STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205101	A. BUILDING **01** B. WING _____	**07/30/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINNACLE HEALTH & REHAB CANTON	**26 PLEASANT ST** **CANTON, ME 04221**

(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: 07.30.2024 Pinnacle Health & Rehab Canton, a long-term care 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 is not in substantial compliance.	E 000		
E 006 SS=F	Plan Based on All Hazards Risk Assessment CFR(s): 483.73(a)(1)-(2) §403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2), §441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §483.475(a)(1)-(2), §484.102(a)(1)-(2), §485.68(a)(1)-(2), §485.542(a)(1)-(2), §485.625(a)(1)-(2), §485.727(a)(1)-(2), §485.920(a)(1)-(2), §486.360(a)(1)-(2), §491.12(a)(1)-(2), §494.62(a)(1)-(2) [(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 the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The	E 006		

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

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E 006	Continued From page 1 plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach. (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. *[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. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment. *[For ICF/IIDs at §483.475(a):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the long term care facility failed to	E 006		

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PINNACLE HEALTH & REHAB CANTON	**26 PLEASANT ST** **CANTON, ME 04221**

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E 006	Continued From page 2 maintain a risk assessment for Emergency Preparedness Plan in accordance with 42 CFR 483.73 Finding: On 07.30.2023, between 09:30 AM and 1:30 PM, a surveyor, with the Maintenance assistant present, observed the following: 1. The was no evidence in the emergency preparedness plan of a risk assessment documented, facility-based and community-based risk assessment, utilizing an all-hazards approach. Assessment states last updated 01.03.2022 The surveyor confirmed this finding with the Maintenance assistant at the time of the observation.	E 006		
E 024 SS=F	Policies/Procedures-Volunteers and Staffing CFR(s): 483.73(b)(6) §403.748(b)(6), §416.54(b)(5), §418.113(b)(4), §441.184(b)(6), §460.84(b)(7), §482.15(b)(6), §483.73(b)(6), §483.475(b)(6), §484.102(b)(5), §485.68(b)(4), §485.542(b)(6), §485.625(b)(6), §485.727(b)(4), §485.920(b)(5), §491.12(b)(4), §494.62(b)(5). [(b) Policies and procedures. The [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 at least every 2 years	E 024		

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E 024	Continued From page 3 [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] (6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. *[For RNHCIs at §403.748(b):] Policies and procedures. (6) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an emergency. *[For Hospice at §418.113(b):] Policies and procedures. (4) The use of hospice employees in an emergency and other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the long term care facility failed to have a plan to utilize volunteers for Emergency Preparedness Plan in accordance with 42 CFR 483.73 Finding: On 07.30.2024, between 09:30 AM and 1:30 PM, a surveyor, with the Maintenance assistant present, observed the following: 1. The was no evidence in the emergency	E 024		

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E 024	Continued From page 4 preparedness plan for the use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. The administrator states the facility does use voluteers in activities. No documentation was provided. The surveyor confirmed this finding with the Maintenance assistant at the time of the observation.	E 024		
E 029 SS=F	Development of Communication Plan CFR(s): 483.73(c) §403.748(c), §416.54(c), §418.113(c), §441.184(c), §460.84(c), §482.15(c), §483.73(c), §483.475(c), §484.102(c), §485.68(c), §485.542(c), §485.625(c), §485.727(c), §485.920(c), §486.360(c), §491.12(c), §494.62(c). (c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the long term care facility failed to maintain a communication plan for Emergency Preparedness Plan in accordance with 42 CFR 483.73 Finding:	E 029		

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E 029	Continued From page 5 On 07.30.2024, between 09:30 AM and 1:30 PM, a surveyor, with the Maintenance assistant present, observed the following: 1. The was no evidence in the emergency preparedness plan of a communications plan. The facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every year. Communication plan was last reviewed on 08.01.2021 documented at bottom of page. The surveyor confirmed this finding with the Maintenance assistant at the time of the observation.	E 029		
K 000	INITIAL COMMENTS Federal Recertification Survey: Date: 07.30.2024 Pinnacle Health & Rehab Canton, a Long Term Care Facility, was surveyed to the National Fire Protection Association 101 Life Safety Code 2012 Edition as reference on 42 CFR 483.90 (a-d) physical environment and is not in substantial compliance.	K 000		
K 163 SS=F	Interior Nonbearing Wall Construction CFR(s): NFPA 101 Interior Nonbearing Wall Construction Interior nonbearing walls in Type I or II construction are constructed of noncombustible or limited-combustible materials. Interior nonbearing walls required to have a minimum 2 hour fire resistance rating are permitted to be fire-retardant-treated wood enclosed within noncombustible or	K 163		

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K 163	Continued From page 6 limited-combustible materials, provided they are not used as shaft enclosures. 19.1.6.4, 19.1.6.5 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the long-term care facility failed to maintain the integrity of the 2-hour wall between the LTC, and the Living Center side of the building per NFPA 101, Life Safety Code, 2012 edition, section 19.1.6.5. Finding: On 07/30/2024, between 09:30 AM and 1:30 PM, this surveyor, observed the following finding with the Maintenance Assistant present: 1. The 3-hour door in the 90 minute frame in the only 2-hour separation wall did not self-close and latch due to air flow. Fire rated doors shall self-close and positively latch upon release. This surveyor confirmed this finding with the Maintenance Assistant, at the time of the observation.	K 163		
K 211 SS=D	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	K 211		

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K 211	Continued From page 7 by: Based on observation and interview during the facility tour, the long-term care facility failed In 2 of 4 smoke compartments to maintain the exit discharges to continuously maintained free of all obstacles or impediments. No furnishings, decorations, or other objects shall obstruct exits or their access thereto, egress therefrom, or visibility thereof. Ref: NFPA 101, Life Safety Code, 2012 Edition, Sections 7.1.10.1-2, 7.1.6.4, 19.2.2.2.5 and 19.2.1. Findings: On 07.30.2024, between 9:30 AM and 1:30 PM, a surveyor, with the Maintenance assistant present, observed the following: 1. North Wing has a med cart with laptop plugged in and stored in hallway across from room 119. The nurse states this is where they store the med cart normally. 2. Living Center barrel bolt on outside of staff bathroom door could be used to lock someone in the bathroom. 3. Living Center near room 221 barrel bolt on outside of client bathroom door could be used to lock someone in the bathroom. The surveyor confirmed these findings with the Maintenance assistant at the time of the observation.	K 211		
K 293 SS=D	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in	K 293		

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K 293	Continued From page 8 accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the long-term care facility in 2 of 4 smoke compartments failed to maintain exit signs in accordance with 7.10 per NFPA 101, Life Safety Code, 2012 Edition, Sections 19.2.10.1 & 7.10 Findings: On 07.30.2024, between 9:30 AM and 1:30 PM, a surveyor, with the Maintenance assistant present, observed the following: 1. Above cross corridor doors by the laundry room has Exit sign that does not illuminate. 2. Business office Exit sign above the exterior door does not illuminate. 3. Above cross corridor door by room 206 has an Exit sign that does not illuminate. 4. Business office Exit sign by conference area does not illuminate. The surveyor confirmed these findings with the Maintenance assistant at the time of the observation.	K 293		
K 321 SS=F	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	K 321		

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K 321	Continued From page 9 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, and interview, the long-term care facility failed to maintain the hazard area enclosures in accordance with NFPA 101, Life Safety Code, 2012 edition, sections 19.3.2.1. Findings: On 07/30/2024, between 09:30 AM and 1:30 PM, this surveyor, observed the following findings with the Maintenance Assistant present:	K 321		

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K 321	Continued From page 10 1. The Living Center soiled linen door has a 1/2 inch gap at the top of the door. 2. The salon is being used as a storage area. The door doesn't self-close and latch. 3. The laundry room door doesn't self-close and latch upon release. This surveyor confirmed these findings with the Maintenance Assistant at the time of the observation.	K 321		
K 331 SS=D	Interior Wall and Ceiling Finish CFR(s): NFPA 101 Interior Wall and Ceiling Finish 2012 EXISTING Interior wall and ceiling finishes, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and have a flame spread rating of Class A or Class B. The reduction in class of interior finish for a sprinkler system as prescribed in 10.2.8.1 is permitted. 10.2, 19.3.3.1, 19.3.3.2 Indicate flame spread rating(s). This REQUIREMENT is not met as evidenced by: Based on observation and interview, the long-term care facility in 1 of 4 smoke compartments failed to maintain exposed interior finish in accordance with 10.2 per NFPA 101, Life Safety Code, 2012 Edition, Sections 19.3.3.1 & 19.3.3.2 Findings:	K 331		

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K 331	Continued From page 11 On 07.30.2024, between 9:30 AM and 1:30 PM, a surveyor, with the Maintenance assistant present, observed the following: 1. Living Center Patient room 203 door has carpet not treated affixed to the bottom of the door measuring 26" Maintenance assistant states he installed carpet but to scratches on the door. He did not treat carpet with flame retardant spray and provided no documentation. 2. Living Center Patient room 204 door has carpet not treated affixed to the bottom of the door measuring 26" Maintenance assistant states he installed carpet but to scratches on the door. He did not treat carpet with flame retardant spray and provided no documentation. 3. Living Center Patient room 205 door has carpet not treated affixed to the bottom of the door measuring 26" Maintenance assistant states he installed carpet but to scratches on the door. He did not treat carpet with flame retardant spray and provided no documentation. 4. Living Center soiled linen room door has carpet not treated affixed to the bottom of the door measuring 26" Maintenance assistant states he installed carpet but to scratches on the door. He did not treat carpet with flame retardant spray and provided no documentation. The surveyor confirmed these findings with the Maintenance assistant at the time of the observation.	K 331		
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 12 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, Interview and documentation review, the long-term care facility failed to maintain Fire alarm inspection records for review per NFPA 101, Life Safety Code, 2012 edition, sections 9.6.1.3, and 9.6.1.5, and NFPA 72, National Fire Alarm and Signal Code, 2010 edition, Section 14.6.2 Findings: On 07/30/2024, between 09:30 AM and 1:30 PM, this surveyor, observed the following findings with the Maintenance Assistant and the Administrator. 1. Upon documentation review in the white Fire Alarm Inspection binder, no current fire alarm annual inspection report could be produced. The most recent fire alarm report was dated 08/11/2022. Neither the maintenance Assistant, nor the Maintenance Lead, (by phone) could locate any other documentation regarding the fire alarm inspection. The Administrative assistant could not produce one from the computer database upon request. Please provide the most recent fire alarm inspection report for both buildings. 2. Upon documentation review in the white Fire Alarm Inspection binder, no current fire alarm smoke detector sensitivity report could be	K 345		

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K 345	Continued From page 13 produced. There are no sensitivity reports in the binder. Neither the maintenance Assistant, nor the Maintenance Lead, (by phone) could locate any other documentation regarding the fire alarm inspection sensitivity test. The Administrative assistant could not produce one from the computer database upon request. Please provide the sensitivity report for both buildings. 3. According to the fire alarm report from 2022, the Maple Wood building fire alarm is not monitored for automatic emergency forces notification. 4. The smoke detector in Maple Wood resident room 301 was removed from the room. This surveyor confirmed these findings with Administrator, Maintenance Assistant, and Maintenance Lead, (by phone), at the time of the observation and review.	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 available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source	K 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205101	A. BUILDING 01 B. WING	07/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINNACLE HEALTH & REHAB CANTON	26 PLEASANT ST CANTON, ME 04221

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K 353	Continued From page 14 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, interview and documentation review, the long-term care facility failed to maintain and provide documentation of maintedance of the sprinkler system per NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems, 2011 edition, sections 4.3.1, 4.3.3, 4.3.5, and 5.2.1.1.4, and in accordance with NFPA 101, Life Safety Code, 2012 edition, sections 9.7.5, and 9.7.8. Findings: On 07/30/2024, between 09:30 AM and 1:30 PM, this surveyor, observed the following findings with the Maintenance Assistant and the Administrator present. 1. The most recent quarterly sprinkler inspection report on file was dated in June of 2023. No other reports were in the binder labeled Sprinkler Inspections. Neither the maintenance Assistant, nor the Maintenance Lead, (by phone) could locate any other documentation regarding the sprinkler inspection. The office could not locate any records to review. Please provide the last 4 quarterly sprinkler inspection reports, and maintain them on file for review. 2. An escutcheon is missing from the sprinkler head in the kitchen above the pot rack.	K 353		

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K 353	Continued From page 15 This surveyor confirmed these findings with Administrator, Maintenance Assistant, and Maintenance Lead, (on the phone) at the time of the observation and review.	K 353		
K 363 SS=F	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies.	K 363		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 712	Continued From page 17	K 712		
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar 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 observation, Interview and documentation review, the long-term care facility failed to conduct fire drills in accordance with NFPA 101, Life Safety Code, 2012 edition, sections 19.7.1. Finding: On 07/30/2024, between 09:30 AM and 1:30 PM, this surveyor, observed the following findings with the Maintenance Assistant present. 1. The fire drills are not being conducted quarterly per shift. The master sheet shows the June 19th drill happening on 3rd shift, but it actually occurred on 1st shift per the drill log. There was no drill done by third shift in the second quarter of 2024. 2. The drill for February 26th, occurred at 8:30 PM. It is labeled as a silent drill. The times for coded announcement are from 2100-0600. This is outside these times. A coded announcement over an intercom or similar device is still required.	K 712		

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K 363	Continued From page 16 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, Interview and documentation review, the long-term care facility failed to maintain the corridor doors to resist the passage of smoke in accordance with NFPA 101, Life Safety Code, 2012 edition, sections 19.3.6.3 Findings: On 07/30/2024, between 09:30 AM and 1:30 PM, this surveyor, observed the following findings with the Maintenance Assistant present in all 3 residential care areas. 1. Resident room 107 has clothing hanging on the doorknob with hangers which prevent the door from fully closing. 2. Resident Room 207 door doesn't fully close as it hits on the top of the door frame. 3. Resident room 304 door doesn't latch upon closure. 4. The clean linen storage closet door has a 5/16 gap at the top of the door making it not resist the passage of smoke. This surveyor confirmed these findings with Maintenance Assistant at the time of the observation and review.	K 363		

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PINNACLE HEALTH & REHAB CANTON	26 PLEASANT ST CANTON, ME 04221

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K 712	Continued From page 18 3. The drill from July 29th was at 06:30 AM and labeled a silent drill. The times for coded announcement are from 2100-0600. There is no mention of any coded announcement over an intercom or similar device on the sheet. This is outside these times. A coded announcement over an dintercom or similar device is still required. 4. Upon interview, this surveyor asked the maintenance assistant what RACE and PASS stood for to verify instruction on life safety procedures and equipment, as he writes it on the fire drill documentation page. The employee had to go find a clipboard and read it off the back. Note: This surveyor showed the maintenance assistant the code reference regarding the quarterly drills and night drills in their LSC from their shelf during the documentation review. This surveyor asked the maintenance assistant what RACE stood for as it is on each fire drill documentation page. The employee had to go find a clipboard and read it off the back. This surveyor confirmed this finding with Administrator, Maintenance Assistant, and Maintenance Lead the time of the observation and review.	K 712		
K 753 SS=D	Combustible Decorations CFR(s): NFPA 101 Combustible Decorations Combustible decorations shall be prohibited unless one of the following is met: o Flame retardant or treated with approved fire-retardant coating that is listed and labeled for product. o Decorations meet NFPA 701. o Decorations exhibit heat release less than	K 753		

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K 753	Continued From page 19 100 kilowatts in accordance with NFPA 289. o Decorations, such as photographs, paintings and other art are attached to the walls, ceilings and non-fire-rated doors in accordance with 18.7.5.6(4) or 19.7.5.6(4). o The decorations in existing occupancies are in such limited quantities that a hazard of fire development or spread is not present. 19.7.5.6 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the long-term care facility failed to treat with approved fire-retardant coating per NFPA 101, Life Safety Code, 2012 Edition, Sections 19.7.5.6 (4) Finding: On 07.30.2024, between 9:30 AM and 1:30 PM, a surveyor, with the Maintenance assistant present, observed the following: 1. Physical Therapy room has large plastic plant decoration hanging on the wall. The Maintenance assistant was unable to provide documentation and was unsure if quilt was treated. The surveyor confirmed this finding with the Maintenance assistant at the time of the observation.	K 753		
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to	K 761		

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K 761	Continued From page 20 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 observation, Interview and documentation review, the long-term care facility failed to conduct an annual fire door per NFPA 80, Standard for Fire Door and Other Opening Protectives, 2010 edition, section 5.2 and in accordance with NFPA 101, Life Safety Code, 2012 edition, sections 19.7.6, and 8.3.3.1. Finding: On 07/30/2024, between 09:30 AM and 1:30 PM, this surveyor, observed the following findings with the Maintenance Assistant and the Administrator. 1. The facility failed to complete the assessment of all fire doors in the facility. The facility had no documentation that the doors had been inspected by a trained employee or an outside qualified vendor since 06/13/2022. No other reports were in the binder labeled Fire Door Inspections. All other sheets were blank. Neither the maintenance Assistant, nor the Maintenance Lead, (by phone) could locate any other documentation regarding the fire door inspection. This surveyor confirmed this finding with Administrator, Maintenance Assistant, and Maintenance Lead the time of the observation	K 761		

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K 761	Continued From page 21 and review.	K 761		
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 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)	K 918		

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K 918	Continued From page 22 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and generator inspection documentation review during the facility tour, the long-term care facility failed to maintain the Essential Electric System Generator per NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, sections 8.3.7. and 8.4.1, and NFPA 99, Healthcare Facilities Code, 2012 edition, section 6.4.4.1.1.3. Findings: On July 16th, 2024, between 9:00 AM and 12:00 PM, a surveyor, with the Maintenance Director and Administrator present, observed the following: 1. Emergency Power Supply Systems, including all appurtenant components, shall be inspected weekly. The weekly generator inspection reports do not show a voltage conductance test for sealed batteries or an electrolyte specific gravity reading for unsealed automotive batteries. The only item listed on the weekly inspection paper is the hour meter. 2. No monthly generator inspections were conducted in the months of March, April, May, June, or July of 2024. Upon interview of the maintenance assistant, the maintenance lead has been out and it hasn't been done since since he left. The only generator inspection has been the weekly recording of the hour meter. The surveyor confirmed these findings with the Maintenance Assistant, Maitenance Lead, (by Phone) and Administrator at the time of the	K 918		

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K 918	Continued From page 23 observation.	K 918		
K 919 SS=D	Electrical Equipment - Other CFR(s): NFPA 101 Electrical Equipment - Other List in the REMARKS section any NFPA 99 Chapter 10, Electrical Equipment, 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 10 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the long-term care facility in 1 of 4 smoke compartments failed to test and maintain multiple outlet connections in patient rooms NFPA 99, Healthcare Facilities Code, 2012 Edition, Sections 10.2.3.6 Finding: On 07.30.2024, between 9:30 AM and 1:30 PM, a surveyor, with the acting Maintenance assistant present, observed the following: 1. Living Center nurse's station multiple outlet connections that are not hospital grade and have no record of testing connection. The surveyor confirmed this finding with the acting Maintenance assistant at the time of the observation.	K 919		
K 923 SS=D	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage	K 923		

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K 923	Continued From page 24 Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation, and interview, the long-term care facility failed to store oxygen	K 923		

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PINNACLE HEALTH & REHAB CANTON	**26 PLEASANT ST** **CANTON, ME 04221**

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K 923	Continued From page 25 cylinders in accordance with NFPA 99, Heathcare Facilities Code, 2012 edition, section 11.3.2.3(2) Finding: On 07/30/2024, between 09:30 AM and 1:30 PM, this surveyor, observed the following findings with the Maintenance Assistant present. 1. The oxygen storage room contained 13 E cylinders that are marked to contain 24 cubic feet each. (312 cubic feet) In storage rooms of Oxygen between 300 and 3000 cubic feet there shall be no combustibles within 5 feet of the cylinders. There are combustibles to include wood shelving within five feet of the oxygen cylinders. This surveyor confirmed this finding with the Maintenance Assistant, at the time of the observation.	K 923		