STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	594041	A. BUILDING ______ B. WING ______	**4/24/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAURELS OF CARSON CITY	**620 NORTH SECOND STREET CARSON CITY, MI 48811**

(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 April 24, 2025, an Emergency Preparedness Survey was conducted by the Michigan Department of Licensing and Regulatory Affairs, Bureau of Survey and Certification. At the survey Laurels of Carson City 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 April 24, 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, Laurels of Carson City 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 2006. The building is fully sprinklered and has supervised smoke detection in the corridors and spaces open to the corridors. The facility has 82 certified beds. At the time of the survey the census was 78.	K0000		

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

Electronically Signed — 05/13/2025

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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 observation and interview, the facility failed to ensure automatic emergency lighting is provided in accordance with 7.9. This deficient practice could affect all occupants staff and visitors in the event the emergency power systems fail to operate as designed at the time of an electrical utility power outage. Findings Include: On April 24, 2025 at approximately 10:29 am, observation revealed the facility failed to provide a battery pack emergency light at the transfer switch located in the main electrical room. This finding was confirmed by interview with the facility environmental supervisor at the time of observation. As required by 7.9.2.3	K0291	K291 Emergency Lighting SS=F 1. A battery pack emergency light was installed at the transfer switch located in the main electrical room on 5/15/25. 2.Residents residing within the facility have the potential to be affected. 3.Facility administrator has re-educated the maintenance director on the regulatory requirement for an emergency backup light at the transfer switch. The facility preventative maintenance system (TELS) has been updated to ensure that back up lighting is testing per regulatory standards. 4.Facility Administrator and/or designee will verify regulatory compliance with emergency backup lighting monthly x4. Findings will be reported to the QAPI committee for further review and/or recommendations. The Administrator is responsible for sustained compliance.	5/15/2025
K0321 SS= E	Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and	K0321	K321 Hazardous Areas SS=E 1. The power chair in room 121 was unplugged immediately and relocated for charging. The resident residing in room 121 was educated that the facility will need to charge the chair in a safe area (Therapy Room). 2.Residents residing within the facility have the potential to be affected. Residents utilizing power chairs have been educated that chairs need to be charged in the Therapy Dept and not within their rooms.	5/14/2025

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	zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide hazardous areas protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 19.3.5.9. Doors shall be self-closing or automatic-closing. This deficient practice could potentially affect occupants within the resident room and 15 others within the smoke compartment in the event of a release of an hazardous gas within the area as a result of charging a wheel chair battery within residents rooms and care areas. Findings Include: On April 24, 2025 at approximately 9:44 am, observation revealed a wheel chair battery charger within resident room #121 located at sub acute rehab wing. Interview with the environmental supervisor revealed the residents wheel chair battery is being charged within the residents room as needed. This finding was confirmed by interview with the facility Environmental Supervisor at the time of observation. As required by 8.7.1.1		3.Staff have been educated that wheelchairs cannot be charged in resident rooms but only in the Therapy Room. 4.The Maintenance Director and/or designee will audit weekly x4, monthly x3 to ensure that wheelchairs are being charged in the designated area. Findings will be reported to the QAPI Committee for further review and recommendations. The Administrator is responsible for sustained compliance.	

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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 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 record review and interview, the facility failed to ensure cooking facilities are protected in accordance with NFPA 96. This deficient practice could potentially affect kitchen staff and 23 occupants within the nearest smoke compartment in the event of a fire within the kitchen hood system. Findings Include: 1.On April 24, 2025 A review of the facility records revealed the facility failed to provide documentation of the required semi annual hood cleaning service report. An invoice for the hoods was provided by Regional Staff however the hood cleaning report was not provided. This finding	K0324	K324 Cooking Facilities SS=E 1. The required semiannual hood cleaning was completed on 4/9/25. The monthly hood suppression inspection was completed May 1, 2025 and signed off through TELS and signed off on the tag that is located in the dietary dept. 2. The NHA validated that the TELS system has a monthly task to complete the monthly hood suppression inspection and that it was signed off in a timely manner by the Maintenance Director. 3. The NHA educated the Maintenance Director on obtaining and uploading service inspections into the TELs system and completing the monthly hood suppression inspection. 4. The NHA will validate that the monthly hood suppression inspections are completed and checked off monthly x3 months and that service reports are uploaded into the TELS system from the Date of Compliance. The results of these audits will be forwarded to the QA Committee to ensure continued compliance. The NHA is responsible for ongoing compliance.	5/14/2025

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	was confirmed by interview with the facility Regional staff at the time of observation. As required by NFPA 96 11.4 2 On April 24, 2025 A review of the facility records revealed the facility failed to provide documentation of the required owners monthly hood suppression inspection. This finding was confirmed by interview with the facility Regional Staff at the time of observation. As required by NFPA 17 A 7.2			