STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	184010	A. BUILDING _____ B. WING _____	**3/6/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH WOODS NURSING CENTER	**2532 CADILLAC DR FARWELL, MI 48622**

(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 6, 2025, an Emergency Preparedness Survey was conducted by the Michigan Department of Licensing and Regulatory Affairs, Bureau of Survey and Certification. At the survey, North Woods Nursing 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 SS=	INITIAL COMMENTS On March 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, North Woods Nursing 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. The facility is a one story building of type V (111) construction, built in 1953. The building is fully sprinklered and has supervised smoke detection in the corridors and spaces open to the corridors. The facility has 71 certified beds. At the time of the survey the census was 61.	K0000		

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

Electronically Signed | 03/21/2025

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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K0291 SS= F	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: Based on record review and interview, the facility failed to ensure all battery powered emergency lighting testing/maintenance is provided in accordance with NFPA. This deficient practice could affect all occupants in the event of a fire emergency. Findings Include: 1. On March 6, 2025, during review of facility records at approximately 10:50 AM, revealed the facility failed to provide documentation all battery powered emergency lighting was tested annually for 90 minutes per NFPA 101, 7.9.3.1.1. No activity reports were provided at the time of survey. 2. On March 6, 2025, during review of facility records at approximately 10:52 AM, revealed the facility failed to provide documentation all battery powered emergency lighting was function tested monthly for 30 seconds per NFPA 101, 7.9.3.1.1. No documentation was provided by exit of the survey. These findings were confirmed through interview with the Director of Facilities at the time of record review.	K0291	K291 Emergency Lighting Element 1 Action taken to identify residents: No residents were identified. Element 2: Identification of other residents: All occupants could be affected in the event of an electrical power failure. Element 3; (1): Measures Taken: The Administrator or designee will conduct and document the needed annual 90-minute testing of the facilities battery-operated emergency lighting. Element 3; (2): Measures Taken: The Administrator or designee will conduct and document the needed monthly 30-second testing of the facilities battery-operated emergency lighting. Element 4: Monitoring: The Administrator or designee will compile a report of the battery-operated emergency lighting test for review and recommendations by the Quality Assurance Performance Improvement Committee Monthly X 3, and periodically thereafter. The Administrator will assume responsibility for attained compliance.	4/8/2025

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K0355 SS= F	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 all occupants in the event of fire emergency. Findings Include: On March 6, 2025, at approximately 12:23 PM, observation revealed fire extinguisher located in attic space is not being checked at least every 30-day intervals per NFPA 10, 7.2.1.2. There were several other fire extinguishers throughout the facility (Therapy Storage room, two in Boiler room) that were missing 30-day inspections. These findings were confirmed through interview with the Director of Facilities at the time of observation.	K0355	K355 Portable Fire Extinguishers Element 1 Action taken to identify residents: No residents were identified. Element 2: Identification of other residents: All occupants could be affected in the event of an electrical power failure. Element 3: Measures Taken: The Administrator or designee will add the attic fire extinguisher locations on the monthly fire extinguisher log. The Administrator will also verify that all the fire extinguishers are verified from the outside contracted annual fire sprinkler inspection that was performed on the facility fire extinguisher. Element 4: Monitoring: The Administrator or designee will compile a report of the monthly inspections of the fire extinguishers for review and recommendations by the Quality Assurance Performance Improvement Committee Monthly X 2 and periodically thereafter. The Administrator will assume responsibility for attained compliance.	4/8/2025