STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	284010	A. BUILDING _____ B. WING _____	**5/7/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLA AT TRAVERSE POINT	**2828 CONCORD ST TRAVERSE CITY, MI 49684**

(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 7, 2025, an Emergency Preparedness Survey was conducted by the Michigan Department of Licensing and Regulatory Affairs, Bureau of Survey and Certification. At the survey, The Villa at Traverse Point was found to be 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 | 05/16/2025

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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K0000 SS=	INITIAL COMMENTS On May 6, 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, The Villa at Traverse Point 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 facility is a one story building with three partial basements original built prior to 1958, of type V (000) construction. The floor system is wood frame. There were additions built in 1976, 1980, 1996 and 2016, of Type II (000) construction. The building is classified as one building with no 2 hour fire separations. The building is fully sprinklered and has supervised smoke detection in the corridors and spaces open to the corridors. The facility has 96 certified beds. At the time of the survey the census was 75.	K0000		
K0222 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 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	K0222	LSC Annual Survey 5.7.25 K 222Egress Doors Element 1 Main entrance door near station 1 was immediately adjusted and validated as working correctly with irreversible opening sequence triggering as it should. Element 2 A full facility audit was conducted to validate	5/23/2025

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	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 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		that all other egress doors were functioning properly. No other issues were identified. Element 3 The maintenance director was educated on the regulations of tag K222 in accordance to the NFPA 101 guidance The regulatory maintenance schedule within TELS was reviewed and deemed appropriate, in addition to all other routine scheduled door inspections Element 4 The maintenance director will validate the proper functioning of all egress doors daily and indefinitely per TELS schedule. NHA will validate with Maint. Director weekly that all doors are working correctly. The results of all ongoing audits will be reviewed by the QAPI committee The NHA is responsible for ongoing compliance	

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	approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide delayed egress locking system arrangements in accordance with NFPA. This deficient practice could affect approximately 15 occupants in the event of a fire emergency. Findings Include: On May 7, 2025, at approximately 12:10 PM, observation revealed the facility failed to maintain the delayed egress door locking system located at the main entrance door near nurse's station 1. The delayed egress device would not enter an irreversible opening sequence when the panic bar was activated per NFPA 101, 19.2.2.2.4 (2), 7.2.1.6.1. These findings were confirmed through interview with the Maintenance Director at the time of observation.			
K0324 SS= E	Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer	K0324	LSC Annual Survey 5.7.25 K 324Cooking Facilities Element 1 The fire suppression system over the range with the shelf was inspected by Fire Control who adjusted the angle and type of the nozzles as well as adding 1. Fire control then validated that this system was adequate for proper suppression. Element 2 A facility wide audit does not reveal any other ansul systems of suppression similar to the	5/23/2025

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	patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure cooking appliances are designed in accordance with NFPA. This deficient practice could affect approximately 6 occupants in the event of a fire emergency. Findings Include: On May 7, 2025, at approximately 1:04 PM, observation revealed a shelf protruding out over the stove top burners which could be an obstruction per NFPA 96, 10.2.7.3. This could cause the hood suppression system to be ineffective during a fire. These findings were confirmed through interview with the Maintenance Director at the time of observation.		one mentioned, nor does it reveal any other obstructed sprinkler heads as part of the standard facility suppression system. Element 3 The maintenance director was educated on the regulations of tag K 324 in accordance to the NFPA 101 guidance The regulatory maintenance schedule within TELS was reviewed and deemed appropriate, in addition to all other routine scheduled inspections and maintenance of the fire suppression systems. Element 4 The maintenance director will audit the ansul system monthly in addition to all other routine TELS tasks to ensure nozzles are in proper place and working order. The results of all ongoing audits will be reviewed by the QAPI committee The NHA is responsible for ongoing compliance	

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K0355 SS= E	Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure portable fire extinguishers are selected, installed, inspected and maintained in accordance with NFPA. This deficient practice could affect approximately 6 occupants in the event of a fire emergency. Findings Include: On May 7, 2025, at approximately 12:56 PM, observation revealed the ABC fire extinguisher located in the laundry room is mounted higher than the allowed per NFPA 10, 6.1.3.8.1. The top of the fire extinguisher was mounted at approximately 66 inches above the floor. These findings were confirmed through interview with the Maintenance Director at the time of observation.	K0355	LSC Annual Survey 5.7.25 K 355Portable Fire Extinguishers Element 1 The laundry room fire extinguisher was moved down 6 inches to the proper height and validated to be mounted correctly. Element 2 An inspection was performed of all fire extinguishers in the facility to ensure none were mounted any higher 60 inches Element 3 The maintenance director was educated on the regulations of tag K 355 in accordance to the NFPA 101 guidance The regulatory maintenance schedule within TELS was reviewed and deemed appropriate, in addition to all other routine scheduled fire extinguisher inspections Element 4 The maintenance director will continue to validate monthly per TELS the mounting of all fire extinguishers at the proper height. The NHA will validate these findings with the Maint. Director. The results of all ongoing audits will be reviewed by the QAPI committee The NHA is responsible for ongoing compliance	5/23/2025