

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>244010</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>5/21/2025</b>
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NAME OF PROVIDER OR SUPPLIER  <b>THE VILLA AT THE BAY</b>	STREET ADDRESS, CITY, STATE, ZIP CODE  <b>1500 SPRING ST PETOSKEY, MI 49770</b>
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E0000 SS=	Initial Comments  On May 21, 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 the Bay was found not to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.73, Emergency Preparedness.	E0000		
E0020 SS= F	Policies for Evac. and Primary/Alt. Comm. §403.748(b)(3), §416.54(b)(2), §418.113(b)(6)(ii), §441.184(b)(3), §460.84(b)(3), §482.15(b)(3), §483.73(b)(3), §483.475(b)(3), §485.68(b)(1), §485.542(b)(3), §485.625(b)(3), §485.727(b)(1), §485.920(b)(2), §491.12(b)(1), §494.62(b)(2) [(b) Policies and procedures. The [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 [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] [(3) or (1), (2), (6)] Safe evacuation from the [facility], which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. *[For RNHCs at §403.748(b)(3) and ASCs at §416.54(b)(2) and REHs at §485.542(b)(3):] Safe evacuation from the [RNHC] or ASC or REHs] which includes the following: (i) Consideration of care needs of evacuees. (ii)	E0020		

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>Staff responsibilities. (iii) Transportation. (iv) Identification of evacuation location(s). (v) Primary and alternate means of communication with external sources of assistance. * [For CORFs at §485.68(b)(1), Clinics, Rehabilitation Agencies, OPT/Speech at §485.727(b)(1), and ESRD Facilities at §494.62(b)(2):] Safe evacuation from the [CORF; Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services; and ESRD Facilities], which includes staff responsibilities, and needs of the patients. * [For RHCs/FQHCs at §491.12(b)(1):] Safe evacuation from the RHC/FQHC, which includes appropriate placement of exit signs; staff responsibilities and needs of the patients.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to develop policies and procedures including safe evacuation from the facility, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternative means of communication with external sources of assistance. This deficient practice could affect all occupants in the event of an emergency.</p> <p>Findings Include:</p> <p>On May 21, 2025 at approximately 11:35 AM, record review of their emergency evacuation policies and transportation agreements revealed the facility would utilize a specific bussing company for the evacuation of residents in the event of an emergency. At this time, interview</p>			

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E0041 SS= F	<p>with the Maintenance Director revealed when asked if they still use this company for evacuation, he responded "No...we utilize the agreements the county emergency operations center has." The Maintenance Director stated if the facility has a contract or written letter of understanding with the county emergency operations center stating the availability of their transfer agreements, he responded "no we do not". This finding was confirmed by the Maintenance Director and Administrator at the time of discovery.</p> <p>Hospital CAH and LTC Emergency Power §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b) (1)(i) and (ii) of this section. §483.73(e), §485.625(e), §485.542(e) (e) Emergency and standby power systems. The [LTC facility CAH and REH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.542(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2), §485.542(e) (2) Emergency generator inspection and</p>	E0041		

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	<p>testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3), §485.542(e)(2) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. * [For hospitals at §482.15(h), LTC at §483.73(g), REHs at §485.542(g), and CAHs §485.625(g).] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: <a href="http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html">http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html</a>. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99,</p>			

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	<p>issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009..</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to implement emergency and standby power systems based on the emergency plan. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99), Life Safety Code (NFPA 101) and NFPA 110, when a new structure is built or when an existing structure or building is renovated. The facility must implement the emergency power system inspection, testing and maintenance requirements found in NFPA 99, NFPA 110 and NFPA 101, LSC. Facilities that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. This deficient practice could affect all occupants in the event of a power failure.</p> <p>Findings Include:</p> <p>On May 21, 2025 at approximately 10:45 AM, record review of the "power outage d/t Storm" report and interview with the Administrator and Maintenance Director revealed the facility</p>			

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	<p>emergency generator failed while supplying power to the building during a utility power failure between March 29, 2025 and April 2, 2025. At this time, interview with the Maintenance Director &amp; Administrator and review of the After Action Report from the event revealed the emergency generator failed on March 30,2025, at approximately 7:00 PM, which left the building without power until approximately 8:24 PM, at which time facility staff were able to get the generator running again. On March 31,2025, the facility determined the issue with the generator was the "computer board" and an emergency order was placed with their generator contractor for repair parts. On April 1, 2025, the facility generator contractor arrived onsite to repair the generator. The repair required the generator to be shut down for a period of time. At approximately 10:50 AM on April 1, 2025, the generator was shut down and the building was without power until approximately 1:00 PM, at which time the generator was fixed and power restored to the building.</p> <p>On May 21, 2025 at approximately 11:39 AM, record review of the facility Electrical Power Outage &amp; Emergency Generator Power System Failure policies revealed the facility would secure a backup generator if their primary generator failed. Interviews and record review confirmed although the facility was aware of the planned shutdown for repairs on April 1, 2025, they failed to obtain a temporary generator, thereby leaving the facility without emergency power for over two hours.</p> <p>This finding was confirmed by the Maintenance Director and Administrator at the time of discovery.</p>			

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K0000 SS=	<p><b>INITIAL COMMENTS</b></p> <p>On May 21, 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 the Bay 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 (222) construction built in 1962, with an addition in 1972. The building is fully sprinklered and has supervised smoke detection in the corridors and spaces open to the corridors.</p> <p>The facility has 110 certified beds. At the time of the survey the census was 82.</p>	K0000			
K0222 SS= E	<p><b>Egress Doors</b> 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: <b>CLINICAL NEEDS OR SECURITY THREAT LOCKING</b> 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 <b>SPECIAL NEEDS LOCKING</b></p>	K0222			

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	<p>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</p> <p>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</p> <p>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</p> <p>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</p> <p>This REQUIREMENT is not met as evidenced by:</p>			

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	<p>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 all of the occupants on 300 wing in the event of an emergency.</p> <p>Findings Include:</p> <p>On May 21, 2025, at approximately 2:03 PM, observation revealed the 15-second delayed egress door by room 301 failed to have a "PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS" sign as required by NFPA 101, 7.2.1.6.1.1 (4). This finding was confirmed by the Maintenance Director at the time of discovery.</p>				

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K0241 SS= D	<p>Number of Exits - Story and Compartment Number of Exits - Story and Compartment Not less than two exits, remote from each other, and accessible from every part of every story are provided for each story. Each smoke compartment shall likewise be provided with two distinct egress paths to exits that do not require the entry into the same adjacent smoke compartment. 18.2.4.1-18.2.4.4, 19.2.4.1-19.2.4.4 This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and interview, the facility failed to ensure not less than 2 remote and accessible exits were provided from every part of every story and smoke compartment in accordance with 19.2.4.1 through 19.2.4.4. This deficient practice could affect 3 occupants in the event of a fire.</p> <p>Findings include:</p> <p>On May 21, 2025 at approximately 1:30 PM, observation revealed the basement maintenance shop, mechanical room had only one exit.</p> <p>This finding was confirmed by the Maintenance Director at the time of discovery.</p>	K0241			

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K0353 SS= E	<p>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 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:</p> <p>Based on observation, record review and interview, the facility failed to provide sprinkler system maintenance and testing as required by NFPA 25. This deficient practice could affect approximately all of the 300 wing occupants in the event of a fire.</p> <p>Findings Include:</p> <p>On May 21, 2025, at approximately 1:52 PM, observation revealed electrical wiring taped to the sprinkler pipe in the outdoor water storage room. This finding was confirmed by the Maintenance Director at the time of observation.</p>	K0353		
K0363 SS= E	Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings,	K0363		

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	<p>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:</p> <p>Based on observation and interview, the facility failed to ensure doors protecting corridor</p>			

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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
	<p>openings are capable of resisting the passage of smoke as required by NFPA 19.3.6.3. This deficient practice could affect all of the 300 wing occupants in the event of a fire.</p> <p>Findings Include:</p> <p>On May 21, 2025, at approximately 2:05 PM, observation revealed the 300 wing clean linen doors failed to close and latch when testing the coordinating device. This finding was confirmed by the Maintenance Director at the time of discovery.</p>			

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K0374 SS= F	<p>Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and interview, the facility failed to ensure smoke barrier doors meet the requirements of the LSC. This deficient practice could affect all occupants in the event of a fire.</p> <p>Findings Include:</p> <p>1) On May 21, 2025, at approximately 1:40 PM, observation revealed the smoke barrier doors by room 203 failed to completely close and latch to a smoke tight fit as required by 8.5.4.4.</p> <p>2) On May 21, 2025, at approximately 2:07 PM, observation revealed the smoke barrier door by 300 wing nurses station going into the dining room failed to completely close to a smoke tight fit as required by 8.5.4.4.</p> <p>These findings were confirmed by the Maintenance Director at the time of discovery.</p>	K0374		
K0923	Gas Equipment - Cylinder and Container	K0923		

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SS= D	<p>Storage Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. &gt;300 but &lt;3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited-combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by:</p>				

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	<p>Based on observation and interview, the facility failed to ensure storage of nonflammable gasses meet all requirements of NFPA 99. This deficient practice could affect 3 occupants in the event of a fire.</p> <p>Findings Include:</p> <p>On May 21, 2025 at approximately 1:49 PM, observation revealed 5 unsecured oxygen cylinders located in the oxygen storage room. This finding was confirmed by the Maintenance Director at the time of observation.</p>				