthly x3 and PRN.<br>Administrator is responsible for maintaining compliance | 4/18/2025 |
| K0741<br>SS= F | Smoking Regulations Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or | K0741 | K 741<br>Facility moved free standing smoking ash tray pole and picnic table to required distance from building.<br>No smoking signs were placed in areas of concern to ward off smoking near building.<br>Staff was educated on smoking away from the building or smoking privileges would be reviewed and possibly revoked. Maintenance | 4/18/2025 |

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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 |
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| | shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4<br>This REQUIREMENT is not met as evidenced by:<br><br>Based on observation and interview, the facility failed to ensure smoking regulations were adopted and meet all provisions as required by 19.7.4. This deficient practice could affect all occupants in the event of a fire emergency.<br><br>Findings Include:<br><br>On 03/25/2025, at between 2:25-2:35 PM, observation revealed during the outside perimeter walk of the building over 100 cigarette butts were discarded on the ground in the tree shrubbery and leaves on the ground in front of all the emergency exits of the building. These cigarette butts were not discarded into a noncombustible container as required.<br><br>This finding was confirmed by interview with Facility Maintenance at the time of observation. | | director was educated on K741 smoking regulation.<br>Maintenance Director will complete facility rounds to ensure concerns observed will be addressed at the time of observation. Results of audits will be reported to QAPI Monthly x3 and PRN.<br>Administrator is responsible for maintaining compliance | |