STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	754060	A. BUILDING _____ B. WING _____	**5/19/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FROH COMMUNITY HOME	**307 N FRANKS AVENUE STURGIS, MI 49091**

(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 May 19, 2025, an Emergency Preparedness Survey was conducted by the Michigan Department of Licensing and Regulatory Affairs, Bureau of Survey and Certification. At the survey Froh Community Home was found to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.73, Emergency Preparedness.	E0000		
K0000 SS=	INITIAL COMMENTS On May 19, 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, Froh Community Home 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. The one story facility with partial basement and penthouse was built in 1968, with an addition in 1976, and was determined to be type II (000) construction. The physical therapy wing addition was built in 2011, and determined to be of Type II (000) construction. The building is fully sprinklered and has supervised smoke detection in the corridors and spaces open to the corridors. The facility has 65 certified beds. At the time of the survey the census was 60.	K0000		

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

Electronically Signed | 06/09/2025

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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K0345 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 This REQUIREMENT is not met as evidenced by: Based on observation 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 potentially affect all occupants in the event of a failure to activate the fire alarm system at the time of a fire. Findings Include: On May 19, 2025, at approximately 11:00 am, observation revealed the fire alarm pull box located at the activities west exit door was obstructed and could not be immediately accessed. This finding was confirmed by interview with the facility Maintenance Director at the time of observation. As required by NFPA 72, 17.14.5.	K0345	Obstructions in front of the Activities fire alarm pull box have been removed. All other pull stations have been inspected and none are obstructed. All pull-station areas will be inspected on a weekly basis by the maintenance department to make sure there are no obstructions preventing access to the pull stations. All Department Managers and Maintenance staff will be inserviced on keep pull stations free from obstructions. The Maintenance Director will monitor compliance by completing rounds weekly, observing for obstructed pull stations.	6/30/2025
K0353 SS= F	Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of	K0353	The ceiling tiles in the wheelchair storage room have been installed. All other areas of the building have been inspected and no other ceiling tiles are missing. Ceiling tiles will be inspected on a weekly basis by the maintenance department and documented in	6/30/2025

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	Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide sprinkler system maintenance and testing as required by NFPA 25. This deficient practice could potentially affect all occupants in the event the sprinkler system fails to operate as a result of no heat collection process due to missing ceiling tiles within the drop ceiling grid. Findings Include: On May 19, 2025, at approximately 11:05 am, observation revealed ceiling tiles missing from the ceiling grid located within the wheelchair storage room, at station 2 near the nurse station. This finding was confirmed by interview with the facility Maintenance Director at the time of observation. As required by NFPA 25, 5.2.1.		the preventative maintenance log. The Maintenance Director will monitor compliance by completing rounds weekly, observing for missing ceiling tiles.	
K0363 SS= E	Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings,	K0363	Maintenance removed all over the door hangers and mounted PPE holders with a different method so as not to impede door	6/30/2025

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	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 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: Based on observation and interview, the facility failed to ensure doors protecting		from having a positive latch. All other doors have been inspected to ensure that no obstructions keep the doors from latching. The maintenance staff will check doors weekly and document checks in the preventative maintenance log. The Maintenance Director will monitor compliance by conducting rounds weekly, observing for door latching issues.	

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	corridor openings can resist the passage of smoke as required by NFPA 19.3.6.3. This deficient practice could potentially affect 24 occupants within the smoke compartment in the event the door fails to prevent the passage of smoke throughout the smoke compartments at the time of a fire. Findings Include: 1. On May 19, 2025, at approximately 10:50 am, observation revealed resident room door # 3 located at cottonwood hall failed to close and positive latch. Personal protective equipment hangers were observed mounted on the top of the door preventing the door from closing and positive latching. This finding was confirmed by interview with the facility Maintenance Director at the time of observation. As required by 19.3.6.3 2. On May 19, 2025, at approximately 11:29 am, observation revealed resident room door #44 located at maple hall failed to close and positive latch. Personal protective equipment hangers were observed mounted on the top of the door preventing the door from closing and positive latching. 3. On May 19, 2025, at approximately 11:32 am, observation revealed resident room door #4 located at maple hall failed to close and positively latch. Personal protective equipment hangers were observed mounted on top of the door preventing the door from closing and positive latching.			
K0522 SS= E	HVAC - Any Heating Device HVAC - Any Heating Device Any heating device, other than a central heating plant, is designed and installed so combustible materials cannot be	K0522	Hydrocollator was removed from the shelf and towel location and installed on a metal shelf. All other heat producing equipment has been reviewed to ensure that combustible items are	6/30/2025

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	ignited by device, and has a safety feature to stop fuel and shut down equipment if there is excessive temperature or ignition failure. If fuel fired, the device also: * is chimney or vent connected. * takes air for combustion from outside. * provides for a combustion system separate from occupied area atmosphere. 19.5.2.2 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure any heating device other than a central heating plant is designed and installed so combustible materials cannot be ignited by the device, has a safety feature to stop fuel and shut down the equipment if there is excessive temperature or ignition failure and meets all additional provisions as required by 19.5.2.2. This deficient practice could potentially affect 8 occupants within the therapy area in the event ordinary combustibles are in contact with a heat source to cause a fire. Findings Include: On May 19, 2025, at approximately 11:08 am, observation revealed the hydrocollator machine used for hot pads setting on top of a towel. The hydrocollator machine was observed to be hot enough to cause heat burn to the touch of a human hand. This finding was confirmed by interview with the facility Maintenance Director at the time of observation. As required by 19.5.2.2.		not touching them. Department Managers and Maintenance staff will be inserviced on the safe use of heat producing equipment. The Maintenance Director will monitor compliance by conducting rounds weekly, observing for combustible materials are keep away from heat producing equipment	