STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504060	A. BUILDING _____ B. WING _____	**6/11/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ORCHARDS AT ARMADA	**22600 ARMADA RIDGE RD ARMADA, MI 48005**

(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 June 11, 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 Orchards At Armada was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.73, Emergency Preparedness.	E0000		
K0000 SS=	INITIAL COMMENTS On June 11, 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 Orchards At Armada 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 1 story building of Type II (III) construction with no basement, built in 1974, with additions built in 2000 and 2009, of the same construction type. The building is fully sprinklered and has supervised smoke detection in the corridors and spaces open to the corridors. The facility has 67 certified beds. At the time of the survey the census was 64.	K0000		

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

Electronically Signed | 06/26/2025

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 affect all 64 facility residents in the event of a fire. Findings Include: On June 11, 2025 at 12:27 PM, observation revealed the facility failed to provide the required circuit breaker locking device in the circuit breaker panel in the Mechanical Room (Memory Care) for their installed fire alarm booster module. This could potentially render the system susceptible to malicious tampering. These findings were confirmed in interview with the facility Maintenance Director at the time of observation.	K0345	ELEMENT 1 The circuit breaker locking device has been placed on in the circuit breaker panel in the Mechanical room on Orchard View. ELEMENT 2 The Maintenance Director and/or designee did an audit on all circuit breaker panels in the facility to ensure there is a locking device present. Any areas of noncompliance were addressed immediately. ELEMENT 3 The Maintenance Director has been reeducated to ensure that the required circuit breaker locking device in the circuit breaker panel mechanical room for our installed fire alarm booster module on Orchard View is present. ELEMENT 4 The Maintenance Director/designee will conduct weekly audits for 2 months to ensure that the required circuit breaker locking device in the circuit breaker panel mechanical room for our installed fire alarm booster module on Orchard View is present. ELEMENT 5 Date of compliance 06/27/2025. The Maintenance Director and/or designee will be responsible for sustained compliance.	6/27/2025
K0711 SS= E	Evacuation and Relocation Plan Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their	K0711	ELEMENT 1 On 6/27/25 an evacuation map was placed on Autum Ridge to identify the current location	6/27/2025

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	evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure there is a written plan for the protection of all residents and for their evacuation in the event of an emergency, employees are periodically instructed in their duties under the plan as required by 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2 and 19.7.2.3. This deficient practice could affect 26 of 64 facility residents in the event of a fire or other emergency condition where area evacuation is required. Findings Include: On June 11, 2025 at 12:20 PM, observation revealed the facility failed to proved the required Evacuation Map in the Maple Ridge corridor. Evacuation maps identify your location within the facility and highlight designated evacuation routes to the exterior of the building. These findings were confirmed in interview with the facility Maintenance Director at the time of observation.		within the facility and highlight designated evacuation routes to the exterior of the facility. ELEMENT 2 Rounds were conducted by the Maintenance Director and/or designee on all fire corridors to ensure there are evacuation maps present. ELEMENT 3 The Maintenance Director has been reeducated on maintaining evacuation maps throughout the building in all fire corridors. ELEMENT 4 The Maintenance Director/designee will conduct weekly audits for 1 month to ensure all fire corridors have the required evacuation maps. ELEMENT 5 Date of compliance 06/27/2025. The Maintenance Director and/or designee will be responsible for sustained compliance.	

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