STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275029	A. BUILDING **01** B. WING _____	**06/15/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA OF BILLINGS	**2115 CENTRAL AVE** **BILLINGS, MT 59102**

(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
E 000	Initial Comments Based on the regulatory requirements and standards of 42 Code of Federal Regulations (CFR) 483.73 Emergency Preparedness (EP) Final Rule Requirement for Long Term Care Facilities effective 11/15/17, an EP survey was performed on 6/15/2021. Review and revision of the currently facility plan had taken place on January 2021. No deficiencies were cited.	E 000		
K 000	INITIAL COMMENTS Based on the regulatory requirements and standards of 42 Code of Federal Regulations (CFR) 483.70(a) for Long Term Care Facilities (LTC), a life safety code (LSC) recertifcation survey was completed on 6/15/2021. Under this regulatory requirement, the facility must meet the applicable provisions of the National Fire Protection Association's (NFPA) 101 LSC, 2012 Edition, and those mandatory Codes referenced by that edition. The facility was surveyed specifically using Chapter 19 Existing Health Care Occupancies. The building construction type was found to be Type V (111) and contains ten smoke compartments. No new construction has occurred since the last survey of the facility on 8/27/19. There are no other occupancies associated with this facility. The facility is licensed for 161 beds and at the time of survey, the census was 111. These requirements were not met as evidenced by the following deficiencies:	K 000		
K 222	Egress Doors	K 222		7/30/21

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

Electronically Signed | 07/02/2021

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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K 222 SS=E	Continued From page 1 CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be	K 222		

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K 222	Continued From page 2 permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to ensure exits were free and clear of obstruction to egress and signs or objects which may confuse exiting occupants, in accordance with NFPA 101, 2012 Edition, Section 7.1.10.1 and 7.1.10.2.1. These deficiencies affect 3 of 10 smoke compartments. Findings include: 1. During an observation on 6/15/21 at 9:26 a.m., the main entry lobby area was inspected. There was a table and chairs placed directly in front of the marked exit doors leading to the veranda next to the main entry doors. 2. During an observation on 6/15/2021 at 10:06	K 222	1. The maintenance Director moved the table and chairs away from the marked exit doors leading to the veranda next to the main entry on 6-15-21. The stop signs on the mid-hall exit door and the summit hall exit door were removed on 6/15/21. 2. The maintenance director or designee validated that all exits were clear of obstruction and exits have no stops signs placed at them on 6/16/21 3. The Administrator or designee will re-educate staff on ensuring exits are free and clear of obstructions to egress doors and signs or objects which may confuse existing occupants on or before 7/7/21.	

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K 222	Continued From page 3 a.m., the Sapphire mid-hall exit door was inspected. There was a "STOP" sign on the door, which is a marked exit door. The sign on the door may create confusion as to whether or not the exit is functional. 3. During an observation on 6/15/2021 at 10:10 a.m., the Summit hall exit door was inspected. There was a "STOP" sign on the door, which is a marked exit door. The sign on the door may create confusion as to whether or not the exit is functional.	K 222	4. Maintenance Director or designee will audit exit doors to ensure doors are free of obstruction and signs or objects that could confuse existing occupants. Audits will be conducted weekly x 4 then monthly x 2 months. Results of the audits will be presented to QAPI on or before 7/22/21 and monthly there after to identify trends and sustainability.	
K 291 SS=D	Emergency Lighting CFR(s): NFPA 101 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, the facility failed to provide emergency lighting per NFPA 101-2012, Sections 19.2.9.1 and 7.9.3.1.1. These deficiencies affect the entire facility. Findings include: 1. Review of the facility records for testing of the emergency lighting documentation showed the facility had only performed the 30 second tests on the emergency lighting, but failed to do the required 90 minute test.	K 291	1. The facility can not correct the documentation for this test. 2. Maintenance Director or designee will complete the 90 min test on the emergency lighting on or before 7/20/21. 3. Administrator or designee to re-educate Maintenance Director on completing yearly 90-minute testing on the emergency lighting on or before 7/7/21. 4. Maintenance Director or designee will audit documentation on the annual 90-minute test on the emergency lighting. Audits will be conducted Annually. Results of the audits will be presented to QAPI on or before 7/22/21 and monthly thereafter to identify trends and sustainability.	7/30/21

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K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 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 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, the facility failed to assure hazardous rooms had doors which were able to close, and latch under the power of a self-closing device, in accordance with NFPA 101, 2012 Edition, Sections 19.3.2.1 and 19.3.2.1.3.	K 321	1. The Maintenance Director fitted the storage room on Crossroads with a self-closer on 7/1/21. 2. The maintenance Director or designee validated that rooms that were being used as storage had self-closers	7/30/21

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K 321	Continued From page 5 This deficiency affects 1 of 10 smoke compartments in the facility. Findings include: 1. During an observation on 6/15/21 at 10:02 a.m., the Crossroads storage room was inspected. The room was over 50 square feet and was not fitted with a self-closer.	K 321	throughout the facility on 7/1/21 3. Administrator or designee to re-educate Maintenance Director on any room over 50 feet in the facility that is being used as a storage the door is fitted with a self-closer on or before 7/7/21. 4. Maintenance Director or designee will audit the facility to ensure rooms that are being used as storage have self-closers throughout the facility. Audits will be conducted weekly x 4 then monthly x 2 months. Results of the audits will be presented to QAPI on or before 7/22/21 and monthly thereafter to identify trends and sustainability.	
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 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 interview and record review, the facility failed to ensure all test documents related to the fire alarm system was available for review in accordance with NFPA 72 National Fire Alarm and Signaling Code, 2010 Edition, Table 14.4.5. These deficiencies affect all of the smoke compartments. Findings include:	K 345	1. The facility can not correct the absence of the smoke detectors sensitivity test performed in the last two years. 2. Maintenance Director or designee will have the smoke detectors sensitivity test performed on or before 7/6/21 3. Administrator or designee to re-educate Maintenance Director on the	7/30/21

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K 345	Continued From page 6 1. During record review on 6/15/21, records for the fire alarm and smoke detection systems were reviewed. The smoke detector sensitivities had not been completed within the last two years. The fire alarm contractor was interviewed at this time of the survey. He stated the panel was not fully addressable and the sensitivities needed to be done manually.	K 345	requirement for the smoke detectors sensitivity test performed on or before 7/7/21. 4. Maintenance Director or designee will audit documentation smoke detectors sensitivity test. Audits will be conducted Annually. Results of the audits will be presented to QAPI on or before 7/22/21 and monthly thereafter to identify trends and sustainability.	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to maintain the sprinkler system in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems, 2010 Edition, Section 8.5.6.1.	K 353	1. The Maintenance Director removed the items on the refrigerator in the OT kitchen that was within 18” of the sprinkler head directly above it on 6/16/21. The	7/30/21

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K 353	Continued From page 7 This deficiency affects 1 of 10 smoke compartments in the facility. Findings include: 1. During an observation on 6/15/21 at 10:20 a.m., the OT kitchen was inspected. There was storage piled on the refrigerator within 18" of the sprinkler head directly above it. 2. During facility record review on 6/15/21, it was not clear if the gauges had all been calibrated or replaced every five years. An observation of one of the gauges showed 2015 was written on the gauge. It had not been replaced in five years.	K 353	facility cannot correct the documentation on calibrated or replaced gauges on the fire suppression sprinkler system. 2. The maintenance Director or designee validated the sprinkler heads throughout the facility have the 18" clearance on 6/16/21. The Maintenance Director or designee will have the gauges on the fire suppression system replaced and calibrated on or before 7/7/21. 3. Administrator or designee to re-educate Maintenance Director on 18" clearance of sprinkler heads in the facility and the gauges on the fire suppression system replaced and calibrated every five years on or before 7/7/21. 4. Maintenance Director or designee will audit the facility to ensure 18" clearance of sprinkler heads in the facility and gauges on the fire suppression system replaced and calibrated. Audits will be conducted weekly x 4 then monthly x 2 months. Results of the audits will be presented to QAPI on or before 7/22/21 and monthly thereafter to identify trends and sustainability.	
K 355 SS=E	Portable Fire Extinguishers CFR(s): NFPA 101 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, the facility failed to	K 355	1. The facility can not correct the missed	7/30/21

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K 355	Continued From page 8 inspect portable fire extinguishers in accordance with NFPA 10 Standard for Portable Fire Extinguishers, 2010 Edition, Section 7.2.1.2. These deficiencies affect 4 of 10 smoke compartments. Findings include: 1. During an observation on 6/15/21 at 8:45 a.m., the portable extinguisher in the generator enclosure was inspected. It was missing the monthly inspection tag. 2. During an observation on 6/15/21 at 9:09 a.m., the portable extinguisher in the boiler room was found to had not been initialed as having been inspected since the annual check of the portables in the building. 3. During an observation on 6/15/21 at 9:16 a.m., the portable extinguisher near the vault room was found to had not been initialed as having been inspected since the annual check of the portables in the building. 4. During an observation on 6/15/21 at 9:46 a.m., the memory care portable extinguisher was missing the May inspection.	K 355	documentation for the monthly inspection of the portable fire extinguishers in the facility. The Maintenance Director replaced the monthly inspection tag on the portable fire extinguisher in the generator enclosure on 6/17/21. The Maintenance Director inspected and initialed the fire extinguishers in the boiler room, the vault room, and the memory care unit on 6/17/21. 2. The Maintenance Director or designee validate the monthly inspection completed and inspection tags on the portable fire extinguishers throughout the facility on 6/17/21. 3. Administrator or designee to re-educate Maintenance Director on monthly inspection of portable fire extinguishers and inspection tags on portable fire extinguishers on or before 7/7/21. 4. Maintenance Director or designee will audit the portable fire extinguishers for monthly inspections and monthly inspection tags attached to portable fire extinguishers. Audits will be conducted monthly x 4. Results of the audits will be presented to QAPI on or before 7/22/21 and monthly thereafter to identify trends and sustainability.	
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core	K 363		7/30/21

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K 363	Continued From page 9 wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observations, the facility failed to ensure doors were resistant to the passage of smoke in accordance with NFPA 101, 2012 Edition, Sections 19.3.6.3.1. This deficiency affects 1 of 10 smoke compartments.	K 363	1. The Maintenance Director has filled in the holes around the locking mechanism to the kitchenette on Sapphire on 7/1/21. 2. The Maintenance Director or designee to validate doors throughout the	

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K 363	Continued From page 10 Findings include: 1. During an observation on 6/15/21 at 9:37 a.m., the kitchenette by the Sapphire nurses station was inspected. The door to the room had the door handle replaced with a smaller one, leaving large open holes through the door.	K 363	facility to ensure there are no gaps or holes in door on 6/27/21. 3. Administrator or designee to re-educate Maintenance Director on ensuring that there are no gaps or holes in doors that would ensure the doors are resistant to the passage of smoke on 7/7/21. 4. Maintenance Director or designee will audit the facility's doors to ensure they are resistant to the passage of smoke. Audits will be conducted weekly x 4 then monthly x 2 months. Results of the audits will be presented to QAPI on or before 7/22/21 and monthly thereafter to identify trends and sustainability.	
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on record review, the facility failed to conduct fire drills for every shift in every quarter in accordance with NFPA 101, 2012 Edition, section 19.7.1.6. This deficiency affects the entire facility.	K 712	1. Facility can not correct documentation on fire drills. 2. Maintenance Director or designee conducted a fire drill and education on 6/23/21.	7/30/21

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K 712	Continued From page 11 Findings include: 1. Review of facility documents regarding fire drills on 6/15/21 reflected the facility failed to have most documentation for having completed fire drills or drill trainings over the past year during the Covid lockdowns. The facility did not have any documentation that trainings, in lieu of fire drills, had taken place during the times there were no documented fire drills.	K 712	3. Administrator or designee to re-educate staff on completion of fire drills on every shift quarterly on or before 7/7/21. 4. Maintenance Director or designee will audit the fire drill logs and documentation to ensure completion. Audits will be conducted weekly x 4 then monthly x 2 months. Results of the audits will be presented to QAPI on or before 7/22/21 and monthly thereafter to identify trends and sustainability.	
K 741 SS=D	Smoking Regulations CFR(s): NFPA 101 Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall	K 741		7/30/21

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K 741	Continued From page 12 be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to uphold their smoking policy in regard to staff smoking in accordance with NFPA 101 Life Safety Code, Section 19.7.4. This deficiency affects the entire building. Findings include: 1. During an observation on 6/15/21 at 8:50 a.m., the service area behind the kitchen was inspected. This area also contained the enclosure for the generator and the emergency stop button for the generator. There was a large grease dumping container next to the generator enclosure. It contained previously dumped grease from the kitchen and was also quite covered in grease on the outside around the lid of the container. In around the lid were many cigarette butts and cigarette wrappers, along with other smaller pieces of paper, lending to a way to start a fire next to the generator and the remote stop button for the generator. In an interview on 6/15/21 at 8:50 a.m., staff member A stated the employees are to be smoking way down the street, not here behind the building.	K 741	1. The Maintenance Director cleaned and removed flammable items from around and on top of the grease container outside the facility on 7/1/21 2. The maintenance Director or designee validated that staff are smoking in designated smoke area 7/1/21 3. Administrator or designee to re-educate staff on where the designated smoking area is located for the facility on or before 7/7/21. 4. Maintenance Director or designee will audit the grease container and generator area to ensure that staff is smoking in the designated area. Audits will be conducted weekly x 4 then monthly x 2 months. Results of the audits will be presented to QAPI on or before 7/22/21 and monthly thereafter to identify trends and sustainability.	
K 761 SS=E	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101	K 761		7/30/21

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K 761	Continued From page 13 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on record review, the facility failed to test the fire doors in fire assemblies annually in accordance with NFPA 101-2012, Sections 7.2.1.15.1, 4.6.12 and in accordance with NFPA 80-2010, Section 5.2 (written report). This deficiency affects all of the fire/smoke compartments. Findings include: 1. Review of the fire safety maintenance records on 6/15/21, reflected the lack of the annual fire door assembly testing documentation. The facility must identify the required fire/smoke barriers, as well as electronically controlled doors and doors with special locking arrangement in the building and show inspections of all components of the doors in those barriers.	K 761	1. The facility can not fix the lack of documentation for the annual fire door assembly testing. 2. The maintenance Director or designee will have the annual fire door assembly testing completed on or before 7/7/21. 3. Administrator or designee to re-educate the Maintenance Director on the requirement for annual testing on fire door assembly on or before 7/7/21. 4. Maintenance Director or designee will audit annual testing on fire door assembly. Audits will be conducted Annually. Results of the audits will be presented to QAPI on or before 7/22/21 and monthly thereafter to identify trends and sustainability.	
K 914 SS=D	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101	K 914		7/30/21

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K 914	Continued From page 14 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on record review, the facility failed to maintain the receptacles in patient areas. The deficient practice affected the entire facility. Findings include: Record review on 6/15/2021 revealed non-hospital grade receptacles located in resident rooms throughout the facility did not have annual retention testing as required by sections 6.3.4.1.2 and 6.3.4.1.3 in NFPA 99, Health Care Facilities Code. Actual NFPA Standard: NFPA 99 (2012), 6.3.4.1 Maintenance and Testing of Electrical System.	K 914	1. The facility cannot fix the lack of documentation for the annual retention testing on hospital grade receptacles located in resident rooms. 2. The maintenance Director or designee will have the annual retention testing on hospital grade receptacles located in resident rooms completed on or before 7/6/21. 3. Administrator or designee to re-educate the Maintenance Director on the requirement for annual retention testing on hospital grade receptacles located in resident room on or before 7/7/21.	

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K 914	Continued From page 15 6.3.4.1.2 Additional testing of receptacles in patient care rooms shall be performed at intervals defined by documented performance data. 6.3.4.1.3 Receptacles not listed as hospital-grade, at patient bed locations and in locations where deep sedation or general anesthesia is administered, shall be tested at intervals not exceeding 12 months. 6.3.3.2 Receptacle Testing in Patient Care Rooms. 6.3.3.2.1 The physical integrity of each receptacle shall be confirmed by visual inspection. 6.3.3.2.2 The continuity of the grounding circuit in each electrical receptacle shall be verified. 6.3.3.2.3 Correct polarity of the hot and neutral connections in each electrical receptacle shall be confirmed. 6.3.3.2.4 The retention force of the grounding blade of each electrical receptacle (except locking-type receptacles) shall be not less than 115 g (4 oz).	K 914	4. Maintenance Director or designee will audit annual retention testing on hospital grade receptacles located in resident rooms. Audits will be conducted Annually. Results of the audits will be presented to QAPI on or before 7/22/21 and monthly thereafter to identify trends and sustainability.	
K 919 SS=D	Electrical Equipment - Other CFR(s): NFPA 101 Electrical Equipment - Other List in the REMARKS section any NFPA 99 Chapter 10, Electrical Equipment, requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 10 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to keep the room housing the Emergency Power Supply System (EPSS) free from any other equipment per NFPA 110 2010 Edition, Section 7.2.1.2. This	K 919	1. The Maintenance Director removed items that were being stored in the generator enclosure on 6/29/21 2. The maintenance Director or	7/30/21

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K 919	Continued From page 16 deficiency affects all facility smoke compartments. Findings include: 1. During an observation on 6/15/21 at 8:45 a.m., the outdoor generator enclosure was inspected. The facility was using the enclosure as storage for various items.	K 919	designee will validate that enclosures housing the EPSS are free from equipment in the facility are not being used as storage on 6/29/21. 3. Administrator or designee to re-educate the Maintenance Director on the requirement for enclosures housing the EPSS are free from equipment in the facility are not being used as storage on or before 7/7/21. 4. Maintenance Director or designee will audit the generator enclosure housing the EPSS are free from equipment in the facility are not being used as storage. Audits will be conducted weekly x 4 then monthly x 2 months. Results of the audits will be presented to QAPI on or before 7/22/21 and monthly thereafter to identify trends and sustainability.	
K 923 SS=D	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 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 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	K 923		7/30/21

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K 923	Continued From page 17 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: Based on observation the facility failed to maintain oxygen cylinders per NFPA 99-2012, Section 11.6.2.3. The deficiency affects 1 of 10 smoke compartments. Findings include: 1. During an observation on 6/15/21 at 10:07 a.m., the oxygen storage room was inspected. There was one E-sized oxygen tank observed sitting on the floor of the room, unsecured by chains or by being placed in a rack.	K 923	1. The Maintenance Director secured the E-sized oxygen tank sitting on the floor in the oxygen storage room on 6/15/21. 2. The Maintenance Director or designee validated that oxygen tanks in the facility are secured correctly on 6/16/21. 3. Administrator or designee to re-educate the staff on the requirement for oxygen tanks to be stored and secured correctly on or before 7/7/21. 4. Maintenance Director or designee will audit the storage of oxygen tanks in the facility. Audits will be conducted weekly x 4 then monthly x 2 months. Results of the audits will be presented to QAPI on or	

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K 923	Continued From page 18	K 923	before 7/22/21 and monthly thereafter to identify trends and sustainability.	