DEPARTI	MENT OF HEALTH AN	ID HUMAN SERVICES				FORM APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES			ОМ	B NO. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDIN	PLE CONSTRUCTION G 01		DATE SURVEY COMPLETED
		275123	B. WING			01/24/2022
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
EAGLE CL	LIFF MANOR			1415 YELLOWSTONE RIVER RD BILLINGS, MT 59105		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLETION DATE
E 000	Initial Comments		E 00	00		
	standards of 42 Code (CFR) 483.73 Emerge Final Rule Requireme Facilities effective 11/	ry requirements, the				
E 036 SS=F	EP Training and Testi CFR(s): 483.73(d)	ng	E 0;	36		2/13/22
	§483.475(d), §484.10 §485.625(d), §485.72 §486.360(d), §491.12 *[For RNCHIs at §403	2(d), §482.15(d), §483.73(d), 12(d), §485.68(d), 17(d), §485.920(d), 12(d), §494.62(d). 3.748, ASCs at §416.54, PRTFs at §441.184, PACE				
		SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE		(X6) DATE
Electroni	cally Signed					02/11/2022

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.

	S FOR MEDICARE &					NO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG 01	· · · ·	TE SURVEY MPLETED
		275123	B. WING		C	1/24/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
EAGLE C	LIFF MANOR			1415 YELLOWSTONE RIVER RD BILLINGS, MT 59105		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR ((EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
E 036	§484.102, CORFs at "Organizations" unde §485.920, OPOs at § §491.12:] (d) Training must develop and ma preparedness training based on the emerge paragraph (a) of this s paragraph (a) (1) of th procedures at paragra the communication pl section. The training be reviewed and updat *[For LTC facilities at and testing. The LTC maintain an emergen and testing program to emergency plan set for section, risk assessm this section, policies at (b) of this section, and paragraph (c) of this s testing. The ICF/IIDs at §483 testing. The ICF/IID n an emergency prepar program that is based forth in paragraph (a) assessment at paragraph policies and procedur section, and the comm paragraph (c) of this s testing program must least every 2 years. T	§485.68, CAHs at §486.625, r 485.727, CMHCs at 486.360, and RHC/FHQs at and testing. The [facility] initain an emergency g and testing program that is ncy plan set forth in section, risk assessment at is section, policies and aph (b) of this section, and an at paragraph (c) of this and testing program must ated at least every 2 years. §483.73(d):] (d) Training c facility must develop and cy preparedness training hat is based on the orth in paragraph (a) of this ient at paragraph (a)(1) of and procedures at paragraph d the communication plan at section. The training and be reviewed and updated at 8.475(d):] Training and testing d on the emergency plan set of this section, risk raph (a)(1) of this section, res at paragraph (b) of this	EC	136		

Facility ID: MT275123

If continuation sheet Page 2 of 36

					OMB NO. 0938-039		
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	LE CONSTRUCTION 01	(X3) DATE SURVEY COMPLETED		
		275123	B. WING		01/24/2022		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
EAGLE CI	LIFF MANOR		1415 YELLOWSTONE RIVER RD BILLINGS, MT 59105				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION		
E 036	Continued From page §483.470(i).	2	E 03	6			
	testing, and orientation develop and maintain preparedness training orientation program the emergency plan set for section, risk assessment this section, policies a (b) of this section, and paragraph (c) of this se and orientation program updated at every 2 yes This REQUIREMENT by: Based on record revised develop and maintain program that is based Preparedness plan. T potential to affect all se residents of the facilit Findings include: 1. Review of the facilit	g, testing and patient hat is based on the orth in paragraph (a) of this nent at paragraph (a)(1) of and procedures at paragraph d the communication plan at section. The training, testing am must be evaluated and ears. is not met as evidenced iew, the facility failed to an EP training and testing d on the facility's Emergency This deficiency has the staff, volunteers, and y.		 The facility failed to train all staff of Annual Emergency Preparedness Program. The facility will conduct an Emergency Preparedness in-service all staff and educate them on the Emergency Preparedness Plan. All staff, volunteers and residents of facility have the potential to be affect this deficient practice. The facility will ensure that an Emergency Prepared Plan in-service for all staff is complet least annually to maintain compliance 3. On or before 2/10/2022, the Corpor Regional Vice President of Operation educate all staff on the facilities Emergency Preparedness Plan. An all-staff Emergency Preparedness education audit will be conducted dat Monday through Friday for 2 weeks, once weekly for 2 months to ensure fa all staff have been educated on the Emergency Preparedness Plan or as deemed necessary by the QAPI team 	for of the ed by ness ed at e. orate ns will ess ily then that		

Event ID: TUQ921

Facility ID: MT275123

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	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION 01	(X3) DATE SURVEY COMPLETED	
		275123	B. WING		01/2	24/2022
NAME OF P	ROVIDER OR SUPPLIER		:	STREET ADDRESS, CITY, STATE, ZIP CODE		
EAGLE C	LIFF MANOR			1415 YELLOWSTONE RIVER RD BILLINGS, MT 59105		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETIO DATE
E 036	Continued From page 3 E		E 036	5. Compliance will be met by 2/13/2	022	
E 037 SS=F	EP Training Program CFR(s): 483.73(d)(1)		E 037			2/13/22
	 §441.184(d)(1), §460 §483.73(d)(1), §483.4 §485.68(d)(1), §485. §485.920(d)(1), §486. *[For RNCHIs at §403 Hospitals at §482.15, at §484.102, "Organiz OPOs at §486.360, R (1) Training program the following: (i) Initial training in en policies and procedur staff, individuals proviarrangement, and vol expected roles. (ii) Provide emergence least every 2 years. (iii) Maintain document preparedness training (iv) Demonstrate staff procedures. (v) If the emergency procedures are signiff must conduct training procedures. *[For Hospices at §41 hospice must do all o (i) Initial training in en policies and procedures. 	unteers, consistent with their y preparedness training at ntation of all emergency f knowledge of emergency preparedness policies and icantly updated, the [facility] on the updated policies and 8.113(d):] (1) Training. The				

Facility ID: MT275123

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IDENTIFICATION NUMBER:				MPLETED
275123	B. WING		0	1/24/2022
		STREET ADDRESS, CITY, STATE, ZIP CODE		
		1415 YELLOWSTONE RIVER RD BILLINGS, MT 59105		
ICY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO	JLD BE	(X5) COMPLETIO DATE
aff knowledge of emergency ency preparedness training at iew and rehearse its adness plan with hospice by nonemployee staff), with laced on carrying out the ary to protect patients and entation of all emergency ng. y preparedness policies and hificantly updated, the hospice by on the updated policies and 1.184(d):] (1) Training must do all of the following: emergency preparedness ures to all new and existing oviding services under tolunteers, consistent with their and, provide emergency ng every 2 years. aff knowledge of emergency ng. y preparedness policies and hificantly updated, the PRTF and on the updated policies and bificantly updated, the PRTF and on the updated policies and hificantly updated policies and hificantly updated policies and hificantly updated policies and	E 03	37		
		& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIF A. BUILDING 275123 B. WING	& MEDICAID SERVICES (*1) PROVIDER/SUPPLIENCLIA IDENTIFICATION NUMBER: (x2) MULTIFLE CONSTRUCTION A. BUILDING 01 275123 B. WING STATEMENT OF DEFICIENCIES NOY MUST BE PRECEDED BY FULL R LINGS, MT S9105 ID PREFIX TAG PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SMUDER'S PLAN OF CORRECTIVE ACTION SMUD CROSS-REFERENCE TO THE APPR DEFICIENCY) ge 4 E 037 aff knowledge of emergency ency preparedness training at ewand rehearse its ddness plan with hospice ng nonemployee staff), with laced on carrying out the ary to protect patients and entation of all emergency ing. .y preparedness policies and inficantly updated, the hospice ng on the updated policies and entation of all emergency ing. or the updated policies and entation of all new and existing povidie gervices under rolunteers, consistent with their ng, provide emergency ing every 2 years. aff knowledge of emergency ing. .y preparedness policies and aff knowledge of emergency ing. .y preparedness policies and aff knowledge of emergency ing on the updated, the PRTF ng on the updated policies and aff knowledge of emergency ing. .y preparedness policies and 	& MEDICAID SERVICES ONE 1 (x1) PROVIDERSUPPLENCLIA IDENTIFICATION NUMBER: (x2) MULTIPLE CONSTRUCTION A BUILDING 01 (x3) DA CO (x1) PROVIDERSUPPLENCLIA IDENTIFICATION NUMBER: (x2) MULTIPLE CONSTRUCTION A BUILDING 01 (x3) DA CO (x1) PROVIDERSUPPLENCLIA INTO VELOWSTONE RIVER RD BILLINGS, MT 59105 (x3) DA CO STATEMENT OF DEFICIENCIES VENUSTE BRECEDED BY FULL R LSC IDENTIFYING INFORMATION) PREFX TAG PROVIDERS PLAN OF CORRECTION VENUSTE BRECEDED BY FULL R LSC IDENTIFYING INFORMATION) PREFX TAG PROVIDERS PLAN OF CORRECTION VENUSTE BRECEDED BY FULL R LSC IDENTIFYING INFORMATION) PREFX TAG PROVIDERS PLAN OF CORRECTION VENUSTE BRECEDED BY FULL R LSC IDENTIFYING INFORMATION) PREFX TAG PROVIDERS PLAN OF CORRECTION VENUSTE BRECEDED BY FULL R LSC IDENTIFYING INFORMATION) PREFX TAG PROVIDERS PLAN OF CORRECTION VENUSTE BRECEDED BY FULL R LSC IDENTIFYING INFORMATION) PREFX TAG PROVIDERS PLAN OF CORRECTION VENUSTE BRECEDED BY FULL R LSC IDENTIFYING INFORMATION) PREFX TAG PROVIDERS PLAN OF CORRECTION VENUSTE BRECEDED BY FULL R LSC IDENTIFYING INFORMATION) PREFX TAG PROVIDERS PLAN OF CORRECTION VENUSTE BRECEDED BY FULL R LSC IDENTIFYING INFORMATION) PREFX TAG PROVIDERS PLAN OF CORRECTION VENUSTE BRECEDED BY FULL R LSC IDENTIFYING INFORMATION PREFX TAG PROVIDERS PLAN OF CORRECTION VENUSTE BRECEDED BY FULL R LSC IDENTIFYING INFORMATION PREFX PLAN OF CORRECTIVE ACTION NUMBER PROVIDERS VENUSTE BRECEDED BY FULL R LSC IDENTIFYING INFORMATION PREVE PLAN OF CORRECTIVE ACTION NUMER () 11 TREAL () 10 TRE

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		275123	B. WING		0,	1/24/2022
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF	P CODE	
EAGLE CI	IFF MANOR			1415 YELLOWSTONE RIVER RD BILLINGS, MT 59105		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETIO DATE
E 037	Continued From page	e 5	E 0	37		
		nergency preparedness				
		res to all new and existing				
	•	iding on-site services under				
		tors, participants, and				
		t with their expected roles. cy preparedness training at				
	least every 2 years.	y proparoanoco training at				
		f knowledge of emergency				
		informing participants of				
		go, and whom to contact in				
	case of an emergenc (iv) Maintain docume					
		preparedness policies and				
	procedures are signif	icantly updated, the PACE				
	must conduct training procedures.	on the updated policies and				
		t §483.73(d):] (1) Training cility must do all of the				
	following:	cinty must do an or the				
	•	nergency preparedness				
		es to all new and existing				
	staff, individuals prov					
	expected role.	unteers, consistent with their				
	-	y preparedness training at				
	least annually.	, F				
	. ,	ntation of all emergency				
	preparedness training					
	(IV) Demonstrate stan procedures.	f knowledge of emergency				
		.68(d):](1) Training. The				
	CORF must do all of					
	(i) Provide initial train	ing in emergency s and procedures to all new				
		ividuals providing services				
	under arrangement, a	· •				

Facility ID: MT275123

If continuation sheet Page 6 of 36

		MEDICAID SERVICES				NO. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION G 01	(X3) DATE SURVEY COMPLETED	
		275123	B. WING		0	1/24/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
EAGLE C	LIFF MANOR			1415 YELLOWSTONE RIVER RD BILLINGS, MT 59105		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
E 037	least every 2 years. (iii) Maintain documer (iv) Demonstrate staff procedures. All new p and assigned specific the CORF's emergen their first workday. The include instruction in alarm systems and si equipment. (v) If the emergency procedures are signiff must conduct training procedures. *[For CAHs at §485.6 The CAH must do all (i) Initial training in em policies and procedur reporting and extingu and where necessary personnel, and guests cooperation with firefi authorities, to all new individuals providing s and volunteers, consi roles. (ii) Provide emergence least every 2 years. (iii) Maintain documer (iv) Demonstrate staff procedures. (v) If the emergency procedures are signifi	eles. by preparedness training at thation of the training. f knowledge of emergency bersonnel must be oriented c responsibilities regarding cy plan within 2 weeks of the location and use of gnals and firefighting r preparedness policies and icantly updated, the CORF on the updated policies and con the updated policies and con the updated policies and con the following: the following: the regency preparedness res, including prompt ishing of fires, protection, r, evacuation of patients, s, fire prevention, and ghting and disaster and existing staff, services under arrangement, stent with their expected by preparedness training at	E 03	37		

Facility ID: MT275123

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 03/01/2022 MAPPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION 01	(X3) DATE COMF	SURVEY PLETED
		275123	B. WING			01/	24/2022
NAME OF PI	ROVIDER OR SUPPLIER	I	I	S	STREET ADDRESS, CITY, STATE, ZIP CODE		-
EAGLE CLIFF MANOR			415 YELLOWSTONE RIVER RD				
				E	BILLINGS, MT 59105		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
E 037	Continued From page	97	E	037			
	CMHC must provide preparedness policies and existing staff, ind under arrangement, a with their expected ro documentation of the demonstrate staff kno procedures. Thereaf emergency prepared years. This REQUIREMENT by: Based on record rev implement the annua to all staff members, members' expected r a disaster. This defici occupants and staff in Findings include: 1. Record review of th training documents of facility failed to show	training. The CMHC must owledge of emergency ter, the CMHC must provide mess training at least every 2 ⁻ is not met as evidenced iew, the facility failed to I training of the EP program consistent with each team oles during an emergency or ency affects all of the in the facility.			 The facility failed to train all staff or Annual Emergency Preparedness Program as well as to include each st members responsibilities during an emergency. The facility will conduct a Emergency Preparedness Plan in-ser and review staff's responsibilities durin an emergency for all staff. All staff, volunteers and residents of facility have the potential to be affected this deficient practice. The Facility will ensure that an all-staff Emergency Preparedness Plan in-service to revies staff's responsibilities during an emergency is completed annually to maintain compliance. On or before 2/10/2022, the Corpor Regional Vice President of Operations educate all staff on the facilities Emergency Preparedness Plan and the responsibilities during an emergency. An all-staff Emergency Preparedness Plan and the responsibilities during an emergency. An all-staff Emergency Preparedness Plan and the responsibilities during an emergency. An all-staff Emergency Preparedness Plan and the responsibilities during an emergency. An all-staff Emergency Preparedness Plan and the responsibilities during an emergency. An all-staff Emergency Preparedness Plan and the responsibilities during an emergency. An all-staff Emergency Preparedness Plan and the responsibilities during an emergency. 	aff n vice ng f the d by w ate s will neir ss y nen	

Event ID: TUQ921

Facility ID: MT275123

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			CONSTRUCTION	(X3) DATE SURVEY	
	IDENTIFICATION NUMBER:	. ,		COMPLETED	
	275123	B. WING		01/24/2022	
ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE		
LIFF MANOR					
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLET	
Continued From page 8		E 037	all staff have been educated on the Emergency Preparedness Plan to ir their responsibilities during an emer or as deemed necessary by the QAI team. 5. Compliance will be met by 2/13/2	gency PI	
		E 039		2/13/22	
§460.84(d)(2), §482. §483.475(d)(2), §484 §485.625(d)(2), §485	15(d)(2), §483.73(d)(2), 1.102(d)(2), §485.68(d)(2), 5.727(d)(2), §485.920(d)(2),				
"Organizations" unde §485.920, RHCs/FQ	er §485.727, CMHCs at HCs at §491.12, and ESRD				
to test the emergenc	y plan annually. The [facility]				
community-based ev (A) When a communaccessible, conduct exercise every 2 year	ery 2 years; or nity-based exercise is not a facility-based functional rs; or				
natural or man-made activation of the eme exempt from engagir community-based or functional exercise for actual event.	emergency that requires rgency plan, the [facility] is ng in its next required individual, facility-based blowing the onset of the				
	(EACH DEFICIENC REGULATORY OR Continued From pag EP Testing Requirem CFR(s): 483.73(d)(2) §416.54(d)(2), §418. §460.84(d)(2), §482. §483.475(d)(2), §482. §483.475(d)(2), §484. §485.625(d)(2), §484. §491.12(d)(2), §494. *[For ASCs at §416.5 "Organizations" unde §485.920, RHCs/FQ Facilities at §494.62] (2) Testing. The [faci to test the emergenc must do all of the foll (i) Participate in a ful community-based ev (A) When a commun accessible, conduct a exercise every 2 yea (B) If the [facility natural or man-made activation of the eme exempt from engagir community-based or functional exercise for actual event.	CORRECTION IDENTIFICATION NUMBER: IDENTIFICATION NUMBER: IDENTIFICATION NUMBER: IDENTIFICATION NUMBER: INTER IF MANOR SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 8 EP Testing Requirements CFR(s): 483.73(d)(2) §416.54(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §485.625(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §484.102(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/FOHCs 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 (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	IDENTIFICATION NUMBER: A. BUILDING G 275123 B. WING	CORRECTION IDENTIFICATION NUMBER: A BUILDING 81 ROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE LIFF MANOR STREET ADDRESS, CITY, STATE, ZIP CODE ILLINGS, MT 59105 BILLINGS, MT 59105 REGULATORY OR LSC IDENTIFYING INFORMATION) PREXX REGULATORY OR LSC IDENTIFYING INFORMATION) PREXX Continued From page 8 E 037 EP Testing Requirements E 037 CFR(s): 483.73(d)(2) \$445.113(d)(2), \$441.184(d)(2), \$443.437(d)(2), \$445.473(d)(2), \$445.473(d	

Facility ID: MT275123

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		MEDICAID SERVICES				IO. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION G 01	(X3) DATE SURVEY COMPLETED	
		275123	B. WING		0	1/24/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
EAGLE CI	LIFF MANOR			1415 YELLOWSTONE RIVER RD BILLINGS, MT 59105		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
E 039	Continued From page		E 03	39		
	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-scal community-based or i functional exercise; o	individual, facility-based				
		Irill; or se or workshop that is led by des a group discussion using				
	a narrated, clinically-r scenario, and a set of	elevant emergency				
	directed messages, o designed to challenge (iii) Analyze the [facili	e an emergency plan.				
	maintain documentati	ion of all drills, tabletop jency events, and revise the				
	*[For Hospices at 418	3.113(d):] ses that provide care in the				
	patient's home. The leavercises to test the e	hospice must conduct emergency plan at least e must do the following:				
	(i) Participate in a ful community based eve	l-scale exercise that is ery 2 years; or				
	accessible, conduct a functional exercise ev					
	the emergency plan,	y that requires activation of the hospital is exempt from				
	engaging in its next re community-based exe facility-based function onset of the emergen	ercise or individual nal exercise following the				
	(ii) Conduct an additi opposite the year the	onal exercise every 2 years, full-scale or functional raph (d)(2)(i) of this section				

Facility ID: MT275123

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	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING 0	CONSTRUCTION 1	(X3) DATE SURVEY COMPLETED	
		275123	B. WING		01	/24/2022
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
EAGLE CI	IFF MANOR		1415 YELLOWSTONE RIVER RD BILLINGS, MT 59105			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIC DATE
	 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 lead a facilitator and includes a group discussion us 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 pe year. The hospice must do the following: (i) Participate in an annual full-scale exercise 		E 039			
	is community-based; (A) When a community accessible, conduct a facility-based function (B) If the hospice exp man-made emergence the emergency plan, the engaging in its next re- based or facility-base following the onset of (ii) Conduct an additi may include, but is not (A) A second full-sca community-based or a exercise; or (B) A mock disaster of (C) A tabletop exercise	or ty-based exercise is not in annual individual hal exercise; or eriences a natural or by that requires activation of the hospice is exempt from equired full-scale community d functional exercise the emergency event. onal annual exercise that ot limited to the following: le exercise that is a facility based functional				

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If continuation sheet Page 11 of 36

		MEDICAID SERVICES			OMB NO. 0938-0
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG 01	(X3) DATE SURVEY COMPLETED
		275123	B. WING _		01/24/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF	CODE
EAGLE C	LIFF MANOR			1415 YELLOWSTONE RIVER RD BILLINGS, MT 59105	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE COMPLET D THE APPROPRIATE DATE
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.		EC	039	
	conduct exercises to twice per year. The I do the following: (i) Participate in an a is community-based; (A) When a commun accessible, conduct a facility-based function (B) If the [PRTF, Hos actual natural or man requires activation of [facility] is exempt fro required full-scale co facility-based function onset of the emerger (ii) Conduct an I and that may include following: (A) A second full-scale community-based or functional exercise; c (B) A mock (C) A tabletop ev led by a facilitator an	§485.625(d):] IF, Hospital, CAH] must test the emergency plan [PRTF, Hospital, CAH] must annual full-scale exercise that or ity-based exercise is not an annual individual, nal exercise; or spital, CAH] experiences an n-made emergency that the emergency plan, the om engaging in its next mmunity based or individual, nal exercise following the ncy event. [additional] annual exercise or , but is not limited to the ale exercise that is individual, a facility-based or disaster drill; or kercise or workshop that is			

Facility ID: MT275123

If continuation sheet Page 12 of 36

						NO. 0938-03
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG 01	. ,	ATE SURVEY MPLETED
		275123	B. WING		- (01/24/2022
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA	ATE, ZIP CODE	
EAGLE CI	LIFF MANOR			1415 YELLOWSTONE RIVE BILLINGS, MT 59105	R RD	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIATE EFICIENCY)	(X5) COMPLETIO DATE
E 039	Continued From page	e 12	EC	39		
	questions designed to challenge an emergency plan.					
	(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop					
	exercises, and emerg [facility's] emergency	pency events and revise the plan, as needed.				
		E organization must conduct				
	annually. The PACE	emergency plan at least organization must do the				
	following: (i) Participate in an a is community-based;	nnual full-scale exercise that				
		ty-based exercise is not				
	facility-based function					
	man-made emergend	riences an actual natural or by that requires activation of				
	engaging in its next re	the PACE is exempt from equired full-scale community acility-based functional				
		e onset of the emergency				
	(ii) Conduct an a years opposite the ye	dditional exercise every 2 ear the full-scale or functional				
		raph (d)(2)(i) of this section y include, but is not limited to				
	(A) A second full-sca	le exercise that is individual, a facility based				
	functional exercise; o (B) A mock disaster	r				
	a facilitator and includ	se or workshop that is led by des a group discussion,				
		ically-relevant emergency f problem statements,				

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		ND HUMAN SERVICES MEDICAID SERVICES			FORM APPROV OMB NO. 0938-03	
TATEMENT C	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG 01	(X3) DATE SURVEY COMPLETED	
		275123	B. WING _		01/24/2022	
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z		
	IFF MANOR		1415 YELLOWSTONE RIVER RD		0	
				BILLINGS, MT 59105		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	((EACH CORRECTIVE CROSS-REFERENCED	DATE	
E 039	Continued From page designed to challeng (iii) Analyze the PAC	e an emergency plan.	EO)39		
	maintain documentat	tion of all drills, tabletop gency events and revise the				
	*[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 unannounc emergency procedur ICF/IID] must do the	ed staff drills using the es. The [LTC facility, following:				
	is community-based;	annual full-scale exercise that or ity-based exercise is not				
	accessible, conduct a facility-based function	an annual individual, nal exercise.				
	actual natural or man requires activation of	 facility experiences an n-made emergency that the emergency plan, the 				
	required a full-scale of	t from engaging its next community-based or sed functional exercise				
	following the onset of (ii) Conduct an addit	f the emergency event. ional annual exercise that ot limited to the following:				
	(A) A second full-sca community-based or	ale exercise that is an individual, facility based				
		drill; or ise or workshop that is led by				
	narrated, clinically-re and a set of problem					
	messages, or prepar challenge an emerge (iii) Analyze the [LTC					

Facility ID: MT275123

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	S FOR MEDICARE &					NO. 0938-03	
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION NG 01	. ,	OATE SURVEY OMPLETED	
		275123	B. WING			01/24/2022	
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	STATE, ZIP CODE		
EAGLE CL	IFF MANOR			1415 YELLOWSTONE RIV BILLINGS, MT 59105	/ER RD		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	(EACH CORRE	'S PLAN OF CORRECTION ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIC DATE	
E 039	Continued From page	2 14	E	139			
	exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed.						
	*[For ICF/IIDs at §483	3.475(d)]:					
	, _	ID must conduct exercises					
		/ plan at least twice per year.					
	The ICF/IID must do t	-					
	(i) Participate in an ar is community-based;	nnual full-scale exercise that					
		ty-based exercise is not					
	accessible, conduct a	-					
	facility-based function						
	-	eriences an actual natural or					
	man-made emergend	y that requires activation of					
		the ICF/IID is exempt from					
	engaging in its next re						
	•	individual, facility-based					
		llowing the onset of the					
	emergency event.	onal annual exercise that					
	. ,	ot limited to the following:					
	(A) A second full-scal	0					
		an individual, facility-based					
	functional exercise; o						
	(B) A mock disaster d						
		e or workshop that is led by					
		les a group discussion,					
		cally-relevant emergency					
	scenario, and a set of directed messages, o						
	designed to challenge						
	(iii) Analyze the ICF/I						
		ion of all drills, tabletop					
	exercises, and emerg	ency events, and revise the					
	ICF/IID's emergency	plan, as needed.					
	*[For HHAs at §484.1	021					
1		021					

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			0.00					
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		NSTRUCTION	· · ·	TE SURVEY MPLETED	
		275123	B. WING			(1/24/2022	
NAME OF PR	ROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE			
EAGLE CL	IFF MANOR				YELLOWSTONE RIVER RD INGS, MT 59105			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETIC DATE	
E 039	Continued From page	e 15	E	039				
	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,							
	or.	nal exercise every 2 years;						
		xperiences an actual natural						
		ency that requires activation						
	-	n, the HHA is exempt from						
	engaging in its next re	-						
		individual, facility based						
		llowing the onset of the						
	emergency event.	onal exercise every 2 years,						
	opposite the year the							
		raph (d)(2)(i) of this section						
		t may include, but is not						
	limited to the following	•						
	. ,	-scale exercise that is						
		an individual, facility-based						
	functional exercise; o (B) A mock disas							
	. ,	ercise or workshop that is						
	led by a facilitator and							
	2	arrated, clinically-relevant						
	emergency scenario,	and a set of problem						
		messages, or prepared						
		o challenge an emergency						
	plan.	s response to and maintain						
		drills, tabletop exercises, and						
	emergency events, a							
	emergency plan, as n							
	*[For OPOs at §486.3	3601						
	(d)(2) Testing. The OI							

Facility ID: MT275123

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			000	E CONSTRUCTION	OMB NO. 0	
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	LE CONSTRUCTION 01	(X3) DATE SUF COMPLET	
		275123	B. WING		01/24/	2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
				1415 YELLOWSTONE RIVER RD		
EAGLE CI	LIFF MANOR			BILLINGS, MT 59105		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE C	(X5) COMPLETION DATE
E 039	Continued From pag	e 16	E 03	9		
		y plan. The OPO must do the		Š		
	following:					
	•	based, tabletop exercise or				
		nually. A tabletop exercise is				
	led by a facilitator an	÷ .				
		narrated, clinically relevant				
		, and a set of problem				
		messages, or prepared				
		to challenge an emergency eriences an actual natural or				
		cy that requires activation of				
		the OPO is exempt from				
		required testing exercise				
		f the emergency event.				
	(ii) Analyze the OPO	's response to and maintain				
		tabletop exercises, and				
		and revise the [RNHCI's and				
	OPO's] emergency p	olan, as needed.				
	*[RNCHIs at §403.7					
	(d)(2) Testing. The R					
	must do the following	emergency plan. The RNHCI				
		y. based, tabletop exercise at				
		letop exercise is a group				
	-	acilitator, using a narrated,				
	· ·	hergency scenario, and a set				
	-	ts, directed messages, or				
	-	designed to challenge an				
	emergency plan.					
	(ii) Analyze the RNH					
		tion of all tabletop exercises,				
		nts, and revise the RNHCI's				
		needed. T is not met as evidenced				
	by:				.	
		view, the facility failed to		1. The facility failed to conduct an a		
	develop and implement			full-scale emergency exercise, and		
	Intenarenness testing	g program to annually	1	annual emergency table top exercis	se. ine 👘	

Facility ID: MT275123

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		ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 03/01/202 MAPPROVE O. 0938-039
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION 1	(X3) DAT	E SURVEY PLETED
		275123	B. WING			01	/24/2022
NAME OF P	ROVIDER OR SUPPLIER	1		SI	TREET ADDRESS, CITY, STATE, ZIP CODE		
	LIFF MANOR			14	415 YELLOWSTONE RIVER RD		
				В	ILLINGS, MT 59105		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
E 039	exercise. This deficie facility. Findings include: Record review of the	ale exercise, and a table top ency affects everyone in the facility EP plan on 01/24/22 documentation regarding a a table-top exercise	E	039	 facility will conduct a full-scale emerge 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 top exercise is conducted annually to maintain compliance. 3. On or before 2/10/2022, the Corporate Regional Vice President of Operations conduct a full-scale emergency exercion conduct a full-scale emergency exercing conduct a table top exercise. 4. An Emergency Preparedness Exer- audit will be conducted twice weekly for one week, then once every six month ensure that the facility has met compliance by having at least one full scale emergency exercise, and one ta- top exercise or as deemed necessary the QAPI team. 	nt table s will ise. e s will cise or s to able by	
K 000		tory requirements and	K	000	5. Compliance will be met by 2/13/202	22.	
	(CFR) 483.70(a) for I (LTC), a life safety co survey was performe regulatory requireme applicable provisions Protection Associatio Edition, and those ma by that edition. The fa	n's (NFPA) 101 LSC, 2012 andatory Codes referenced					

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			a			IO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION G 01	· · ·	E SURVEY IPLETED
		275123	B. WING		0	1/24/2022
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
EAGLE CL	IFF MANOR			1415 YELLOWSTONE RIVER RD BILLINGS, MT 59105		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETIO DATE
K 000	Continued From page	9 18	K OC	00		
	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					
		o hour separation is present.				
		for 125 beds and at the				
	time of survey 35 resi	dents was the census.				
	These requirements we by the following deficition	vere not met as evidenced encies:				
K 222	Egress Doors		K 22	22		2/13/22
SS=D	CFR(s): NFPA 101					
	Egress Doors					
		eans of egress shall not be				
		or a lock that requires the om the egress side unless				
	using one of the follow	-				
	arrangements: CLINICAL NEEDS OF	R SECURITY THREAT				
	LOCKING					
		g arrangements for the s of the patient are used,				
		ce shall be permitted on				
		ons shall be made for the				
		pants by: remote control of				
		ks or keys carried by staff at h reliable means available				
	to the staff at all times					
		.6, 19.2.2.2.5.1, 19.2.2.2.6				
		CKING ARRANGEMENTS				
		arrangements for the				
		atient are used, all of the ocking requirements are				
	being met. In addition					

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	S FOR MEDICARE &					<u>IO. 0938-039</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION NG 01	· · ·	TE SURVEY MPLETED
		275123	B. WING		01/24/2022	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
EAGLE C	LIFF MANOR			1415 YELLOWSTONE RIVER RD BILLINGS, MT 59105		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AL DEFICIENCY)	HOULD BE	(X5) COMPLETIOI DATE
K 222	electrical locks that fa upon loss of power to protected by a super- system and the locked complete smoke detec constantly monitored within the locked spa and detection system doors upon activation 18.2.2.5.2, 19.2.2.2 DELAYED-EGRESS ARRANGEMENTS Approved, listed dela installed in accordance permitted on door as ordinary hazard conte throughout by an app fire detection system automatic sprinkler si 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROL ARRANGEMENTS Access-Controlled Eg installed in accordance permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY I ARRANGEMENTS Elevator lobby exit ac accordance with 7.2. door assemblies in but	ail safely so as to release o the device; the building is vised automatic sprinkler ed space is protected by a ection system (or is at an attended location ce); and both the sprinkler as are arranged to unlock the b. 2.5.2, TIA 12-4 LOCKING yed-egress locking systems ce with 7.2.1.6.1 shall be semblies serving low and ents in buildings protected proved, supervised automatic or an approved, supervised ystem. LED EGRESS LOCKING gress Door assemblies ce with 7.2.1.6.2 shall be	K			

Facility ID: MT275123

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		ID HUMAN SERVICES				FOR	D: 03/01/2022 M APPROVED
STATEMENT (S FOR MEDICARE & OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION	(X3) DATE	D. 0938-0391 E SURVEY PLETED
		275123	B. WING			01	/24/2022
NAME OF PI	ROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE	1 0.	
EAGLE CI	IFF MANOR				115 YELLOWSTONE RIVER RD		
				Б	ILLINGS, MT 59105		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
K 222	Continued From page	e 20	K	222			
		nce with NFPA 101, 2012 1.5., 10.2.			one releasing operation. The facility w replace the doorknob and locks on the door leading from the kitchen to the ha to ensure that the door can be opened	e all,	
	Findings include:				one motion. The facility will remove the slide latch lock on the door leading fro the kitchen to the dining room. 2. Everyone in the facility have the	e	
	a.m., the kitchen was from the kitchen to th with a lock which requ	tion on 01/24/22 at 11:28 inspected. The door leading e hall was found to be fitted uired more than one motion e room has the capacity to cople.			2. Everyone in the facility have the potential to be affected by this deficier 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.		
	a.m., the kitchen was from the kitchen to th	tion on 01/24/22 at 11:29 inspected. The door leading e dining room was fitted with ch required more than one bor.			 On or before 2/11/2022 the doorknot and locks on the door leading from the kitchen to the hall will replaced with a that can be opened in one motion. On before 2/11/2022 the slide latch lock o the door leading from the kitchen to th dining room will be removed. A door lock audit will be completed twice weekly for one week, and then o quarterly for six months or as deemed necessary by the QAPI team. Compliance will be met by 2/13/202 	or or n e nce	
K 321 SS=E	Hazardous Areas - E CFR(s): NFPA 101	nclosure	K	321			2/13/22
	having 1-hour fire res fire rated doors) or ar system in accordance When the approved a system option is used	protected by a fire barrier istance rating (with 3/4 hour a automatic fire extinguishing with 8.7.1 or 19.3.5.9. automatic fire extinguishing					

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 03/01/202 MAPPROVE O. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ⁻ A. BUILDI		CONSTRUCTION		E SURVEY PLETED
		275123	B. WING			01	/24/2022
NAME OF P	ROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE		
	LIFF MANOR			14	15 YELLOWSTONE RIVER RD		
				BI	ILLINGS, MT 59105		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
K 321	Doors shall be self-cl and permitted to have protective plates that from the bottom of the Describe the floor and hazardous areas that 19.3.2.1, 19.3.5.9 Area Separation N// a. Boiler and Fuel-Fir b. Laundries (larger tt c. Repair, Maintenand d. Soiled Linen Room e. Trash Collection R (exceeding 64 gallons f. Combustible Storag (over 50 square feet) g. Laboratories (if cla Hazard - see K322) This REQUIREMENT by: Based on observatio hazardous rooms had close, and latch unde device, in accordance Edition, Sections 19.3 This deficiency affect compartments in the Findings include: 1. During an observa a.m., the housekeepi inspected. The room	n accordance with 8.4. osing or automatic-closing e nonrated or field-applied do not exceed 48 inches e door. d zone locations of are deficient in REMARKS. Automatic Sprinkler A ed Heater Rooms han 100 square feet) ce, and Paint Shops ns (exceeding 64 gallons) ooms s) ge Rooms/Spaces ssified as Severe is not met as evidenced m, the facility failed to assure d doors which were able to er the power of a self-closing the with NFPA 101, 2012 3.2.1 and 19.3.2.1.3. s 2 of 7 smoke	K	321	 The facility failed to ensure that root that were being used as storage had automatic door closures installed on t The facility will place an automatic do closure on the housekeeping closet b rosebud. The facility will remove all storage out of room 309, which will th not require an automatic door closure is a resident room. Everyone in the facility had the pote to be affected by this deficient practic The facility will audit all resident room once weekly to ensure no storage is placed in resident rooms. The facility audit all storage areas once weekly to ensure that all storage areas have 	hem. or y en as it ential e. s will	

Event ID: TUQ921

Facility ID: MT275123

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TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI TIPI	LE CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED
		275123	B. WING		01/24/2022
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
EAGLE CI	LIFF MANOR				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETIC
K 321	Continued From pag	je 22	К 32	1	
				automatic door closures affixed to	the
		ation on 01/24/22 at 11:56		doors.	
	-	inspected. The room was		3. On or before 2/11/2022 all stora be removed from room 309. On or	
	There was no self-cl	l is over 50 square feet. oser on the door		2/11/2022 an automatic door closu	
				be placed on the housekeeping do	
				rosebud.	, ,
				4. A resident room and storage clo	
				audit will be completed to ensure	
				rooms are free of storage, and sto	-
				closets have door closures on the	
				weekly for four weeks, then month months or as deemed necessary l	-
				QAPI team.	
				5. Compliance will be met by 2/13	/2022.
K 351 SS=E		nstallation	K 35		2/13/22
	Spinkler System - In 2012 EXISTING	stallation			
		hospitals where required by			
	-	e protected throughout by an			
	approved automatic				
		PA 13, Standard for the			
	Installation of Sprink	•			
		truction, alternative protection			
		tted to be substituted for n specific areas where state			
	or local regulations	•			
		ers are not required in clothes			
		eping rooms where the area			
		ot exceed 6 square feet and			
		overs the closet footprint as			
	sprinkler Systems.	3, Standard for Installation of			
		9.3.5.3, 19.3.5.4, 19.3.5.5,			
		0.0.0.0, 10.0.0.7, 10.0.0.0,			
	19.4.2, 19.3.5.10, 9.	7.9.7.1.1(1)			

Facility ID: MT275123

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	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIP	LE CONSTRUCTION		10. 0938-039 TE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		· · · ·	MPLETED
		275123	B. WING		o	1/24/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
EAGLE C	LIFF MANOR			1415 YELLOWSTONE RIVER RD BILLINGS, MT 59105		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
K 351	Continued From page		K 35			
		n the facility failed to ensure installed clear of ceiling		1. The facility failed to ensure t		
	· ·	ccordance with NFPA 13		ceiling light was not within 12 ir sprinkler head and failed to ens		
		allation of Sprinkler Systems,		the light was not lower than the		
Th co	2010 Edition, Section	8.6.5.2 and Table 8.6.5.1.2.		of the sprinkler head in the dini	•	
	This deficiency affect	s 1 of 7 smoke		The facility will move the light s at least 12 inches away from sp		
	compartments in the			head, and that it is not lower th		
				defector of the sprinkler head.		
	Findings include:			2. Everyone in the facility had t		
	1 During an observa	ation on 01/24/22 at 11:31		to be affected by this deficient p The facility will audit all lights w		
	-	ea to the dining room was		facility to ensure that they are a		
	_ · ·	g mounted light in the room		inches away from sprinkler hea		
		nkler head next to it. The		lower than the deflectors of the heads.	sprinkler	
		nches of the light, and the he deflector on the sprinkler		3. On or before 2/11/2022 the li	aht in the	
	head.			dining room will be removed an		
				least 12 inches away from the s	•	
				head and will not be any lower	than the	
				deflector of a sprinkler head.4. A light and sprinkler head au	dit will be	
				completed to ensure that all light		
				facility are at least 12 inches av		
				sprinkler heads and no lower th deflectors of the sprinkler head		
				twice weekly Monday through F		
				all areas of the facility have bee		
				reviewed, and then at least onc	•	
				for three months or as deemed by the QAPI team.	necessal y	
				5. Compliance will be met by 2/	13/2022.	
K 353 SS=F	Sprinkler System - Ma CFR(s): NFPA 101	aintenance and Testing	K 35	3		2/13/22
	Sprinkler System - M	aintenance and Testing				
	Automatic sprinkler a	-				

Facility ID: MT275123

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 03/01/2022 / APPROVED). 0938-0391
STATEMENT	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION 1	(X3) DATE COMP	SURVEY LETED
		275123	B. WING			01/	24/2022
NAME OF P	ROVIDER OR SUPPLIER		I	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	LIFF MANOR			14	415 YELLOWSTONE RIVER RD		
				В	BILLINGS, MT 59105		
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
K 353	inspected, tested, any with NFPA 25, Standa Testing, and Maintain Protection Systems. I maintenance, inspect maintained in a secur available. a) Date sprinkler system b) Who provided system c) Water system sup Provide in REMARKS any non-required or p system. 9.7.5, 9.7.7, 9.7.8, and This REQUIREMENT by: Based on observation facility failed to: a) have documentation fire alarm inspections immediately upon read for the Inspection, Te Water-Based Fire Pro Edition, Section 4.3.1 b) document monthly per NFPA 25 Standar and Maintenance for Systems, 2011 Edition c) ensure sprinkler sy satisfactory performa activation time in acc Standard for the Insta 2010 Edition, Section d) ensure sprinkler pi	d maintained in accordance ard for the Inspection, aing of Water-based Fire Records of system design, tion and testing are re location and readily stem last checked stem test oply source 6 information on coverage for bartial automatic sprinkler ad NFPA 25 7 is not met as evidenced an and record review, the on of sprinkler inspections, and fire drills available quest per NFPA 25 Standard sting and Maintenance for bection Systems, 2011 ; standpipe gauge readings d for the Inspection, Testing Water-Based Fire Protection n, Section 13.2.7.1.; vstems maintained nce with respect to cordance with NFPA 13 allation of Sprinkler Systems,	K	353	1. A). The facility failed to produce all pertinent documentation upon the surv request. The facility will ensure documentation is available moving forward. B.) Document monthly sandp readings, and a lack of monthly gage checks on both the wet and dry sprink systems. The facility will ensure to documents monthly sandpipe readings and monthly gage checks on both the and dry sprinkler systems. C.) Two cei tiles were observed missing from the dropdown ceiling in the kitchen. The facility will replace the ceiling tiles in th kitchen. There were 3 missing ceiling f in the drop-down ceiling in the laundry room. The facility will replace the ceilir tiles in the laundry room. D.) The sprin head in the kitchen freezer did not hav 18 inches of clearance due to storage.	ipe ler s, wet iling ie iles ng kler re	

Facility ID: MT275123

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		ND HUMAN SERVICES MEDICAID SERVICES				FOF	ED: 03/01/202 RM APPROVE IO. 0938-039
STATEMENT C	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION 1	(X3) DAT	E SURVEY IPLETED
		275123	B. WING			0	1/24/2022
NAME OF PR	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
EAGLE CL	IFF MANOR				415 YELLOWSTONE RIVER RD BILLINGS, MT 59105		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
K 353	Continued From page	e 25	ĸ	353			
		ng and Maintenance for		000	The facility will ensure that there are n	0	
		otection Systems, 2011			storage items within 18 inches of the		
	Edition, Section 5.2.2	-			sprinkler head in the kitchen freezer. E	E). A	
	This deficiency affect				sprinkler head in the shred bin area ha white substance observed on it. The	,	
		-			sprinkler head in the shred bin area w	ill be	
	Findings include:				cleaned. F.) In the control room a blue		
					and green cord were observed zip tied		
	-	able to produce all pertinent			the sprinkler pipe. The blue and green		
		e survey upon request. The had the proper tickets filled			cords will be removed from the sprinkl	er	
	out by the vendor, bu				pipes. 2. Everyone in the facility had the pote	ntial	
	-	not be found for review.			to be affected by this deficient practice A.) The facility will ensure that		
	2. Review of facility d	locumentation for the			documentation is always readily availa	able	
	automatic sprinkler s	ystem on 01/24/22, reflected			moving forward. B.) Monthly sandpipe		
		ssure gauge checks on the			reading and monthly gage checks on	both	
	wet and dry sprinkler	system.			wet and dry sprinkler systems will be completed every month. C.) Ceiling tile	es in	
	•	tion on 01/24/22 at 11:29			all areas will be audited once monthly		
		s inspected. Two ceiling tiles			ensure that they are in place. D.) Sprin	nkler	
		ng from the drop down			heads throughout the facility will be		
	ceiling.				monitored once monthly to ensure that		
	4 During an observa	tion on 01/24/22 at 11:30			there is no storage within 18 inches of sprinkler. E.) Sprinkler heads through		
	-	zer and the kitchen cooler			the facility will be audited monthly to	Jui	
		sprinkler heads in each of			ensure they are free from substances	or	
		rved having storage within 18			debris. F.) Sprinkler pipes in the control		
	inches of them.	- •			room will be audited monthly to ensure		
					that there are no items attached to or		
		tion on 01/24/22 at 11:32			blocking them.		
		ea was inspected. A white			3. On or before 2/11/2022 all		
		rved on the sprinkler head in			documentation will be readily available		
	the room.				viewing. On or before 2/11/2022 sand reading, and monthly gage checks on		
	6 During an observa	tion on 01/24/22 at 11:42			both the wet and dry sprinkler systems		
	-	n was inspected. Three			be completed. On or before 2/11/2022		
	•	erved, missing from the drop			ceiling tiles in the kitchen and laundry		
	down ceiling.	·, ····- ···· ··· ··· ··· ··· ··· ··· ··			area will be replaced. On or before		

Facility ID: MT275123

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			()(0)			D. 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G 01	. ,	E SURVEY PLETED
		275123	B. WING		01	/24/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
EAGLE C	LIFF MANOR			1415 YELLOWSTONE RIVER RD BILLINGS, MT 59105		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
K 353	7. During an observa a.m., the control roo	ation on 01/24/22 at 11:59 m was inspected. A blue cord ere observed, zip tied to the	К 3	 2/11/2022 storage will not inches away from sprinkler before 2/11/2022 sprinkler bin area will be cleaned to from a white substance or before 2/11/2022 the facilit the cords that are zip tied pipes. 4. An audit will be created all documentation in readi weekly for 4 weeks and the three months or as deemed the QAPI team. An audit we ensure that monthly gage checks dry sprinkler systems are monthly for 3 months or as necessary by the QAPI team. An audit will be created to ensure ceilir areas are in place once we month, and then once more months or as deemed nece QAPI team. An audit will be ensure that there is no storinches of sprinkler heads of 4 weeks, and then once more months or as deemed nece QAPI team. An audit will be ensure that there is no storinches of sprinkler heads of 4 weeks, and then once more months or as deemed nece QAPI team. An audit will be ensure that there is no storinches of sprinkler heads of the facility weekly for 4 weeks monthly for 3 months or as necessary by the QAPI team. An audit will be ensure that there is no whor debris on sprinkler heads of the facility weekly for 4 weeks monthly for 3 months or as necessary by the QAPI team. 	r heads. On or head in shred ensure it is free debris. On ore ty will remove to the sprinkler to ensure that ly available once en monthly for ed necessary by vill be created to pipe readings on both wet and completed once s deemed am. An audit will ng tiles in all eekly for one nthly for 3 ressary by the be created to irage within 18 once weekly for nonthly for 3 ressary by the be created to its substances ds throughout esks, and then s deemed am. An audit will there are no nkler pipes in the weeks, and then s deemed	

Event ID: TUQ921

Facility ID: MT275123

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STATEMENT (OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE	CONSTRUCTION	(X3) DATE	D. 0938-039 SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG 0	1	COMF	PLETED
		275123	B. WING			01	/24/2022
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	LIFF MANOR			14	415 YELLOWSTONE RIVER RD		
				В	ILLINGS, MT 59105		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
K 355 SS=E	Portable Fire Extingu CFR(s): NFPA 101	ishers	ĸ	355			2/13/22
	inspected, and mainta NFPA 10, Standard for Extinguishers. 18.3.5.12, 19.3.5.12, This REQUIREMENT by: Based on observation maintain access to pro- accordance with NFP Fire Extinguishers, 20 6.1.3.3.1. This deficiency affect compartments in the Findings include: 1. During an observa- a.m., the middle entra building was inspected in the room was foun- wheelchair being stor 2. During an observa- p.m., the memory car inspected. The portal	shers are selected, installed, ained in accordance with or Portable Fire NFPA 10 T is not met as evidenced an, the facility failed to ortable fire extinguishers in PA 10 Standard for Portable 010 Edition, Section s 2 of 7 smoke facility. tion on 01/24/22 at 11:16 ance on the south side of the ed. The portable extinguisher d to have a a large electric red in front of it.			 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 dinin room fire extinguisher. The facility will ensure that there are no items blocking any fire extinguishers moving forward. Everyone in the facility had the poten 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. 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. 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 comple twice weekly Monday through Friday for four weeks, and then once monthly for months or as deemed necessary by the 	g ntial e e ted r 3	

Event ID: TUQ921

Facility ID: MT275123

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	S FOR MEDICARE &				OMB NO. 09		
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING 0	ECONSTRUCTION 1	(X3) DATE SURV COMPLETE		
		275123	B. WING		01/24/2	022	
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE			
EAGLE C	LIFF MANOR			415 YELLOWSTONE RIVER RD BILLINGS, MT 59105			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	ILD BE CON	(X5) MPLETIO DATE	
K 355	Continued From page	28	K 355	QAPI team.			
K 363 SS=E	Corridor - Doors CFR(s): NFPA 101		K 363	5. Compliance will be met by 2/13/	2022.	3/22	
	required enclosures of hazardous areas resi and are made of 1 3/4 wood or other materia at least 20 minutes. It smoke compartments the passage of smoke to rooms containing fit materials have positive latches are prohibited requirements do not a do not contain flamms Clearance between b covering is not excee complying with 7.2.1. with a device capable when a force of 5 lbf impediment to the clo devices that release of pulled are permitted. of unlimited height are meeting 19.3.6.3.6 are shall be labeled and r materials in complian smoke compartment window assemblies a sprinklered compartment	nents there are no fire resistance of glass or semblies.					

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						NO. 0938-03
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION 5 01	· · ·	ATE SURVEY OMPLETED
		275123	B. WING			01/24/2022
IAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DDE	
AGLE CL	IFF MANOR			1415 YELLOWSTONE RIVER RD BILLINGS, MT 59105		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO TH DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE
K 363	Continued From page	e 29	K 36	3		
	and 485					
		details of doors such as fire				
	etc.	tomatics closing devices,				
	This REQUIREMENT is not met as evidenced					
	by:					
		on, the facility failed to		1. The facility failed to ensu		
	suitable for keeping t	ors to ensure a means		resident room numbers 315 would positively latch once		
		PA 101, 2012 Edition, Section		facility will fix the latches on		
	19.3.6.3.5.			rooms 315 and 317 to ensu		
				appropriately once closed.		
	This deficiency affect			2. Everyone in the facility ha		
	compartments in the	lacinty.		to be affected by this deficient to be affected by this deficient to be facility will audit all residuent to be affected by the facility will be affected by the facility will be affected by the facility will be affected by the facility be affected by the		
	Findings include:			the facility to ensure that the appropriately when closed.		
	1. During an observa	tion on 01/24/22 at 11:58		3. On or before 2/11/2022 a	II resident	
	,	or to resident room 315 was		rooms will be audited to ens		
	exercised. The door v positively latch.	would not close and		resident rooms latch approp closed, and that all defective	-	
				fixed.		
	2. During an observa	tion on 01/24/22 at 12:03		4. An audit will be created to	o monitor all	
		or to resident room 317 was		resident rooms to ensure th		
	exercised. The door v positively latch.	would not close and		latch appropriately when clo 4 weeks, and then monthly		
	positively laten.			or as deemed necessary by		
				team.		
				5. Compliance will be met b	y 2/13/2022.	
K 712	Fire Drills		K 71	2		2/13/22
SS=F	CFR(s): NFPA 101					
	Fire Drills					
		transmission of a fire alarm				
	signal and simulation					
		are held at expected and der varying conditions, at				

Facility ID: MT275123

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		ID HUMAN SERVICES MEDICAID SERVICES			FORM	03/01/2022 APPROVED 0.0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION 01	(X3) DATE COMPI	SURVEY
		275123	B. WING		01/2	24/2022
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
EAGLE CI	LIFF MANOR			1415 YELLOWSTONE RIVER RD BILLINGS, MT 59105		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
K 712 K 761 SS=F	 with procedures and established routine. between 9:00 PM and announcement may be alarms. 19.7.1.4 through 19.7 This REQUIREMENT by: Based on record revised conduct fire drills for the accordance with NFF 19.7.1.6. This deficie occupants. Findings include: 1. Review of facility divides of the last year documentation for conformation for conformation for the shift for the last year documentation for conformation. NOC shift for the thin -PM shift for the fourt -NOC shift for the fo	is aware that drills are part of Where drills are conducted d 6:00 AM, a coded be used instead of audible 7.1.7 T is not met as evidenced iew, the facility failed to every shift in every quarter in PA 101, 2012 Edition, section ncy affects all facility cocuments regarding fire reflected there was no mpleted drills for all shifts	K 71	 The facility failed to conduct fire dri on every shift in every quarter. The fa- will ensure that fire drills are conducte every shift every quarter. Everyone in the facility had the pote to be affected by this deficient practice The facility will ensure fire drills are he on every shift every quarter. On or before 2/11/2022 the Administrator will be in-serviced by the Corporate Vice President of Operation on ensuring that fire drills are held on every shift every quarter. An audit will be created to monitor f drills and ensure a fire drill was compl on each shift once monthly for 3 mont and then quarterly for 6 months or as deemed necessary by the QAPI team 5. Compliance will be met by 2/13/202 	cility d on ential e. eld s irre eted hs, 22.	2/13/22

Facility ID: MT275123

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					OMB NO. 0938-03	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION 01	(X3) DATE SURVEY COMPLETED	
		275123	B. WING		01/24/2022	
NAME OF P	ROVIDER OR SUPPLIER		:	STREET ADDRESS, CITY, STATE, ZIP CODE		
EAGLE CI	LIFF MANOR			1415 YELLOWSTONE RIVER RD BILLINGS, MT 59105		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETI	
K 761	testing possess know that demonstrates ab Written records of ins maintained and are a 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFP/ This REQUIREMENT by: Based on record revif failed to test the fire of annually in accordance Sections 8.3.3.1, 19.7 accordance with NFP (written report). This deficiency affects compartments. Findings include: 1. Review of the fire s on 01/24/22 reflected door assembly testing facility must identify th building and show ins of the fire doors. During an interview o staff member A state maintenance director maintenance paperwo be located. Electrical Systems - M	g the door inspections and redge, training or experience ility. pection and testing are vailable for review. A 80) is not met as evidenced iew and interview, the facility loors in fire assemblies ce with NFPA 101-2012, 7.6, 4.6.12 and in A 80-2010, Section 5.2 is all of the fire/smoke safety maintenance records the lack of the annual fire g documentation. The he required doors in the spections of all components in 01/24/22 at 10:45 a.m., d the facility did not have a	K 761	 The facility failed to test the fire of in fire assemblies annually due to the of documentation. The facility will en- moving forward that fire doors are to during assemblies to ensure proper functioning. Everyone in the facility had the pro- to be affected by this deficient pract The facility will ensure to check fire during fire assemblies to ensure pro- operation and compliance. On or before 2/11/2022 the Corpor Vice President of Operations will ho fire assembly drill and test all fire do and document the outcome of the d fire door operations. An audit will be created to monitor door operations during fire drill assemblies once monthly for three months and then as deemed necess by QAPI team. Compliance will be met by 2/13/2 	ne lack nsure ested otential ice. doors oper orate old a oors rill and or fire sary	
SS=F						

Facility ID: MT275123

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	-	ND HUMAN SERVICES MEDICAID SERVICES				RM APPROVE
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION NG 01		ATE SURVEY
		275123	B. WING _)1/24/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE	•	
				1415 YELLOWSTONE RIVER R	RD	
EAGLEC	LIFF MANOR			BILLINGS, MT 59105		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIZ TAG	X (EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION 'E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETIO DATE
K 914	locations and where anesthesia is admini- installation, replacerr testing is performed a documented perform listed as hospital-gra tested at intervals no isolation monitors (LI intervals of less than actuating the LIM tes which activates both LIM circuits with auto manual test is perform equal to 12 months. I 6.3.3.3.2 after any re electric distribution sy maintained of require repairs or modificatio area tested, and resu 6.3.4 (NFPA 99)	deep sedation or general stered, are tested after initial nent or servicing. Additional at intervals defined by ance data. Receptacles not de at these locations are t exceeding 12 months. Line M), if installed, are tested at or equal to 1 month by st switch per 6.3.2.6.3.6, visual and audible alarm. For omated self-testing, this med at intervals less than or LIM circuits are tested per pair or renovation to the ystem. Records are ed tests and associated ons, containing date, room or	K	914		
	maintain the receptad deficient practice affer Findings include: Record review on 01 grade receptacles loo throughout the facility retention testing as m and 6.3.4.1.3 in NFP Code, 2012 Edition. Actual NFPA Standar Maintenance and Tes 6.3.4.1.2 Additional to	riew, the facility failed to cles in patient areas. The ected the entire facility. /24/22 revealed non-hospital cated in resident rooms y did not have annual equired by sections 6.3.4.1.2 A 99, Health Care Facilities rd: NFPA 99 (2012), 6.3.4.1 sting of Electrical System. esting of receptacles in hall be performed at intervals		 The facility failed to receptacles in patient non-hospital grade rec resident rooms that did retention testing. The non-hospital grade rec resident rooms on or b and ensure all recepta appropriately. Everyone in the facility will test all receptacles in residen compliance. On or before 2/13/2 Regional Vice Preside have a Maintenance D 	areas. There were ceptacles located in d not have annual facility will test all ceptacles located in before 2/13/2022 acles function ility had the potential deficient practice. non-hospital grade t rooms to maintain	

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PRINTED: 03/01/2022 FORM APPROVED

TATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DAT	E SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		· · ·	PLETED	
		275123	B. WING		01	01/24/2022	
NAME OF P	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP CODE	•		
	LIFF MANOR			I415 YELLOWSTONE RIVER RD BILLINGS, MT 59105			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETIO DATE	
K 914	defined by documented performance data.facility come and test all non-medical6.3.4.1.3 Receptacles not listed asgrade receptacles in patient rooms tohospital-grade, at patient bed locations and inensure that all receptacles function						
K 923 SS=E	locations where deep anesthesia is adminis intervals not exceedir 6.3.3.2 Receptacle Te Rooms. 6.3.3.2.1 The physica shall be confirmed by 6.3.3.2.2 The continu each electrical recept 6.3.3.2.3 Correct pola connections in each e confirmed. 6.3.3.2.4 The retention blade of each electric locking-type receptac 115 g (4 oz). Gas Equipment - Cyli	e sedation or general stered, shall be tested at ng 12 months. esting in Patient Care al integrity of each receptacle r visual inspection. ity of the grounding circuit in tacle shall be verified. arity of the hot and neutral electrical receptacle shall be on force of the grounding	K 923	 appropriately. An audit will be created to monitor non-hospital grade receptacles in re- rooms and ensure all receptacles fur appropriately once every 6 months of deemed necessary by the QAPI tear 5. Compliance will be met by 2/13/20 	sident nction n as n.	2/13/22	
	Greater than or equal Storage locations are ventilated in accordan 5.1.3.3.3. >300 but <3,000 cubi Storage locations are within an enclosed im limited- combustible of gates outdoors) that of gases are not stored separated from comb sprinklered) or enclose	e designed, constructed, and nee with 5.1.3.3.2 and the feet e outdoors in an enclosure or terior space of non- or construction, with door (or can be secured. Oxidizing with flammables, and are possibles by 20 feet (5 feet if sed in a cabinet of truction having a minimum rating.					

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			a			O. 0938-03
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION G 01	. ,	E SURVEY IPLETED
		275123	B. WING		0	1/24/2022
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF	CODE	
EAGLE CI	IFF MANOR			1415 YELLOWSTONE RIVER RD BILLINGS, MT 59105		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLETIO DATE
K 923	Continued From page 34		K 92	23		
	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					
	where the sign includ	a cylinder storage room, es the wording as a : OXIDIZING GAS(ES)				
	STORED WITHIN NO	D SMOKING."				
	÷ .	o cylinders are used in order				
	Empty cylinders are s	eived from the supplier.				
		lity employs cylinders with				
	integral pressure gau	ge, a threshold pressure				
		established. Empty cylinders				
		confusion. Cylinders stored				
	in the open are prote	, 11.3.4, 11.6.5 (NFPA 99)				
		is not met as evidenced				
		n, the facility failed to store		1. The facility failed to st		
		ccordance with NFPA 99,		cylinders appropriately. S		
	2012 Edition, Section	111.3.2.3.		were noted being stored	-	
	The deficiency affects	s 1 of 7 smoke		the oxygen tanks within t combustibles were not m		
	compartments in the			from the tanks. The facil		
				signage to prompt staff n	ot to place items	
	Findings include:			within 5 feet of oxygen ta		
	1 During an observa	tion on 01/24/22 at 11:38		that the oxygen tanks are appropriately.	estorea	
		age room was inspected.		2. Everyone in the facility	had the potential	
	Several items were o	bserved being stored directly		to be affected by this defi	cient practice.	
		nks within the room. The		The facility will place sign		
		ot more than five feet from		storage areas to ensure		
	the tanks.			displayed to ensure comp 3. On or before 2/13/2022		
				Regional Vice President	•	

Event ID: TUQ921

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TATEMENT	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE	CONSTRUCTION		NO. 0938-03
ND PLAN OI	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG 01	1	Ċ	OMPLETED
		275123	B. WING _				01/24/2022
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
EAGLE C	LIFF MANOR				115 YELLOWSTONE RIVER RD ILLINGS, MT 59105		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIC DATE
K 923	Continued From page	ge 35	K	923	place signage in the oxygen tank hol areas and provide an in-service to st that there is to be no items within 5 fe oxygen tanks. 4. An audit will be created to monitor oxygen tank storage areas to ensure there are no items within 5 feet of ox tanks and ensure that the tanks are stored appropriately twice weekly for weeks, then once monthly or as deen necessary by the QAPI team. 5. Compliance will be met by 2/13/20	aff eet of that ygen 4 med	

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Facility ID: MT275123

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