STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	744063	A. BUILDING _____ B. WING _____	7/3/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY ON THE LAKE - FORT GRATIOT	5669 LAKESHORE FORT GRATIOT, MI 48059

(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 July 2 - 3, 2025, an Emergency Preparedness Survey was conducted by the Michigan Department of Licensing and Regulatory Affairs, Bureau of Survey and Certification. At the survey, Regency On The Lake - Fort Gratiot 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 July 2 - 3, 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, Regency On The Lake - Fort Gratiot 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 V (III) construction with no basement, built in 2002. The building is fully sprinklered and has supervised smoke detection in the corridors and spaces open to the corridors. The facility has 130 certified beds. At the time of the survey the census was 128.	K0000		
K0711 SS= F	Evacuation and Relocation Plan Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their	K0711	Element I: The dietary staff was given education	7/22/2025

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

Electronically Signed | 07/10/2025

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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	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 all 128 facility residents in the event of a fire in the deep fat fryer and/ or on covered kitchen range and related equipment. Findings Include: On July 3, 2025 between 12:26 PM and 12:30 PM, observation and interview revealed the facility failed to provide periodic staff training consistent with their expected roles related to their published Fire Safety Plan. When Interviewed, 2 of 3 Dietary Staff (Dietary A and Dietary B) were asked the procedures for activation of their installed range hood suppression system. Both answered incorrectly. Additionally, Dietary A was asked which extinguisher present in the kitchen could be used on a grease fire and		regarding the procedure for activing the suppression system and which fire extinguisher to use for a grease fire. Element II: All residents and staff have the potential to be affected by the deficient practice. Element III: The fire prevention plan policy was reviewed by the IDT and deemed appropriate. All dietary staff will be educated on the fire prevention plan with emphasis on the suppression system and the appropriate fire extinguisher to use for a grease fire. The dietary supervisor/designee will ensure new hires are educated on the first day of training in the kitchen. In addition, the fire prevention plan has been added to the staff meeting agenda. Element IV: The dietary supervisor/designee will conduct random audits to ensure the staff can appropriately verbalize the use for fire extinguishers and suppression system. These audits will be weekly for 4 weeks then monthly for 2 months until compliance has been maintained. The results will be brought to the QAPI meetings. Element V: The dietary supervisor/administrator are responsible for continued compliance.	

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	the answer was incorrect. These findings were confirmed in interview with the facility Maintenance Director and the Dietary Manager at the time of observation.			