STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275020	A. BUILDING **01** B. WING _____	**02/23/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLA TERRA OF BILLINGS	**1807 24TH ST W** **BILLINGS, MT 59102**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments Based on the regulatory requirements and standards of 42 Code of Federal Regulations (CFR) 483.73 Emergency Preparedness (EP) Final Rule Requirement for Long Term Care Facilities effective 11/15/17, an initial EP survey was performed on 2/23/22. Under these regulatory requirements, the following deficiencies were cited: E0004 and E0039.	E 000		
E 004 SS=F	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness	E 004		4/1/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/09/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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E 004	Continued From page 1 requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. . This REQUIREMENT is not met as evidenced by: Based on record review, the facility failed to establish an emergency preparedness plan that is maintained, reviewed annually and updated as needed. The deficiency affects all of the staff and the residents who work and/or reside in the facility. Findings include: 1. Review of the facility EP plan on 2/23/22, reflected the facility did not have an updated Emergency Preparedness Plan. There was no evidence the plan had been reviewed and updated in the last year..	E 004	1) The facility will review nd update EP plan by 4/1/22 2) The facility will update, review plan at least annually and as needed. 3) EP plan review will be incorporated into the QAPI process on a quarterly basis to ensure no changes/updates are needed. 4) Administrator or designee will review EP plan quarterly with QAPI to ensure there needs to be no revisions or updates.	
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),	E 039		4/1/22

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E 039	Continued From page 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 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	E 039		

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E 039	Continued From page 3 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 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,	E 039		

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E 039	Continued From page 4 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 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):]	E 039		

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E 039	Continued From page 5 (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 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	E 039		

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E 039	Continued From page 6 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 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	E 039		

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E 039	Continued From page 7 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 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	E 039		

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E 039	Continued From page 8 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 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	E 039		

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E 039	Continued From page 9 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 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	E 039		

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E 039	Continued From page 10 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 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 2/23/2022 showed there was no documentation regarding a second full-scale exercise or a table-top exercise completed by the facility. Facility documentation	E 039	1) The facility will conduct a full scale exercise or table top exercise by 4/1/22. 2) The facility will conduct EP exercises in accordance with 483.73(d) annually. 3) EP exercises will be reviewed at QAPI quarterly to ensure exercises have been completed or are scheduled to occur per regulation. 4) Administrator or designee will review scheduled exercises quarterly with QAPI to ensure they are completed per regulation.	

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E 039	Continued From page 11 of all covid precautions and procedures counts as one full scale exercise for the year.	E 039		
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 recertification safety code (LSC) survey was performed on 2/23/2022. Under this regulatory requirement, the facility must meet the applicable provisions of the National Fire Protection Association's (NFPA) 101 LSC, 2012 Edition, and those mandatory Codes referenced by that edition. The facility was surveyed specifically using Chapter 19 Existing Health Care Occupancies. The building construction type was found to be Type V (111) and contained nine main floor smoke compartments and one basement smoke compartment. No new construction has occurred since the last survey of the facility on 10/6/20. There are no other occupancies associated with this facility. The facility is licensed for 150 beds and at the time of survey, the census was 63 residents. The facility does not meet the prescriptive requirements of the applicable LSC or its referenced Codes that require each floor/section of the building to have at least two acceptable exits as written under deficiency K241. The Fire Safety Evaluation System (FSES) based on the National Fire Protection Association (NFPA) 101A, Guide on Alternative Approaches to Life Safety, 2013 Edition, has been utilized to determine whether or not a level of safety is provided which is equivalent to the LSC. The	K 000		

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K 000	Continued From page 12 FSES conducted on 10/6/2020 indicated that an equivalent level of safety will be provided with the correction of the following deficiencies: These requirements were not met as evidenced by the following deficiencies: K211, K222, K223, K291, K321, K353, K355, K363, K374, K712, K761, K914, K918, K927	K 000		
K 211 SS=E	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to keep the means of egress open to full and instant use in accordance with NFPA 101, 2012 Edition, Section 7.2.1.5.1. and the facility failed to secure non wheeled medical equipment in the egress path in accordance with NFPA 101, 2012 Edition, Sections 7.1.10.1, and 19.2.3.4(5). This deficiency affects 4 of 9 smoke compartments. Findings include: 1. During an observation on 2/23/2022 at 9:30 a.m., the main exit and mountain view exit egress paths were inspected. The sidewalks had not been cleared of snow and the path to the public way was packed with snow and ice. 2. During an observation on 2/23/2022 at 10:14	K 211	1) Main exit, Mountain View exit, receiving dock exit, employee exit, PT exit, Copper West exit from TV room and Copper West exit public pathway have been cleared of ice and snow pack. Copper East hall has been cleared of all non wheeled items. 2) All means of egress will be continuously maintained free of all obstructions to full use in case of emergency. 3) Administrator or designee will educate staff that all means of egress be continuously free of all obstruction to full use in case of emergency on or before 4/1/22. 4) Audits will be conducted weekly X4, then monthly X2, to ensure that all means	4/1/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275020	A. BUILDING **01** B. WING _____	**02/23/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLA TERRA OF BILLINGS	**1807 24TH ST W** **BILLINGS, MT 59102**

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K 211	Continued From page 13 a.m., the receiving dock exit and the employee exit was inspected. The pathways to the public way had not been cleared of snow after the last snowfall, and the pathways were now covered with packed snow and ice. 3. During an observation on 2/23/2022 at 10:23 a.m., the PT exit was inspected. The pathways to the public way had not been cleared of snow after the last snowfall, and the pathways were now covered with packed snow and ice. 4. During an observation on 2/23/22 at 10:29 a.m., Copper East hall was inspected. There were non-wheeled items such as a storage shelving unit, small plastic storage drawers, boxes, and trash cans being stored in the corridor. These are not wheeled medical equipment, and they cannot legitimately be cleared from the corridor during a fire drill or actual fire. 5. During an observation on 2/23/2022 at 10:45 a.m., the Copper West exit from the TV room was inspected. The pathway to the public way had not been cleared of snow after the last snowfall, and the pathway was now covered with packed snow and ice. 6. During an observation on 2/23/2022 at 10:45 a.m., the Copper West end hall exit was inspected. The pathway to the public way had not been cleared of snow after the last snowfall, and the pathway was now covered with packed snow and ice.	K 211	of egress are continuously free of all obstruction to full use in case of emergency. Audits will be presented to QAPI for discussion and development of corrective action if needed to sustain compliance.	
K 222 SS=E	Egress Doors CFR(s): NFPA 101	K 222		4/1/22

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K 222	Continued From page 14 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected	K 222		

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K 222	Continued From page 15 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, a)maintain egress doors with only one releasing operation in accordance with NFPA 101, 2012 Edition, Sections 7.2.1.5., 10.2.; b)ensure doors in the path of egress did not require the use of a key, a tool, or special knowledge or effort for operation from the egress side in accordance with NFPA 101-2012, Section 7.2.1.5.3 and 7.2.1.6.2. This deficiency affects 2 of 9 main floor smoke compartments in the facility. Findings include: 1. During an observation on 2/23/22 at 9:35 a.m.,	K 222	1) The lock on the scheduling office door will be replaced with a door handle and knob that unlocks with one motion upon egress. The egress door on Rimview will be fixed so the delayed egress will initiate with pressure on the crash bar. 2) All egress doors in facility will be checked to ensure door handles and knobs unlock with one motion. Delayed egress doors in the facility will be checked to ensure they initiate with pressure on the crash bars. 3)Administrator or designee will educate Maintenance Director on door handles or knobs must unlock with one motion and that delayed egress doors initiates with pressure on the crash bar on or before 4/1/22.	

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K 222	Continued From page 16 the scheduling office door was inspected. The locking door knob was found to be a two-step locking knob. Door handles and knobs must unlock with one motion upon egress. 2. During an observation on 2/23/22 at 10:40 a.m., the exit door at the end of Rimview hall was inspected. The exit door was locked with a magnetic locking device programmed with delayed egress. The delayed egress function of the door would not initiate with pressure on the crash bar.	K 222	4) Administrator or designee will audit egress doors in the facility weekly X2, then monthly X2 to ensure that egress doors have a handle and knob that unlock with one motion. Administrator or designee will audit weekly 2, then monthly 2 to ensure that delayed egress doors initiate with pressure on the crash bar. Audits will be presented to QAPI for discussion and development of corrective action if needed to sustain compliance.	
K 223 SS=D	Doors with Self-Closing Devices CFR(s): NFPA 101 Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to ensure corridor doors with automatic self-closing devices were maintained in accordance with NFPA 101-2012, Section 19.2.2.2.7 and section 19.2.2.2.8.	K 223	1)The back kitchen door to the corridor will not be wedged open. 2)All other doors with self- closing devices in the facility will be checked to ensure they are not wedged open. 3)Administrator or Designee will educate	4/1/22

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K 223	Continued From page 17 This deficiency affects 1 of 9 main floor smoke compartments. Findings include: 1. During an observation on 2/23/22 at 10:08 a.m., the back kitchen door to the corridor was wedged open. The self-closing device was unable to close and latch the door.	K 223	staff on self- closing doors not being wedged open on or before 4/1/22. 4)Audits will be conducted weekly X4, then monthly X2 for ensure self closing doors in the facility are not wedged open. Audits will be presented to QAPI for discussion and development of corrective action if needed to sustain compliance.	
K 241 SS=D	Number of Exits - Story and Compartment CFR(s): NFPA 101 Number of Exits - Story and Compartment Not less than two exits, remote from each other, and accessible from every part of every story are provided for each story. Each smoke compartment shall likewise be provided with two distinct egress paths to exits that do not require the entry into the same adjacent smoke compartment. 18.2.4.1-18.2.4.4, 19.2.4.1-19.2.4.4 This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to provide two acceptable exits from the basement per NFPA 101, 2012 Edition, Sections 19.2.4.2, 7.1.3.2.1(3)(a), and 7.5.1.6. There were no resident rooms or treatment areas in the basement. This deficiency affects the one smoke compartment in the basement. Findings include: 1. The basement was examined during the course of the survey on 2/23/2022. There were two interior stairways serving as the means of egress from the basement. Neither of the two stairways had direct access to the exterior from	K 241	No response is necessary for tag K241 if the facility accepts the FSES conducted during this survey and submits an acceptable plan of correction for all other deficiencies not subject to the FSES. The facility must note its acceptance of the FSES for this deficiency by having the Administrator or designee sign the line below and date it. Facility Administrator or designee accepts the FSES: Margaret Schwend, Administrator	3/7/22

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K 241	Continued From page 18 the basement level. The stairways opened onto either the main floor corridor by the elevator lobby or onto the main level near the staff break room/time clock. The stairway near the laundry did not have a one hour separation. There was a stairway from the boiler room directly to the exterior; however, this stairway is not considered a means of egress from the basement as indicated in Section 7.5.1.6 of the LSC, exit access shall be arranged so that it is not necessary to pass through any area identified as being hazardous, which was the boiler room in this building's basement.	K 241	Date: 3/7/22	
K 291 SS=D	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on record review, the facility failed to provide emergency lighting per NFPA 101-2012, Sections 19.2.9.1 and 7.9.3.1.1. This affects all locations where the battery powered emergency light fixtures were utilized. Findings include: 1. Review of the facility records for testing of the emergency lighting on 2/23/2022 showed a lack of supporting documentation for the 90 minute annual test performed on the emergency lights throughout the facility. Staff member A stated it had not been done.	K 291	1)The 90-minute annual test will be completed by 4/1/22 2)The 90-minute annual test will be completed annually 3)Administrator or designee will educate Maintenance Director on completing the 90-minute annual test on or before 4/1/22. 4)Administrator or designee will conduct audit annually. Audit will be presented to QAPI for discussion and development of corrective action if needed to sustain compliance.	4/1/22

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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 partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to assure hazardous rooms had doors which were able to close, and latch under the power of a self-closing device, in accordance with NFPA 101, 2012 Edition, Sections 19.3.2.1 and 19.3.2.1.3.	K 321	1)Room 101 and room 103 will cleared of storage items and will not require a self-closure. The self- closure on the clean linen room on Copper East Hall will be fixed or replaced to ensure it closes and latches upon being exercised.	4/1/22

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K 321	Continued From page 20 This deficiency affects 2 of 9 smoke compartments in the facility. Findings include: 1. During an observation on 2/23/2022 at 9: 39 a.m., resident room 101 was inspected. The room was used as storage and is over 50 square feet. There was no self-closer on the door. 2. During an observation on 2/23/2022 at 9: 39 a.m., resident room 103 was inspected. The room was used as storage and is over 50 square feet. There was no self-closer on the door. 3. During an observation 2/23/22 at 10:33 a.m., the clean linen room on Copper East hall was inspected. The door to the room would not close and latch under the power of the self-closer upon being exercised.	K 321	2)All rooms used for storage will have a self- closure on door. 3)Administrator or designee will educate staff on self -closure doors that are used on storage areas greater than 50 square feet by 4/1/22. 4)Administrator or designee will conduct audits weekly X4, then monthly X2 to ensure that all areas used for storage greater than 50 square feet have a self-closure on the door. Audits will be conducted weekly X4, then monthly X2 on self- closures on doors used on storage areas to ensure that they latch and close upon being exercised. Audit will be presented to QAPI for discussion and development of corrective action if needed to sustain compliance.	
K 353 SS=D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire 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 _____	K 353		4/1/22

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K 353	Continued From page 21 Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and record review, the facility failed to: a) ensure sprinkler systems maintained satisfactory performance with respect to activation time in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems, 2010 Edition, Section 8.1.1(3) b) ensure sprinkler pipes were free of external loads in accordance with NFPA 25, Standard for the Inspection, Testing and Maintenance for Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.2.2. This deficiency affects 3 of 9 main floor smoke compartments and 1 of 1 basement smoke compartment. Findings include: 1. During an observation on 2/23/22 at 9:49 a.m., the basement linen room was inspected. One of the 2' by 4' ceiling tiles was open in the room. This would disrupt the activation of the sprinkler head in the room. 2. During an observation on 2/23/22 at 9:52 a.m., the basement corridor was inspected. There was a flexible electrical conduit zip-tied to a sprinkler pipe near the basement storage room. 3. During an observation on 2/23/22 at 9:54 a.m.,	K 353	1)The 2□ by 4□ ceiling tile in the basement linen room was properly placed so it was not open in the room. The zip tie on flexible electrical conduit has been removed from the sprinkler pipe. Items (light covers, boxes and pipe insulators) stored on the sprinkler pipe have been removed . The large annular ring around the sprinkler head has been fixed. The escutcheon rings on the 2 sprinkler heads have been attached. The light cover in activity room has been replaced. 2)A house wide audit will be conducted to ensure ceiling tiles are in place, that nothing is zip tied to any sprinkler pipes, escutcheon rings are in place, light covers are in place and that there are no annular rings around sprinkler heads 3)Administrator or designee will educate Maintenance Director on making sure all ceiling tiles are in place, nothing is zip tied to the sprinkler pipes, no items can be placed on the sprinkler pipes, escutcheon rings are attached to the sprinkler heads, light covers are in place and there are no annular rings around the sprinkler head on or before 4/1/22. 4)Administrator or designee will conduct audits weekly X4, then monthly X2 to ensure all ceiling tiles are in place, nothing is zip tied to the sprinkler pipes, no items	

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K 353	Continued From page 22 the maintenance shop was inspected. There was a large amount of stored items laying on the sprinkler pipe in the room. Long items such as light covers, boxes, and pipe insulators. 4. During an observation on 2/23/22 at 10:10 a.m., the kitchen janitor's closet by the back door was inspected. The sprinkler head in the room was found to be coming through an abnormally large cutout in the ceiling. There was a very large annular ring around the sprinkler head. 5. During an observation on 2/23/22 at 10:15 a.m., the activity room was inspected. There were two sprinkler heads in the room missing the escutcheon rings. And there was a lighting cover missing, through which one of the sprinkler heads came through, leaving a large annular space around the sprinkler head.	K 353	can be placed on the sprinkler pipes, escutcheon rings are attached to the sprinkler heads, light covers are in place and there are no annular rings around the sprinkler head. Audit will be presented to QAPI for discussion and development of corrective action if needed to sustain compliance.	
K 355 SS=D	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 inspect portable fire extinguishers in accordance with NFPA 10 Standard for Portable Fire Extinguishers, 2010 Edition, Section 7.2.1.2. This deficiency affects 1 of 9 main floor smoke compartments.	K 355	1)Cardboard boxes and garbage can have been moved from in front of the ABC portable fire extinguisher. 2)There will be no boxes or garbage cans placed in front of portable fire extinguishers in the building. 3)Administrator or designee will educate staff on not placing cardboard boxes or	4/1/22

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K 355	Continued From page 23 Findings include: 1. During an observation on 2/23/22 at 10:09 a.m., the kitchen was inspected. There was an ABC portable fire extinguisher in the kitchen. Immediate access to the extinguisher was blocked by cardboard boxes and a garbage can.	K 355	garbage cans in front of portable fire extinguishers in the facility on or before 4/1/22. 4)Administrator or designee will conduct audits weekly X4, then monthly X2 to ensure that boxes or garbage cans are stored in front of portable fire extinguishers. Audit will be presented to QAPI for discussion and development of corrective action if needed to sustain compliance.	
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames	K 363		4/1/22

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	275020	A. BUILDING **01** B. WING _____	**02/23/2022**

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K 363	Continued From page 24 shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to maintain exit corridor doors in accordance with NFPA 101-2012, Section 19.3.6.3.5, and failed to ensure doors were resistant to the passage of smoke in accordance with NFPA 101, 2012 Edition, Sections 19.3.6.3.1. This deficiency affects 2 of 9 main floor smoke compartments. Findings include: 1. During an observation on 2/23/22 at 10:19 a.m., the skilled services Director's office door was inspected. there were holes through the door near the latch. 2. During an observation on 2/23/22 at 10:31 a.m., resident room 324 was inspected. The door was exercised twice, it was found that the door was unable to latch.	K 363	1)Skilled Services Director□s door will be repaired so that there are no holes near the latch. Resident room 324 door will be repaired so that when exercised will latch and close. 2)House wide audit will be conducted to ensure that there are no holes near latches in office doors and resident doors will be exercised to ensure that they latch and close. 3)Administrator or designee will provide education to Maintenance Director to ensure that there are no holes in doors to offices and that all resident room doors when exercised will latch and close on or before 4/1/22. 4)Administrator or designee will conduct audits weekly X4, then monthly X 2 to ensure there are no holes in doors to offices and that resident room doors close and latch when exercised. Audit will be presented to QAPI for discussion and development of corrective action if needed to sustain compliance.	

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K 374 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to ensure fire/smoke barrier doors located in the fire/smoke partitions were maintained per NFPA 101-2012, Section 19.3.7.8. This deficiency affects 2 of 9 smoke compartments in the facility. Findings include: 1. During an observation on 12/23/22 at 10:28 a.m., the rear set of cross-corridor smoke/fire doors in Copper east hall were inspected. The doors failed to close and latch when exercised.	K 374	1)The rear set of cross corridor smoke/fire doors will be repaired so that they close and latch when exercised. 2)All cross-corridor smoke/fire doors will be audited to ensure they close and latch when exercised. 3)Administrator or designee will provide education to Maintenance Director on ensuring that cross corridor smoke/fire close and latch when exercised on or before 4/1/22. 4)Administrator or designee will conduct audits weekly x4, then monthly X2 to ensure that cross corridor smoke/fire close and latch when exercised. Audit will be presented to QAPI for discussion and development of corrective action if needed to sustain compliance.	4/1/22
K 712 SS=F	Fire Drills CFR(s): NFPA 101	K 712		4/1/22

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K 712	Continued From page 26 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on record review, the facility failed to conduct fire drills for every shift in every quarter in accordance with NFPA 101, 2012 Edition, section 19.7.1.6. This deficiency affects all facility occupants. Findings include: 1. Review of facility documents regarding fire drills for the last year reflected there was no documentation for a completed drill, for the night shift of the fourth quarter of 2021. The fire drill documentation also did not show that someone was being trained to simulate a call to 911. This is not in regards to notifying the fire department that the facility was going to do a fire drill, but to train staff that the fire department must still be physically called during a fire, even though the dialer contacts the monitoring agency.	K 712	1)No immediate correction could be done for fourth quarter of 2021. 2)Fire drill will be conducted under varying conditions at least quarterly on each shift. 3)Administrator or designee will educate Maintenance Director on timing/frequency of fire drills and training staff on calling 911 during a fire even though the dialer contacts the monitoring agency on or before 4/1/22. 4)Administrator or designee will conduct audits quarterly X4 to ensure fire drills are conducted under varying conditions at least quarterly on each shift. Audit will be presented to QAPI for discussion and development of corrective action if needed to sustain compliance.	
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101	K 761		4/1/22

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K 761	Continued From page 27 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on record review, the facility failed to test the fire doors in fire assemblies annually in accordance with NFPA 101-2012, Sections 7.2.1.15.1, 4.6.12 and in accordance with NFPA 80-2010, Section 5.2 (written report). This deficiency affects all of the fire/smoke compartments. Findings include: 1. Review of the fire safety maintenance records on 2/23/2022, reflected the lack of the annual fire door assembly testing documentation. The facility must identify the required fire/smoke barriers, as well as electronically controlled doors and doors with special locking arrangement in the building and show inspections of all components of the doors in those barriers.	K 761	1)The annual fire door assembly testing will be completed. 2)The annual fire door assembly testing will be completed annually. 3)Administrator or designee will educate the Maintenance Director on the annual fire door assembly on or before 4/1/22. 4)Administrator or designee will audit annually to ensure the fire door assembly testing is completed. Audit will be presented to QAPI for discussion and development of corrective action if needed to sustain compliance.	
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101	K 914		4/1/22

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K 914	Continued From page 28 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on record review, the facility failed to maintain the receptacles in patient areas. The deficient practice affected the entire facility. Findings include: Record review on 2/23/2022 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.	K 914	1)Non-hospital grade receptacles located in resident rooms located throughout the facility will have annual retention testing completed as required by sections 6.3.4.1.2 and 6.3.4.1.3 in NFPA 99, Health Care Facilities Code 2012 Edition. 2)Non-hospital grade receptacles located in resident rooms located throughout the facility will have annual retention testing will be completed annually as required by sections 6.3.4.1.2 and 6.3.4.1.3 in NFPA 99, Health Care Facilities Code 2012 Edition. 3)Administrator or designee will educate the Maintenance Director on the	

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K 914	Continued From page 29 6.3.4.1.2 Additional testing of receptacles in patient care rooms shall be performed at intervals defined by documented performance data. 6.3.4.1.3 Receptacles not listed as hospital-grade, at patient bed locations and in locations where deep sedation or general anesthesia is administered, shall be tested at intervals not exceeding 12 months. 6.3.3.2 Receptacle Testing in Patient Care Rooms. 6.3.3.2.1 The physical integrity of each receptacle shall be confirmed by visual inspection. 6.3.3.2.2 The continuity of the grounding circuit in each electrical receptacle shall be verified. 6.3.3.2.3 Correct polarity of the hot and neutral connections in each electrical receptacle shall be confirmed. 6.3.3.2.4 The retention force of the grounding blade of each electrical receptacle (except locking-type receptacles) shall be not less than 115 g (4 oz).	K 914	requirement of testing non-hospital grade receptacles located in resident rooms located throughout the facility as required by sections 6.3.4.1.2 and 6.3.4.1.3 in NFPA 99, Health Care Facilities Code 2012 Edition by 4/1/22. 4)Administrator or designee will audit annually to ensure non-hospital grade receptacles located in resident rooms located throughout the facility as required by sections 6.3.4.1.2 and 6.3.4.1.3 in NFPA 99, Health Care Facilities Code 2012 Edition are tested. Audit will be presented to QAPI for discussion and development of corrective action if needed to sustain compliance.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36	K 918		4/1/22

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K 918	Continued From page 30 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure an annual diesel fuel supply quality test was conducted at least annually per NFPA 110, Section 8.3.8. This deficiency affects the entire facility. Findings include: 1. Review of the emergency generator inspection records on 2/23/22, showed the annual diesel fuel supply quality test was not conducted within the last year. In a interview on 2/23/22 at 11:00 a.m., staff member A stated the fuel quality test had not been completed.	K 918	1)The diesel fuel supply quality test will be completed by 4/1/22. 2)The diesel fuel supply quality test will be completed annually by the facility. 3)Administrator or designee will educate Maintenance director on conducting the annual fuel supply quality test must be completed and documented annually by 4/1/22. 4)Administrator or designee will audit annually to ensure the diesel fuel supply quality test is completed annually. Audit will be presented to QAPI for discussion and development of corrective action if needed to sustain compliance.	
K 927 SS=D	Gas Equipment - Transfilling Cylinders	K 927		4/1/22

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K 927	Continued From page 31 CFR(s): NFPA 101 Gas Equipment - Transfilling Cylinders Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, Transfilling of High Pressure Gaseous Oxygen Used for Respiration. Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99). 11.5.2.2 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to ensure that liquid oxygen transferring met the requirements of NFPA 99 ,1999 Edition, Section 11.5.2.3.1. The deficiency could affect 1 of 9 smoke compartments. The findings include: 1. During an observation on 2/23/2022 at 10:39 a.m., the oxygen storage area was observed. There were 9, 45 liter liquid oxygen tanks stored in the area. There was no sign on the corridor door that oxygen transfer is occurring in this area.	K 927	1)A sign has been placed on the corridor door indicating that oxygen transfer is occurring in the storage area. 2)There are no other oxygen transfer areas located in the facility. 3)Administrator or designee will educate staff about ensuring that there is a sign on the corridor door where oxygen transfer is occurring by 4/1/22. 4)Administrator or designee will audit weekly X4, then monthly X2 to ensure that a sign is on the corridor door where oxygen transfer is occurring. Audit will be presented to QAPI for discussion and development of corrective action if needed to sustain compliance.	