

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 704141	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 5/8/2025
NAME OF PROVIDER OR SUPPLIER MEDILODGE OF HOLLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 1221 EAST 16TH HOLLAND, MI 49423		
(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 May 8, 2025, an Emergency Preparedness Survey was conducted by the Michigan Department of Licensing and Regulatory Affairs, Bureau of Survey and Certification. At the survey Medilodge of Holland 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 May 8, 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, Medilodge of Holland 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 single story structure determined of type V(111) construction built in 2006, with a wood frame attic separated by 1 hour fire rating. The building is fully sprinklered and has supervised smoke detection in residents rooms the corridors and spaces open to the corridors. The facility has 77 certified beds. At the time of the survey the census was 72.	K0000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

05/22/2025

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	<p>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:</p> <p>Based on record review 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 potentially affect all occupants, staff and visitors in the event the fire alarm system fails to operate as designed at the time of a fire.</p> <p>Findings Include:</p> <p>On May 8, 2025 between 12:10 pm and 1:30 pm, record review revealed the facility failed to provide a complete fire alarm sensitivity report with values for all smoke detectors within the facility tested.. A review of the facility fire alarm sensitivity testing report dated 5/21/24, revealed only the range and not values for smoke detectors tested. This finding was confirmed by interview with the facility Maintenance Director at the time of observation. As required by NFPA 72, 14.4.5</p>	K0345	<p>The correct bi-annual fire alarm sensitivity report was obtained on 5-6-25. The report was dated 11-27-24 and contains the correct documentation showing sensitivity values for each device.</p> <p>A one-time audit was completed on all fire alarm documentation by the Maintenance Director on 5-7-25 to ensure all inspections contain the correct information.</p> <p>Education was provided to the Maintenance Director on 5-20-25 as to the requirements of the 2-year sensitivity testing report ensuring that they show the correct values for each device.</p> <p>A monthly audit x3 will be completed by the Maintenance Director or designee to ensure all fire alarm documentation contains the correct information. Audit findings will be presented to the facility QAPI committee and will only be discontinued with substantial compliance and with approval of the facility QAPI.</p> <p>The Administrator is responsible for achieving and sustaining compliance.</p>	5/28/2025

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K0374 SS= E	<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 19.3.7.8 and 8.5.4. This deficient practice could potentially affect 23 occupants within the smoke compartment in the event smoke is allowed to pass through the smoke barrier doors at the time of a fire in the adjoining smoke compartment.</p> <p>Findings Include:</p> <p>On May 8, 2024 at approximately 9:43 am, observation revealed an opening between the smoke barrier doors located at 100/200 hall while in the closed position. The opening was observed to be of more than an 1/8 of an inch between leafs. This finding was confirmed by interview with the facility Maintenance Director at the time of observation. As required by 8.5.4</p>	K0374	<p>The smoke barrier doors located at 100/200 hall had an astragal installed by the Maintenance Director on 5-21-25 to eliminate the gap between the leafs. A one-time audit was completed by the Maintenance Director on 5-20-25 to ensure all double smoke barrier doors did not have anything over an 1/8 gap between the leafs. Education was provided to the Maintenance Director on 5-20-25 as to the requirements of having smoke barrier doors come to a seal to prevent the passage of smoke. A monthly audit x3 will be completed by the Maintenance Director or designee to ensure that there are not any gaps in the double smoke barrier doors. Audit findings will be presented to the facility QAPI committee and will only be discontinued with substantial compliance and with approval of the facility QAPI. The Administrator is responsible for achieving and sustaining compliance.</p>	5/28/2025

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K0511 SS= E	<p>Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and interview, the facility failed to ensure equipment using gas or gas-related piping complies with NFPA 54, and electrical wiring and equipment complies with NFPA 70. This deficient practice could potentially affect 20 occupants and staff within the smoke compartment in the event immediate access to the electrical panels is required as a result of an electrical or fire emergency.</p> <p>Findings Include:</p> <p>On May 8, 2025 at approximately 10:22 am, observation revealed combustible storage blocking access to the electrical panels and generator transfer switch located in the mechanical, networking and generator transfer switch room. This finding was confirmed by interview with the facility Maintenance Director at the time of observation. As required by NFPA 70, 110.32</p>	K0511	<p>The items in front of the electrical panel in the mechanical/networking/transfer switch room were moved by the Maintenance Director on 5-21-25.</p> <p>A one-time audit was completed by the Maintenance Director on 5-21-25 to ensure all storage room areas and electrical panel locations were free from items which would prevent access to them.</p> <p>Education was provided to the Maintenance Staff on 5-20-25 as to the requirements of having a clear path and space in front of all electrical panels.</p> <p>A weekly audit x4 than monthly x3 will be completed by the Maintenance Director or designee to ensure all areas in front of electrical panels are free from items that would restrict access to them. Audit findings will be presented to the facility QAPI committee and will only be discontinued with substantial compliance and with approval of the facility QAPI.</p> <p>The Administrator is responsible for achieving and sustaining compliance.</p>	5/28/2025
K0923 SS= E	<p>Gas Equipment - Cylinder and Container Storag 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. >300 but <3,000 cubic feet Storage locations</p>	K0923	<p>The half empty oxygen cylinder that was located/stored with the full cylinders was removed and put in the correct location on 5-8-2025.</p> <p>A one-time audit was completed on 5-20-25 by the Maintenance Director to ensure all oxygen cylinders were stored in the correct</p>	5/28/2025

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	<p>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> <p>Based on observation and interview the facility failed to ensure storage of nonflammable gasses meet all requirements of NFPA 99, 11.6.5. This deficient practice could potentially affect 30 occupants in the event the empty oxygen cylinder is administered to a resident in need of a full</p>		<p>location. Education was provided to the Maintenance Staff on 5-20-25 by the Regional Maintenance Director as to the requirements of proper oxygen storage. A weekly audit x4 and then monthly x3 will be completed by the Maintenance Director or designee to ensure that oxygen storage containers are being stored properly. Audit findings will be presented to the facility QAPI committee and will only be discontinued with substantial compliance and with approval of the facility QAPI. The Administrator is responsible for achieving and sustaining compliance.</p>		

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	<p>oxygen cylinder at the time of an emergency or medical event requiring oxygen.</p> <p>Findings Include:</p> <p>On May 8, 2024 at approximately 11:41 am, observation revealed a not full oxygen cylinder mixed in with the full oxygen cylinders located at the full oxygen storage bin on the south side of the building exterior. This finding was confirmed by interview with the facility Maintenance Director at the time of observation. As required by NFPA 99, 11.6.5.2</p>				