State of Maine
Department of Public Safety
Office of Fire Marshal
52 State House Station
Augusta, ME 04333-0052

JANET T. MILLS
GOVERNOR

MICHAEL SAUSCHUCK
COMMISIONER

RICHARD MCCARTHY
STATE FIRE MARSHAL

August 23, 2023

Pinnacle Health & Rehab At N Berwick
Attn: Andrea Bouchard, Administrator
47 Elm St
North Berwick, ME 03906

Provider ID#: 205086
Facility ID#: 3116
Event ID#: 0IYK21

Administrator Bouchard,

On **August 22, 2023**, the Office of the Fire Marshal conducted a Life Safety Code and Emergency Preparedness survey to determine if your facility complies with Federal participation requirements for nursing facilities in the Medicare and/or Medicaid program (In which you will be receiving a Form CMS-2567 for Life Safety Code and Emergency Preparedness). Your facility was found not to be in substantial compliance with the participation requirements for Life Safety Code and Emergency Preparedness.

The Federal regulatory requirements referenced in this letter are found in Title 42, Code of Federal Regulations (CFR) and in the National Fire Protection Association (NFPA)101 Life Safety Code Standard, 2012 Edition.

PLAN OF CORRECTION

Attached is Form CMS-2567 "Statement of Deficiencies" which enumerates the deficiencies found as a result of the survey. A Plan of Correction (POC) must be submitted by the **tenth (10th) calendar day** from your receipt of this letter. **Please note that a POC is not needed for isolated deficiencies which cause no harm (S/S of A).** Your POC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- **Include dates when corrective action will be completed**. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility;

- Include documentation to support a waiver request (if appropriate).

You are required to record your plan of correction in the appropriate column on the enclosed Form(s) CMS-2567. **Sign, date, and indicate your title in the blocks provided on page one.** Return the forms(s) with the POC to **State of Maine, Department of Public Safety, Office of State Fire Marshal, 45 Commerce Drive, 52 State House Station, Augusta, ME 04330-0052**.

Remedies will be recommended for imposition by the Centers for Medicare & Medicaid Services (CMS) Regional Office if your facility has failed to achieve substantial compliance by **October 9, 2023,** (Opportunity to Correct). Informal dispute resolution for the cited deficiencies will not delay the imposition of the recommended enforcement actions. A change in the seriousness of the noncompliance may result in a change in the remedy selected. When this occurs, you will be advised of any change in remedy.

RECOMMENDED REMEDIES
Based on the deficiencies cited during the Life Safety Code and Emergency Preparedness Survey of **August 22, 2023**, we are recommending to CMS the imposition of the following remedy(ies):

A Civil Monetary Penalty per day to be determined by CMS.

Directed Plan of Correction (DPOC) effective immediately. The State Agency directs the plan of correction noted on the attached CMS-2567 for deficiencies E015(SS=E), E041(SS=D), K232(SS=D), K300(SS-D), K324(SS=D), K345(SS=F), K353(SS=F), K511(SS=D), K911(SS=F) & K916(SS=F), (Tags). [42 CFR 488.424]

If you do not achieve substantial compliance by **November 23, 2023,** the CMS Regional Office or State Medicaid Agency must deny payments for new (Medicare/Medicaid) admissions. In addition, we may recommend that **termination of your provider agreement be effective on February 23, 2023,** if substantial compliance is not achieved by that time. [42 CFR 488.456]. **Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination**.

ALLEGATION OF COMPLIANCE

The Plan of Correction will serve as your allegation of compliance until substantiated by a revisit or other means. If upon revisit your facility has not achieved substantial compliance, recommended remedies may be imposed as determined by the CMS Regional Office and continue until substantial compliance is achieved. Additionally, CMS Regional Office may impose revised/additional remedies, if appropriate.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 Code of Federal Regulations §488.331, you have one opportunity to question cited deficiencies through an IDR process. You may also contest scope and severity assessments for deficiencies, which may have resulted in a finding of substandard quality of care (SQC) or immediate jeopardy. To be given such an opportunity, you are required to send your written request, along with the specific deficiencies (or why you are disputing the scope and severity assessments of deficiencies which have been found to constitute SQC or immediate jeopardy) to **Fire Marshal Richard McCarthy** at the address below. This request must be sent during the same 10 calendar days you have for submitting a POC for the cited deficiencies. An incomplete IDR process will not delay the effective date of any enforcement action. IDR in no way is to be construed as a formal evidentiary hearing. It is an informal administrative process to discuss deficiencies. If counsel will accompany you, you must indicate this in your request for IDR so that we may also have counsel present.

Please email back the plan of correction to: FMOHealthcare@maine.gov.

If you have any questions, please contact me at (207) 626-3880.

Yours for Better Fire Prevention,

Richard McCarthy
Assistant State Fire Marshal

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205086	A. BUILDING 01 B. WING _____	08/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINNACLE HEALTH & REHAB AT N BERWICK	47 ELM ST NORTH BERWICK, ME 03906

(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 Federal Recertification Survey Survey Date: 08/22/23 Pinnacle Health & Rehab at N Berwick, a long term care facility, is not in substantial compliance with 42 Code of Federal Regulations Part 483.73 Requirement for Long Term Care Facilities for Emergency Preparedness.	E 000		
E 015 SS=E	Subsistence Needs for Staff and Patients CFR(s): 483.73(b)(1) §403.748(b)(1), §418.113(b)(6)(iii), §441.184(b)(1), §460.84(b)(1), §482.15(b)(1), §483.73(b)(1), §483.475(b)(1), §485.542(b)(1), §485.625(b)(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting.	E 015		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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E 015	Continued From page 1 (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal. *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. This REQUIREMENT is not met as evidenced by: Based on observation and record review, the long term care facility failed to provide arrangements with vendors to accommodate the subsistence needs for staff and patients whether they evacuate or shelter in place in the Emergency Preparedness Plan. Findings: On 08/22/2023, between 08:30 am and 11:00 am, a surveyor, with the Administrator present, observed the following:	E 015		

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E 015	Continued From page 2 1. Documentation could not be provided to indicate there was a contract to provide emergency water for this facility. 2. Documentation could not be provided to indicate there was a contract to provide emergency food for this facility. 3. Documentation could not be provided to indicate there was a contract to provide emergency medical supplies for this facility. 4. Documentation could not be provided to indicate there was a contract to provide emergency pharmaceutical supplies for this facility. 5. Documentation could not be provided to indicate there was a contract to provide emergency fuel for this facility. The surveyor confirmed these findings with the Administrator at the time of the observation.	E 015		
E 041 SS=D	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e), §485.542(e) (e) Emergency and standby power systems. The	E 041		

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E 041	Continued From page 3 [LTC facility CAH and REH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.542(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2), §485.542(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3),§485.542(e)(2) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), REHs at §485.542(g), and and CAHs	E 041		

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E 041	Continued From page 4 §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22,	E 041		

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E 041	Continued From page 5 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. This REQUIREMENT is not met as evidenced by: Based on observation and record review, the long term care facility failed to provide arrangements with a vendor to ensure emergency power systems remained operational during an emergency in the Emergency Preparedness Plan. Finding: On 8/22/2023, between 08:30 am and 11:00 am, a surveyor, with the Administrator present, observed the following: 1. Documentation could not be provided to indicate their was a contract in place to provide emergency fuel to the generator during an emergency for the facility. The surveyor confirmed this finding with the Administrator at the time of the observation.	E 041		
K 000	INITIAL COMMENTS Federal Recertification Survey Survey Date: 08/22/2023 Facility was surveyed pursuant to the National Fire Protection Association 101 Life Safety Code, 2012 Edition as referenced in 42 CFR 483.90 (a - d) - Physical Environment and at the time of the inspection, the facility is not in substantial	K 000		

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K 000	Continued From page 6 compliance.	K 000		
K 232 SS=D	Aisle, Corridor, or Ramp Width CFR(s): NFPA 101 Aisle, Corridor or Ramp Width 2012 EXISTING The width of aisles or corridors (clear or unobstructed) serving as exit access shall be at least 4 feet and maintained to provide the convenient removal of nonambulatory patients on stretchers, except as modified by 19.2.3.4, exceptions 1-5. 19.2.3.4, 19.2.3.5 This REQUIREMENT is not met as evidenced by: Based on observation the long-term care facility failed to maintain the required unobstructed width of corridors serving as an exit per NFPA 101, Life Safety Code, 2012 Edition, Section 19.2.3.4(2), and 19.2.3.4(5)(a). Findings: On 08/22/2023, between 08:30 AM and 11:00 AM, surveyors, with the Maintenance Director present, observed the following: 1. A fan projected 11 inches into the A wing corridor by room 27 at a height of 6' 3". Projections shall not be more than 6 inches from the corridor wall and a minimum of 6'-8" in height from the floor. 2. A fan projected 9 inches into the corridor across from the employee break room at a height of 5'8". Projections shall not be more than 6 inches from the corridor wall and a minimum of 6'-8" in height from the floor. 3. Wingback chair and a table obstructing the	K 232		

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K 232	Continued From page 7 egress path in the entry way common / common area. The surveyor confirmed these findings with the Maintenance Director at the time of the observation.	K 232		
K 300 SS=D	Protection - Other CFR(s): NFPA 101 Protection - Other List in the REMARKS section any LSC Section 18.3 and 19.3 Protection requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the long-term care facility failed to maintain means of egress free from obstructions; doors shall not be equipped with a latch or lock that requires special knowledge to operate per NFPA 101, Life Safety Code, 2012 Edition, Sections 19.2.2.2.4 Findings: On 08/22/2023, between 8:30 AM and 11:00 AM, a surveyor, with the Maintenance Director present, observed the following: 1. Main entrance way bathroom has a barrel bolt on the outside of door. The barrel bolt is non-compliant locking device. Maintenance	K 300		

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K 300	Continued From page 8 Director advised the barrel bolt was there to prevent entry of residents because they lock themselves in the bathroom. 2. C-Wing eyewash room has chain lock on the outside of the door. Chain lock is non-compliant locking device. Maintenance Director advised the chain lock was there to prevent entry of residents because they lock themselves in the eyewash room. The surveyor confirmed these findings with the Maintenance Director at the time of the observation.	K 300		
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2	K 324		

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K 324	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on observation the long-term care facility failed to properly install and maintain equipment protected by the kitchen hood extinguishing system NFPA Standard: NFPA 101, Life Safety Code (2012) Sections 19.3.2.5.2*, 9.2.3, NFPA Standard: NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations (2011) Sections 12.1.2.2*, 12.1.2.3, 12.1.2.3.1 Finding: On 08/22/2023, between 8:30 AM and 11:00 AM, a surveyor, with the Maintenance Director present, observed the following: 1.The wheeled, gas-fired stove/oven and wheeled, gas-fired griddle located on the cooking line in the kitchen were not provided with an approved method that would ensure that the appliances were returned to an approved design location after they had been moved for maintenance and cleaning. The surveyor confirmed this finding with the Maintenance Director at the time of the observation.	K 324		
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in	K 345		

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K 345	Continued From page 10 accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the long-term care facility failed to ensure that the fire alarm was maintained in accordance with NFPA 101, Life Safety Code, 2012 Edition, Sections 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 Based on interview and observation on 08/22/2023 between hours of 08:30 am and 11:00 am. this surveyor accompanied with Director of Facilities did observe the following: 1. The facility had no documentation or was aware of the fire alarm system ever being sensitivity tested in the past 5 years. The surveyor confirmed this finding the Maintenance Director at the time of the observation.	K 345		
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily	K 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205086	A. BUILDING **01** B. WING _____	**08/22/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINNACLE HEALTH & REHAB AT N BERWICK	**47 ELM ST** **NORTH BERWICK, ME 03906**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 353	Continued From page 11 available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observations and interview, the facility failed to ensure that Sprinkler System Water Supply Tank was inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 edition, Chapter 9, section 9.1.1.2 This deficient practice could affect the entire facility, patients/residents, visitors, and members of facility staff in this location(S). Findings: Based on interview and observation on 08/22/2023 between hours of 08:30 am and 11:00 am. this surveyor accompanied with Director of Facilities did observe the following: 1. The 10,000 gallon water tank located in the basement of the facility which was not a lined steel tank had not been inspected since May of 2018. This deficiency does not meet the minimum requirements of maintaining a sprinkler system water supply to maintain the proper sprinkler coverage and supply of water to the facility.	K 353		

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K 353	Continued From page 12 2. The sprinkler pipe in the Maintenance Shop had items hanging off it near the Maintenance Directors desk. These findings were verified by the Director of Maintenance at the time of observations and document review	K 353		
K 511 SS=D	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the long-term care facility was drying mops and rags in the dryer which is prohibited per NFPA 101, Life Safety Code, 2012 Edition, Sections 19.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Finding: On 08.22.2023, between 08:30 AM and 10:15 AM, a surveyor, with the Maintenance Director present, observed the following: 1. The facility was drying mop heads and cleaning	K 511		

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PINNACLE HEALTH & REHAB AT N BERWICK	**47 ELM ST** **NORTH BERWICK, ME 03906**

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K 511	Continued From page 13 rags in the dryer after washing them, this deficient practice could affect residents, guest and staff if this practice lead to the rags or mops catching fire while in the dryer. The surveyor confirmed this finding with the Maintenance Director at the time of the observation.	K 511		
K 911 SS=F	Electrical Systems - Other CFR(s): NFPA 101 Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the long-term care facility failed to equip the generator with an emergency stop device outside the generator enclosure per NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, section 5.6.5.6, and NFPA 99, Health Care Facilities Code, 2012 edition, Section 6.4.1.1. Finding: Based on observation and interview on 08/22/2023, between 08:30 AM and 11:00 AM, a surveyor, with the Director of Maintenance observed the following: 1. The only generator remote emergency stop	K 911		

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K 911	Continued From page 14 station/device is inside the generator enclosure/housing. There is no labeled remote emergency stop station/device elsewhere. The surveyor confirmed this finding with the Director of Maintenance at the time of the observation.	K 911		
K 916 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Alarm Annunciator A remote annunciator that is storage battery powered is provided to operate outside of the generating room in a location readily observed by operating personnel. The annunciator is hard-wired to indicate alarm conditions of the emergency power source. A centralized computer system (e.g., building information system) is not to be substituted for the alarm annunciator. 6.4.1.1.17, 6.4.1.1.17.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observations and interview, the facility failed to ensure that the generator had a remote annunciator at a location that could be monitored 24 hours a day while facility was on auxiliary generator power Per NFPA 99, (2012) 6.4.1.1.17. Findings: Based on interview and observation on 08/22/2023 between hours of 08:30 am and 11:00 am. this surveyor accompanied with Director of Facilities did observe the following: 1. No generator annunciator panel at a readily observed location by operating personnel at a	K 916		

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K 916	Continued From page 15 regular workstation such as a nurses station. When this surveyor asked the Maintenance Director if they had a remote annunciator at any nurses station. The maintenance director informed this surveyor that they did not have one installed in the facility. The surveyor confirmed these observations with the maintenance director at the time of the observation.	K 916		