STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275120	A. BUILDING **01** B. WING ______	**12/01/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW CARE CENTER	**600 S 27TH ST** **BILLINGS, MT 59101**

(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 initial EP survey was performed on 12/1/2021. The annual review and revision was completed on 9/1/21. 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) recertification survey was performed on 12/1/21. 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 one upper level and six main level smoke compartments. No new construction has occurred since the last survey of the facility on 12/17/19. There are no other occupancies associated with this facility. The facility is licensed for 100 beds and at the time of survey 60 residents was the census. The facility does not meet the prescriptive requirements of the applicable LSC or its	K 000		

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

Electronically Signed — 12/17/2021

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 000	Continued From page 1 referenced Codes that require two acceptable exits from each floor as written under deficiency K252. The Fire Safety Evaluation System (FSES) based on the National Fire Protection Association (NFPA) 101A, Guide on Alternative Approaches to Life Safety, 2013 Edition, has been utilized to determine whether or not a level of safety is provided which is equivalent to the LSC. The FSES conducted on 12/6/2021 indicates that an equivalent level of safety will be provided with the correction of the following deficiencies: K222, K321, K325, K353, K363, K374, K761, K914 These requirements were not met as evidenced by the following deficiencies:	K 000		
K 222 SS=E	Egress Doors 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	K 222		12/28/21

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K 222	Continued From page 2 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 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:	K 222		

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K 222

Continued From page 3

Based on observation, the facility failed to properly post mandatory signs regarding the function of the delayed egress on the exit doors as required by the code in accordance with NFPA 101, 2012 Edition, Sections 19.2.2.2.4 and 7.2.1.6.1.

This deficiency affects 4 of 6 main floor smoke compartments.

Findings include:

1. During an observation on 12/1/21 at 9:20 a.m., the D-hall exit was inspected. The marked exit doors at the end of the hall were equipped with magnetic locks and delayed egress. There was no signage for the delayed egress.

Upon inspection of the exit path out of D-hall to the public way, it was discovered the facility had moved the fence outside of the memory care unit to extend beyond and encompass the D-hall exit door. The facility also locked the gate in the path of egress with a magnetic lock and did not equip this lock with delayed egress, which would also be a deficient practice, as you cannot have two delayed egress locks in a row in the path of egress.

2. During an observation on 12/1/21 at 9:28 a.m., the E-hall exit was inspected. The marked exit doors at the end of the hall were equipped with magnetic locks and delayed egress. There was no signage for the delayed egress.

3. During an observation on 12/1/21 at 9:57 a.m., the A-hall exit was inspected. The marked exit doors at the end of the hall were equipped with magnetic locks and delayed egress. There was

K 222

1. Signage for delayed egress has been placed on the D hall exit by Maintenance. The fence has been removed from D Hall exit. It will be placed back so it does not encompass D Hall.
Signage has been placed at E hall exit for the delayed egress by Maintenance.
2. All residents could have the potential to be affected.
3. The administrator educated the Maintenance staff regarding the regulations for delayed egress signage requirement.
4. Maintenance has checked all egress doors to ensure signage is posted. Maintenance will do a weekly audit to ensure signage is on all delayed egress doors weekly for one month then monthly. A report of this audit will be given at the monthly QAPI meeting by Maintenance
5. Completion: 12/28/2021

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K 222	Continued From page 4 no signage for the delayed egress.	K 222		
K 252 SS=E	Number of Exits - Corridors CFR(s): NFPA 101 Number of Exits - Corridors Every corridor shall provide access to not less than two approved exits in accordance with Sections 7.4 and 7.5 without passing through any intervening rooms or spaces other than corridors or lobbies. 18.2.5.4, 19.2.5.4 This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to provide for two acceptable exits from the second floor of the building per NFPA 101, 2000 Edition, Sections 19.2.4.1 and 7.2.3.5. This deficiency affects all staff who utilize or work on the second floor. The findings include: The southeast interior stairway leading from the second floor of the building was examined on 12/1/21 at 10:00 a.m. This stairway opens onto the first floor level corridor system that serves the smoke compartment of the nurse's station and activity/dining room areas. The first floor corridor system was not constructed, nor protected, as an exit passageway from the stairway to any exit discharge that leads to the public way. Further, there was no exit door from the stairway itself at the first floor level leading directly to an exterior discharge to the public way. In view of the lack of	K 252	Covered under a Waiver	12/28/21

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K 252	Continued From page 5 an exterior exit door from the southeast stairway itself and the absence of an exit passageway serving this stairway, there was only one acceptable exit from the second floor, that being the northwest stairway.	K 252		
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	K 321		12/28/21

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K 321	Continued From page 6 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. This deficiency affects 1 of 6 main floor smoke compartments in the facility. Findings include: 1. During an observation on 12/1/21 at 10:04 a.m., room B-1 was inspected. The room was used as storage and is over 50 square feet. There was no self-closer on the door.	K 321	1. A self-closer has been placed on room B1 by Maintenance, allowing it to continue to be used as a storage room. 2. All residents could have the potential to be affected. 3. The administrator educated the Maintenances staff on the requirement of self-closure for doors on rooms being used as storage if greater than 50 square foot. 4. Maintenance has checked all rooms to ensure any room being used as storage greater than 50 square feet has a self-closure. Maintenance will audit all rooms monthly to ensure any room being used as storage greater than 50 square foot has a self-closure. A report of this audit will be given monthly to the QAPI Committee by Maintenance	
K 325 SS=D	Alcohol Based Hand Rub Dispenser (ABHR) CFR(s): NFPA 101 Alcohol Based Hand Rub Dispenser (ABHR) ABHRs are protected in accordance with 8.7.3.1, unless all conditions are met: * Corridor is at least 6 feet wide * Maximum individual dispenser capacity is 0.32 gallons (0.53 gallons in suites) of fluid and 18 ounces of Level 1 aerosols * Dispensers shall have a minimum of 4-foot horizontal spacing * Not more than an aggregate of 10 gallons of fluid or 135 ounces aerosol are used in a single smoke compartment outside a storage cabinet, excluding one individual dispenser per room * Storage in a single smoke compartment greater than 5 gallons complies with NFPA 30	K 325		12/28/21

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K 325	Continued From page 7 * Dispensers are not installed within 1 inch of an ignition source * Dispensers over carpeted floors are in sprinklered smoke compartments * ABHR does not exceed 95 percent alcohol * Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11) * ABHR is protected against inappropriate access 18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485 This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to ensure alcohol-based hand rub (ABHR) dispensers were not mounted over ignition sources in accordance with NFPA 101, 2012 Edition, Section 19.3.2.6 (8). This deficiency affects 1 of 6 main floor smoke compartments. Findings include: 1. During an observation on 12/1/21 at 9:52 a.m., the corridor outside the salon was inspected. There was an ABHR dispenser mounted over an outlet in the area.	K 325	1. The ABHR dispenser in the corridor outside the salon above the outlet has been moved by Maintenance 2. All residents have the potential to be affected 3. Maintenance staff has been educated by the administrator that ABHR dispensers cannot be mounted above outlets as it is an ignition source. 4. Maintenance will monitor all mounted ABHR dispensers to ensure placement is not above or within 1" of an outlet. An audit will be done monthly x 1 and then quarterly to ensure placement of AHBR dispensers are not located above or within 1 inch of an outlet. A report of this audit will be given to the QAPI Committee at their monthly meeting.	
K 353 SS=D	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	K 353		12/28/21

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K 353	Continued From page 8 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 and record review, the facility failed to: a) ensure sprinkler pipes were free of external loads in accordance with NFPA 25, Standard for the Inspection, Testing and Maintenance for Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.2.2. b) ensure sprinkler systems maintained satisfactory performance with respect to activation time in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems, 2010 Edition, Section 8.1.1(3) This deficiency affects 1 of 1 upper floor smoke compartments. Findings include: 1. During an observation on 12/1/21 at 9:04 a.m., the upstairs mechanical room was inspected. There were two coolant pipes suspended off the	K 353	1. The suspension of the two coolant pipes have been removed from the sprinkler pipes in the upstairs mechanical room The ceiling tile that was broken in the upstairs hall has been replaced. 2. All residents have the potential to be affected 3. Maintenance personnel has been educated by the administrator regarding items being suspended from sprinkler pipes and ceiling tiles being seated and not broken. 4. An audit of all sprinkler pipes will be done to ensure nothing is suspended from them by Maintenance monthly for three months then quarterly. All ceiling tiles will be audited by Maintenance to ensure they are seated and not broken monthly for three months then quarterly. A report of these audits will be given to the QAPI Committee at their monthly meeting	

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K 353	Continued From page 9 sprinkler pipes in the room. 2. During an observation on 12/1/21 at 9:07 a.m., the upstairs hall was inspected. There was a large corner piece of one of the ceiling tiles that was broken and missing out of the ceiling.	K 353	by Maintenance.	
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 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	K 363		12/28/21

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K 363	Continued From page 10 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 observation, the facility failed to maintain egress doors in accordance with NFPA 101-2012, Section 7.2.1.4.1. This deficiency affects 1 of 6 main floor smoke compartments. Findings include: 1. During an observation on 12/1/2021 at 9:34 a.m., the egress door from resident room E-7 was impeded by a large pile of personal items placed behind it and could not swing open to 90 degrees. This would impede egress from a sleeping room.	K 363	1. The facility has worked with the resident in E7 to sort and reorganize her belongings to allow the door to open to a 90 degree angle. 2. All residents have the potential to be affected. Maintenance has audited all doors to ensure they can open to a 90 degree angle. 3. On 12/14/2021 residents were educated at Resident Council regarding belongings. It was explained that belongings cannot be under the bed or stacked. They need to fit in night stands, dresser and closet. 4. An audit of all doors to ensure they are able to open to a 90 degree angle will be done weekly by Maintenance x 3 months then biweekly x 3 months then monthly. A report of these audits will be given to QAPI Committee at their monthly meeting by Maintenance.	
K 374 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid	K 374		12/28/21

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K 374	Continued From page 11 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: Based on observation, the facility failed to ensure fire/smoke barrier doors located in the fire/smoke partitions were maintained per NFPA 101-2012, Section 19.3.7.8. This deficiency affects 2 of 6 main level smoke compartments. Findings include: 1. During an observation on 12/1/21 at 9:28 a.m., the E-hall cross corridor doors were exercised. The left leaf going into the hall failed to close and latch under the power of the self-closers.	K 374	1. Maintenance has adjusted the closure and latch on the E hall cross corridor door. 2. All residents have the potential to be affected 3. Maintenance has been educated on the need of testing of cross corridor doors for closing and latching when exercised. This education was completed by the administrator. 4. All cross corridor doors have been checked by Maintenance for closing and latching when exercised. All cross corridor doors will be exercised weekly x 1 month then monthly by Maintenance to ensure closure and latching. A report of this audit will be given to QAPI Committee at their monthly meeting.	
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 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.	K 761		12/28/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275120	A. BUILDING **01** B. WING ____	**12/01/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW CARE CENTER	**600 S 27TH ST** **BILLINGS, MT 59101**

(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
K 761	Continued From page 12 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 12/1/21, 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. Annual Fire door assembly testing has been done and documented by Maintenance 2. All residents have the potential to be affected 3. Maintenance staff has been educated by the Administrator, on requirement for annual testing of fire door assembly. 4. Maintenance will do annual testing on fire door assembly and report it to the QAPI Committee at their monthly meeting.	
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 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	K 914		12/28/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275120	A. BUILDING 01 B. WING	12/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW CARE CENTER	600 S 27TH ST BILLINGS, MT 59101

(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
K 914	Continued From page 13 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 12/1/21 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, 2012 Edition. Actual NFPA Standard: NFPA 99 (2012), 6.3.4.1 Maintenance and Testing of Electrical System. 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	K 914	1. All non-hospital grade receptacles located in resident rooms have had annual retention testing done by Maintenance. 2. All residents have the potential to be affected. 3. Maintenance staff has been educated on the requirement for annual retention testing being completed. This education was completed by the Administrator. 4. Maintenance will do annual retention testing of all non-hospital grade receptacles located in resident rooms will be done by Maintenance in the month of November. A report of this testing will be given to QAPI Committee at their monthly meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275120	A. BUILDING **01** B. WING ___	**12/01/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 914	Continued From page 14 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		