STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275123	A. BUILDING **01** B. WING _____	**01/24/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE CLIFF MANOR	**1415 YELLOWSTONE RIVER RD** **BILLINGS, MT 59105**

(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 01/24/22. The facility finished an annual review of the plan on 08/19/21. Under these regulatory requirements, the following deficiencies were cited:	E 000		
E 036 SS=F	. EP Training and Testing CFR(s): 483.73(d) §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d). *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at	E 036		2/13/22

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

Electronically Signed | 02/11/2022

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E 036	Continued From page 1 §484.102, CORFs at §485.68, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at	E 036		

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E 036	Continued From page 2 §483.470(i). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years. This REQUIREMENT is not met as evidenced by: Based on record review, the facility failed to develop and maintain an EP training and testing program that is based on the facility's Emergency Preparedness plan. This deficiency has the potential to affect all staff, volunteers, and residents of the facility. Findings include: 1. Review of the facility EP plan on 01/24/22 showed, the facility did not have any documented annual training for current employees.	E 036	1. The facility failed to train all staff on the Annual Emergency Preparedness Program. The facility will conduct an Emergency Preparedness in-service for all staff and educate them on the Emergency Preparedness Plan. 2. All staff, volunteers and residents of the facility have the potential to be affected by this deficient practice. The facility will ensure that an Emergency Preparedness Plan in-service for all staff is completed at least annually to maintain compliance. 3. On or before 2/10/2022, the Corporate Regional Vice President of Operations will educate all staff on the facilities Emergency Preparedness Plan. 4. An all-staff Emergency Preparedness education audit will be conducted daily Monday through Friday for 2 weeks, then once weekly for 2 months to ensure that all staff have been educated on the Emergency Preparedness Plan or as deemed necessary by the QAPI team.	

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E 036	Continued From page 3	E 036	5. Compliance will be met by 2/13/2022.	
E 037 SS=F	EP Training Program CFR(s): 483.73(d)(1) §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their	E 037		2/13/22

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E 037	Continued From page 4 expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following:	E 037		

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E 037	Continued From page 5 (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. (v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent	E 037		

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E 037	Continued From page 6 with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures.	E 037		

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E 037	Continued From page 7 *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This REQUIREMENT is not met as evidenced by: Based on record review, the facility failed to implement the annual training of the EP program to all staff members, consistent with each team members' expected roles during an emergency or a disaster. This deficiency affects all of the occupants and staff in the facility. Findings include: 1. Record review of the facility EP plan and training documents on 01/24/22 showed, the facility failed to show evidence that staff training for the EP plan was conducted initally for new staff and annually for all current staff.	E 037	1. The facility failed to train all staff on the Annual Emergency Preparedness Program as well as to include each staff members responsibilities during an emergency. The facility will conduct an Emergency Preparedness Plan in-service and review staff's responsibilities during an emergency for all staff. 2. All staff, volunteers and residents of the facility have the potential to be affected by this deficient practice. The Facility will ensure that an all-staff Emergency Preparedness Plan in-service to review staff's responsibilities during an emergency is completed annually to maintain compliance. 3. On or before 2/10/2022, the Corporate Regional Vice President of Operations will educate all staff on the facilities Emergency Preparedness Plan and their responsibilities during an emergency. 4. An all-staff Emergency Preparedness education audit will be conducted daily Monday through Friday for 2 weeks, then once weekly for 2 months to ensure that	

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E 037	Continued From page 8	E 037	all staff have been educated on the Emergency Preparedness Plan to include their responsibilities during an emergency or as deemed necessary by the QAPI team. 5. Compliance will be met by 2/13/2022.	
E 039 SS=F	EP Testing Requirements CFR(s): 483.73(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or	E 039		2/13/22

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E 039	Continued From page 9 functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section	E 039		

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E 039	Continued From page 10 is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed	E 039		

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E 039	Continued From page 11 messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared	E 039		

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E 039	Continued From page 12 questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions	E 039		

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E 039	Continued From page 13 designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop	E 039		

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E 039	Continued From page 14 exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises	E 039		

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E 039	Continued From page 15 to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises	E 039		

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E 039	Continued From page 16 to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on record review, the facility failed to develop and implement an emergency preparedness testing program to annually	E 039	1. The facility failed to conduct an annual full-scale emergency exercise, and an annual emergency table top exercise. The	

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E 039	Continued From page 17 participate in a full-scale exercise, and a table top exercise. This deficiency affects everyone in the facility. Findings include: Record review of the facility EP plan on 01/24/22 showed there was no documentation regarding a full-scale exercise or a table-top exercise completed by the facility.	E 039	facility will conduct a full-scale emergency exercise, and a table top exercise to ensure compliance. 2. Everyone in the facility have the potential to be affected by this deficient practice. The facility will ensure that a full-scale emergency exercise, and a table top exercise is conducted annually to maintain compliance. 3. On or before 2/10/2022, the Corporate Regional Vice President of Operations will conduct a full-scale emergency exercise. On or before 2/11/2022, the Corporate Regional Vice President of Operations will conduct a table top exercise. 4. An Emergency Preparedness Exercise audit will be conducted twice weekly for one week, then once every six months to ensure that the facility has met compliance by having at least one full scale emergency exercise, and one table top exercise or as deemed necessary by the QAPI team. 5. Compliance will be met by 2/13/2022.	
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 01/24/22. 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.	K 000		

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K 000	Continued From page 18 The building construction type was found to be Type II (111) for the orginal building and Type V (111) for the 1998 addition, and contains seven smoke compartments. No new construction has occurred since the last survey of the facility on 02/25/20. The facility is connected to an assisted living facility and a two hour separation is present. The facility is licensed for 125 beds and at the time of survey 35 residents was the census. These requirements were not met as evidenced by the following deficiencies:	K 000		
K 222 SS=D	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 Clinical or Security Locking requirements are being met. In addition, the locks must be	K 222		2/13/22

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K 222	Continued From page 19 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: Based on observation, the facility failed to maintain egress doors with only one releasing	K 222	1. The facility failed to ensure that all egress doors could be exited through with	

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K 222	Continued From page 20 operation in accordance with NFPA 101, 2012 Edition, Sections 7.2.1.5., 10.2. This deficiency affects 1 of 7 smoke compartments in the facility. Findings include: 1. During an observation on 01/24/22 at 11:28 a.m., the kitchen was inspected. The door leading from the kitchen to the hall was found to be fitted with a lock which required more than one motion to open the door. The room has the capacity to hold three or more people. 2. During an observation on 01/24/22 at 11:29 a.m., the kitchen was inspected. The door leading from the kitchen to the dining room was fitted with a slide latch lock which required more than one motion to open the door.	K 222	one releasing operation. The facility will replace the doorknob and locks on the door leading from the kitchen to the hall, to ensure that the door can be opened in one motion. The facility will remove the slide latch lock on the door leading from the kitchen to the dining room. 2. Everyone in the facility have the potential to be affected by this deficient practice. The facility will audit all doorknobs and locks in the facility to ensure that they are able to be exited through with one motion of turning the doorknob, and with no other attached locks. 3. On or before 2/11/2022 the doorknob and locks on the door leading from the kitchen to the hall will replaced with a lock that can be opened in one motion. On or before 2/11/2022 the slide latch lock on the door leading from the kitchen to the dining room will be removed. 4. A door lock audit will be completed twice weekly for one week, and then once quarterly for six months or as deemed necessary by the QAPI team. 5. Compliance will be met by 2/13/2022.	
K 321 SS=E	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	K 321		2/13/22

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K 321	Continued From page 21 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. This deficiency affects 2 of 7 smoke compartments in the facility. Findings include: 1. During an observation on 01/24/22 at 11:36 a.m., the housekeeping closet by Rosebud 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. The facility failed to ensure that rooms that were being used as storage had automatic door closures installed on them. The facility will place an automatic door closure on the housekeeping closet by rosebud. The facility will remove all storage out of room 309, which will then not require an automatic door closure as it is a resident room. 2. Everyone in the facility had the potential to be affected by this deficient practice. The facility will audit all resident rooms once weekly to ensure no storage is placed in resident rooms. The facility will audit all storage areas once weekly to ensure that all storage areas have	

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K 321	Continued From page 22 2. During an observation on 01/24/22 at 11:56 a.m., room 309 was inspected. The room was used as storage and is over 50 square feet. There was no self-closer on the door.	K 321	automatic door closures affixed to the doors. 3. On or before 2/11/2022 all storage will be removed from room 309. On or before 2/11/2022 an automatic door closure will be placed on the housekeeping door by rosebud. 4. A resident room and storage closet audit will be completed to ensure resident rooms are free of storage, and storage closets have door closures on them once weekly for four weeks, then monthly for 3 months or as deemed necessary by the QAPI team. 5. Compliance will be met by 2/13/2022.	
K 351 SS=E	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced	K 351		2/13/22

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K 351	Continued From page 23 by: Based on observation the facility failed to ensure sprinkler heads were installed clear of ceiling mounted fixtures in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems, 2010 Edition, Section 8.6.5.2 and Table 8.6.5.1.2. This deficiency affects 1 of 7 smoke compartments in the facility. Findings include: 1. During an observation on 01/24/22 at 11:31 a.m., the entrance area to the dining room was inspected. The ceiling mounted light in the room was blocking the sprinkler head next to it. The head was within 12 inches of the light, and the light was lower than the deflector on the sprinkler head.	K 351	1. The facility failed to ensure that a ceiling light was not within 12 inches of a sprinkler head and failed to ensure that the light was not lower than the deflector of the sprinkler head in the dining room. The facility will move the light so that it is at least 12 inches away from sprinkler head, and that it is not lower than the defector of the sprinkler head. 2. Everyone in the facility had the potential to be affected by this deficient practice. The facility will audit all lights within the facility to ensure that they are at least 12 inches away from sprinkler heads, and not lower than the deflectors of the sprinkler heads. 3. On or before 2/11/2022 the light in the dining room will be removed and placed at least 12 inches away from the sprinkler head and will not be any lower than the deflector of a sprinkler head. 4. A light and sprinkler head audit will be completed to ensure that all lights in the facility are at least 12 inches away from sprinkler heads and no lower than the deflectors of the sprinkler heads at least twice weekly Monday through Friday until all areas of the facility have been reviewed, and then at least once monthly for three months or as deemed necessary by the QAPI team. 5. Compliance will be met by 2/13/2022.	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are	K 353		2/13/22

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K 353	Continued From page 24 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 and record review, the facility failed to: a) have documentation of sprinkler inspections, fire alarm inspections, and fire drills available immediately upon request per NFPA 25 Standard for the Inspection, Testing and Maintenance for Water-Based Fire Protection Systems, 2011 Edition, Section 4.3.1; b) document monthly standpipe gauge readings per NFPA 25 Standard for the Inspection, Testing and Maintenance for Water-Based Fire Protection Systems, 2011 Edition, Section 13.2.7.1.; c) 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; d) ensure sprinkler pipes were free of external loads in accordance with NFPA 25, Standard for	K 353	1. A). The facility failed to produce all pertinent documentation upon the survey request. The facility will ensure documentation is available moving forward. B.) Document monthly sandpipe readings, and a lack of monthly gage checks on both the wet and dry sprinkler systems. The facility will ensure to documents monthly sandpipe readings, and monthly gage checks on both the wet and dry sprinkler systems. C.) Two ceiling tiles were observed missing from the dropdown ceiling in the kitchen. The facility will replace the ceiling tiles in the kitchen. There were 3 missing ceiling tiles in the drop-down ceiling in the laundry room. The facility will replace the ceiling tiles in the laundry room. D.) The sprinkler head in the kitchen freezer did not have 18 inches of clearance due to storage.	

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K 353	Continued From page 25 the Inspection, Testing and Maintenance for Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.2.2. This deficiency affects the entire facility. Findings include: 1. The facility was unable to produce all pertinent documentation for the survey upon request. The sprinkler standpipes had the proper tickets filled out by the vendor, but the reports were unavailable or could not be found for review. 2. Review of facility documentation for the automatic sprinkler system on 01/24/22, reflected a lack of monthly pressure gauge checks on the wet and dry sprinkler system. 3. During an observation on 01/24/22 at 11:29 a.m., the kitchen was inspected. Two ceiling tiles were observed missing from the drop down ceiling. 4. During an observation on 01/24/22 at 11:30 a.m, the kitchen freezer and the kitchen cooler were inspected. The sprinkler heads in each of the areas were observed having storage within 18 inches of them. 5. During an observation on 01/24/22 at 11:32 a.m, the shred bin area was inspected. A white substance was observed on the sprinkler head in the room. 6. During an observation on 01/24/22 at 11:42 a.m, the laundry room was inspected. Three ceiling tiles were observed, missing from the drop down ceiling.	K 353	The facility will ensure that there are no storage items within 18 inches of the sprinkler head in the kitchen freezer. E). A sprinkler head in the shred bin area had a white substance observed on it. The sprinkler head in the shred bin area will be cleaned. F.) In the control room a blue and green cord were observed zip tied to the sprinkler pipe. The blue and green cords will be removed from the sprinkler pipes. 2. Everyone in the facility had the potential to be affected by this deficient practice. A.) The facility will ensure that documentation is always readily available moving forward. B.) Monthly sandpipe reading and monthly gage checks on both wet and dry sprinkler systems will be completed every month. C.) Ceiling tiles in all areas will be audited once monthly to ensure that they are in place. D.) Sprinkler heads throughout the facility will be monitored once monthly to ensure that there is no storage within 18 inches of the sprinkler. E.) Sprinkler heads throughout the facility will be audited monthly to ensure they are free from substances or debris. F.) Sprinkler pipes in the control room will be audited monthly to ensure that there are no items attached to or blocking them. 3. On or before 2/11/2022 all documentation will be readily available for viewing. On or before 2/11/2022 sandpipe reading, and monthly gage checks on both the wet and dry sprinkler systems will be completed. On or before 2/11/2022 ceiling tiles in the kitchen and laundry area will be replaced. On or before	

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K 353	Continued From page 26 7. During an observation on 01/24/22 at 11:59 a.m., the control room was inspected. A blue cord and a green cord were observed, zip tied to the sprinkler pipe within the room.	K 353	2/11/2022 storage will no less than 18 inches away from sprinkler heads. On or before 2/11/2022 sprinkler head in shred bin area will be cleaned to ensure it is free from a white substance or debris. On ore before 2/11/2022 the facility will remove the cords that are zip tied to the sprinkler pipes. 4. An audit will be created to ensure that all documentation in readily available once weekly for 4 weeks and then monthly for three months or as deemed necessary by the QAPI team. An audit will be created to ensure that monthly sand pipe readings and monthly gage checks on both wet and dry sprinkler systems are completed once monthly for 3 months or as deemed necessary by the QAPI team. An audit will be created to ensure ceiling tiles in all areas are in place once weekly for one month, and then once monthly for 3 months or as deemed necessary by the QAPI team. An audit will be created to ensure that there is no storage within 18 inches of sprinkler heads once weekly for 4 weeks, and then once monthly for 3 months or as deemed necessary by the QAPI team. An audit will be created to ensure that there is no white substances or debris on sprinkler heads throughout the facility weekly for 4 weeks, and then monthly for 3 months or as deemed necessary by the QAPI team. An audit will be created to ensure that there are no items attached to the sprinkler pipes in the control room weekly for 4 weeks, and then monthly for 3 months or as deemed necessary by the QAPI team. 5. Compliance will be met by 2/13/2022.	

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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 maintain access to portable fire extinguishers in accordance with NFPA 10 Standard for Portable Fire Extinguishers, 2010 Edition, Section 6.1.3.3.1. This deficiency affects 2 of 7 smoke compartments in the facility. Findings include: 1. During an observation on 01/24/22 at 11:16 a.m., the middle entrance on the south side of the building was inspected. The portable extinguisher in the room was found to have a a large electric wheelchair being stored in front of it. 2. During an observation on 01/24/22 at 12:08 p.m., the memory care dining room was inspected. The portable extinguisher in the room was found to have several water jugs being stored in front of it.	K 355	1. Facility failed to maintain access to portable fire extinguishers two out of seven times. There was a large electric wheelchair in front of one extinguisher. There were several water jugs being stored in front of the Memory care dining room fire extinguisher. The facility will ensure that there are no items blocking any fire extinguishers moving forward. 2. Everyone in the facility had the potential to be affected by this deficient practice. The facility will audit all areas in front of fire extinguishers to ensure that they are not blocked by any materials are equipment. 3. On or before 2/11/2022 an in-service will be held by the Corporate Vice President of Operations for all staff to educate them on the importance of not blocking the areas in front of fire extinguishers. 4. An audit will be created to monitor the areas in front of all fire extinguishers throughout the entire facility and ensure that no items are blocking the extinguishers. This audit will be completed twice weekly Monday through Friday for four weeks, and then once monthly for 3 months or as deemed necessary by the	2/13/22

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K 355	Continued From page 28	K 355	QAPI team. 5. Compliance will be met by 2/13/2022.	
K 363 SS=E	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 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,	K 363		2/13/22

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K 363	Continued From page 29 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 corridor doors to ensure a means suitable for keeping the doors closed in accordance with NFPA 101, 2012 Edition, Section 19.3.6.3.5. This deficiency affects 1 of 7 smoke compartments in the facility. Findings include: 1. During an observation on 01/24/22 at 11:58 a.m., the corridor door to resident room 315 was exercised. The door would not close and positively latch. 2. During an observation on 01/24/22 at 12:03 p.m., the corridor door to resident room 317 was exercised. The door would not close and positively latch.	K 363	1. The facility failed to ensure that resident room numbers 315 and 317 would positively latch once closed. The facility will fix the latches on resident rooms 315 and 317 to ensure they latch appropriately once closed. 2. Everyone in the facility had the potential to be affected by this deficient practice. The facility will audit all resident rooms of the facility to ensure that they all latch appropriately when closed. 3. On or before 2/11/2022 all resident rooms will be audited to ensure that all resident rooms latch appropriately when closed, and that all defective latches are fixed. 4. An audit will be created to monitor all resident rooms to ensure that all doors latch appropriately when closed weekly for 4 weeks, and then monthly for 3 months or as deemed necessary by the QAPI team. 5. Compliance will be met by 2/13/2022.	
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	K 712		2/13/22

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K 712	Continued From page 30 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 all facility occupants. Findings include: 1. Review of facility documents regarding fire drills for the last year reflected there was no documentation for completed drills for all shifts for: -NOC shift for the third quarter of 2021; -PM shift for the fourth quarter of 2021; -NOC shift for the fourth quarter of 2021.	K 712	1. The facility failed to conduct fire drills on every shift in every quarter. The facility will ensure that fire drills are conducted on every shift every quarter. 2. Everyone in the facility had the potential to be affected by this deficient practice. The facility will ensure fire drills are held on every shift every quarter. 3. On or before 2/11/2022 the Administrator will be in-serviced by the Corporate Vice President of Operations on ensuring that fire drills are held on every shift every quarter. 4. An audit will be created to monitor fire drills and ensure a fire drill was completed on each shift once monthly for 3 months, and then quarterly for 6 months or as deemed necessary by the QAPI team. 5. Compliance will be met by 2/13/2022.	
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. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program.	K 761		2/13/22

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K 761	Continued From page 31 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 and interview, the facility failed to test the fire doors in fire assemblies annually in accordance with NFPA 101-2012, Sections 8.3.3.1, 19.7.6, 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 01/24/22 reflected the lack of the annual fire door assembly testing documentation. The facility must identify the required doors in the building and show inspections of all components of the fire doors. During an interview on 01/24/22 at 10:45 a.m., staff member A stated the facility did not have a maintenance director and some of the maintenance paperwork for the facility could not be located.	K 761	1. The facility failed to test the fire doors in fire assemblies annually due to the lack of documentation. The facility will ensure moving forward that fire doors are tested during assemblies to ensure proper functioning. 2. Everyone in the facility had the potential to be affected by this deficient practice. The facility will ensure to check fire doors during fire assemblies to ensure proper operation and compliance. 3. On or before 2/11/2022 the Corporate Vice President of Operations will hold a fire assembly drill and test all fire doors and document the outcome of the drill and fire door operations. 4. An audit will be created to monitor fire door operations during fire drill assemblies once monthly for three months and then as deemed necessary by QAPI team. 5. Compliance will be met by 2/13/2022.	
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed	K 914		2/13/22

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K 914	Continued From page 32 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 01/24/22 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	K 914	1. The facility failed to maintain the receptacles in patient areas. There were non-hospital grade receptacles located in resident rooms that did not have annual retention testing. The facility will test all non-hospital grade receptacles located in resident rooms on or before 2/13/2022 and ensure all receptacles function appropriately. 2. Everyone in the facility had the potential to be affected by this deficient practice. The facility will test all non-hospital grade receptacles in resident rooms to maintain compliance. 3. On or before 2/13/2022 the Corporate Regional Vice President of Operations will have a Maintenance Director from a sister	

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K 914	Continued From page 33 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	facility come and test all non-medical grade receptacles in patient rooms to ensure that all receptacles function appropriately. 4. An audit will be created to monitor all non-hospital grade receptacles in resident rooms and ensure all receptacles function appropriately once every 6 months or as deemed necessary by the QAPI team. 5. Compliance will be met by 2/13/2022.	
K 923 SS=E	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		2/13/22

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K 923	Continued From page 34 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 store oxygen cylinders in accordance with NFPA 99, 2012 Edition, Section 11.3.2.3. The deficiency affects 1 of 7 smoke compartments in the facility. Findings include: 1. During an observation on 01/24/22 at 11:38 a.m., the oxygen storage room was inspected. Several items were observed being stored directly next to the oxygen tanks within the room. The combustibles were not more than five feet from the tanks.	K 923	1. The facility failed to store oxygen cylinders appropriately. Several items were noted being stored directly next to the oxygen tanks within the room. The combustibles were not more than 5 feet from the tanks. The facility will post signage to prompt staff not to place items within 5 feet of oxygen tanks and ensure that the oxygen tanks are stored appropriately. 2. Everyone in the facility had the potential to be affected by this deficient practice. The facility will place signage in all oxygen storage areas to ensure proper signage is displayed to ensure compliance. 3. On or before 2/13/2022 the Corporate Regional Vice President of Operations will	

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EAGLE CLIFF MANOR	**1415 YELLOWSTONE RIVER RD** **BILLINGS, MT 59105**

(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 923	Continued From page 35	K 923	place signage in the oxygen tank holding areas and provide an in-service to staff that there is to be no items within 5 feet of oxygen tanks. 4. An audit will be created to monitor oxygen tank storage areas to ensure that there are no items within 5 feet of oxygen tanks and ensure that the tanks are stored appropriately twice weekly for 4 weeks, then once monthly or as deemed necessary by the QAPI team. 5. Compliance will be met by 2/13/2022.	