| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 205176 | A. BUILDING **01**<br>B. WING _____ | **02/18/2025** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **FOREST HILL MANOR** | **25 BOLDUC AVE**<br>**FORT KENT, ME 04743** |

| (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 |
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| E 000 | Initial Comments<br><br>Federal Recertification Survey<br>Date of Survey: 02/18/2025<br>Forest Hill Manor 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 Emergency Preparedness. | E 000 | | |
| E 006 SS=D | Plan Based on All Hazards Risk Assessment<br>CFR(s): 483.73(a)(1)-(2)<br><br>§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)<br><br>[(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:]<br><br>(1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.*<br><br>(2) Include strategies for addressing emergency events identified by the risk assessment.<br><br>* [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 plan must do the following:<br>(1) Be based on and include a documented, facility-based and community-based risk | E 006 | | |

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 006 | Continued From page 1<br>assessment, utilizing an all-hazards approach.<br>(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.<br><br>*[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:<br>(1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents.<br>(2) Include strategies for addressing emergency events identified by the risk assessment.<br><br>*[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:<br><br>(1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients.<br>(2) Include strategies for addressing emergency events identified by the risk assessment.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and record review, the long term care facility failed to include a risk assessment with Emergency Preparedness Plan in accordance with 42 CFR §483.73(a). | E 006 | | |

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| E 006 | Continued From page 2<br>Finding:<br><br>On 02/18/2025, between 11:00 AM and 4:00 PM, a surveyor, with the Administrator present, observed the following:<br><br>1. The emergency plan presented by the Administrator did not include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach*<br><br>The surveyor confirmed this finding with the Administrator at the time of the observation o.n 02/18/2025, between 11:00 AM and 4:00 PM. | E 006 | | |
| E 015 SS=D | Subsistence Needs for Staff and Patients<br>CFR(s): 483.73(b)(1)<br><br>§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)<br><br>[(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:<br><br>(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:<br>(i) Food, water, medical and pharmaceutical supplies<br>(ii) Alternate sources of energy to maintain the | E 015 | | |

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| E 015 | Continued From page 3<br>following:<br>(A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions.<br>(B) Emergency lighting.<br>(C) Fire detection, extinguishing, and alarm systems.<br>(D) Sewage and waste disposal.<br><br>*[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures.<br>(6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following:<br>(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:<br>(A) Food, water, medical, and pharmaceutical supplies.<br>(B) Alternate sources of energy to maintain the following:<br>(1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions.<br>(2) Emergency lighting.<br>(3) Fire detection, extinguishing, and alarm systems.<br>(C) Sewage and waste disposal.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and record review, the long term care facility failed to maintain provision of subsistence needs for staff and patients whether they evacuate or shelter in place for Emergency Preparedness Plan in accordance with 42 CFR 483.73(b)(1). | E 015 | | |

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| E 015 | Continued From page 4<br>Findings:<br><br>On 02/18/2025, between 11:00 AM and 4:00 PM, a surveyor, with the Administrator present, observed the following:<br><br>1. The was no documentation in the emergency preparedness plan with a written and updated memorandum of understing for food, water, medical and pharmaceutical supplies and how they would get replenished in the event they had to evacuate or shelter in place.<br><br>2. The was no documentation in the emergency preparedness plan with a written and updated memorandum for fuel to maintain the generator to run for more then the allotted time of fuel on site.<br><br>The surveyor confirmed these findings with the Administrator at the time of the observation on 02/18/2025 between 11:00 AM, and 4:00 PM.. | E 015 | | |
| E 026 SS=D | Roles Under a Waiver Declared by Secretary CFR(s): 483.73(b)(8)<br><br>§403.748(b)(8), §416.54(b)(6), §418.113(b)(6)(C)(iv), §441.184(b)(8), §460.84(b)(9), §482.15(b)(8), §483.73(b)(8), §483.475(b)(8), §485.542(b)(7), §485.625(b)(8), §485.920(b)(7), §494.62(b)(7).<br><br>[(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 | E 026 | | |

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| E 026 | Continued From page 5<br>be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:]<br><br>(8) [(6), (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials.<br><br>*[For RNHCIs at §403.748(b):] Policies and procedures. (8) The role of the RNHCI under a waiver declared by the Secretary, in accordance with section 1135 of Act, in the provision of care at an alternative care site identified by emergency management officials.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and record review, the long-term facility failed to include documentation regarding the role of the facility for operation under a waiver declared by the Secretary, in accordance with section 1135 in the Emergency Preparedness Plan in accordance with 42 CFR 483.73(b)(8).<br><br>Finding:<br><br>On 02/18/2025, between 11:00 AM and 4:00 PM, a surveyor, with the Administrator present, observed the following:<br><br>1. There are no policies or procedures int eh Emergency Preparedness Plan that describes the role of the facility under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an | E 026 | | |

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| E 026 | Continued From page 6<br>alternate care site identified by emergency management officials.<br><br>The surveyor confirmed this finding with the Administrator at the time of the record review. | E 026 | | |
| E 031 SS=D | Emergency Officials Contact Information<br>CFR(s): 483.73(c)(2)<br><br>§403.748(c)(2), §416.54(c)(2), §418.113(c)(2), §441.184(c)(2), §460.84(c)(2), §482.15(c)(2), §483.73(c)(2), §483.475(c)(2), §484.102(c)(2), §485.68(c)(2), §485.542(c)(2), §485.625(c)(2), §485.727(c)(2), §485.920(c)(2), §486.360(c)(2), §491.12(c)(2), §494.62(c)(2).<br><br>[(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]. The communication plan must include all of the following:<br><br>(2) Contact information for the following:<br>(i) Federal, State, tribal, regional, and local emergency preparedness staff.<br>(ii) Other sources of assistance.<br><br>*[For LTC Facilities at §483.73(c):] (2) Contact information for the following:<br>(i) Federal, State, tribal, regional, and local emergency preparedness staff.<br>(ii) The State Licensing and Certification Agency.<br>(iii) The Office of the State Long-Term Care Ombudsman.<br>(iv) Other sources of assistance.<br><br>*[For ICF/IIDs at §483.475(c):] (2) Contact | E 031 | | |

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| E 031 | Continued From page 7<br>information for the following:<br>(i) Federal, State, tribal, regional, and local emergency preparedness staff.<br>(ii) Other sources of assistance.<br>(iii) The State Licensing and Certification Agency.<br>(iv) The State Protection and Advocacy Agency.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, and record review, the long-term facility failed to include required contact information in the communication plan in accordance with 42 CFR 483.73(c).<br><br>Finding:<br><br>On 02/18/2025, between 11:00 AM and 4:00 PM, a surveyor, with the Administrator present, observed the following:<br><br>1. There was no contact information in the emergency preparedness plan for Office of the State Long-Term Care Ombudsman.<br><br>The surveyor confirmed this finding with the Administrator at the time of the record review on 02/18/2025 between 11:00 AM and 4:00 PM. | E 031 | | |
| K 000 | INITIAL COMMENTS<br><br>Federal Recertification Survey<br>Date of Survey 02/18/2025<br>Forest Hill Manor, a long-term care facility, was surveyed pursuant to the National Fire Protection Association, 101 Life Safety Code, 2012 Edition as referenced in Part 483.90(a-d) - Physical Environment is not in substantial compliance. | K 000 | | |
| K 211<br>SS=D | Means of Egress - General<br>CFR(s): NFPA 101 | K 211 | | |

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| K 211 | Continued From page 8<br>Means of Egress - General<br>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.<br>18.2.1, 19.2.1, 7.1.10.1<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations and interviews with the Director of Facilities and the Maintenance Employee present, the facility failed to maintain the means of egress is continuously maintained free of all obstructions to full use in case of emergency in accordance with National Fire Protection Association (NFPA) 101, Life Safety Code, 2012 edition, sections 19.2.1, 7.1.10.1, 7.1.5<br><br>Finding include:<br><br>Observations and Interviews, of exits during a facility tour on 02/18/2025 between 11:00 AM and 4:00 PM with the Director of Facilities and the Maintenance Employee present:<br><br>1. The exit signs in the basement level corridor are installed at 6 feet, 6 inches in height to the bottom of the sign instead of the required minimum 6 feet, 8 inches required by the life Safety Code. This deficient practice could affect the occupants, visitors and staff while trying to exit the building under reduced visibility of the exit areas.<br><br>2. The exit discharge from the nurses station to the public way was not cleared of snow and ice. | K 211 | | |

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| K 211 | Continued From page 9<br>These findings were verified by the Director of Facilities and the Maintenance Employee at the time of observation on 02/18/2025 between 11:00 AM and 4:00 PM. | K 211 | | |
| K 232 SS=D | Aisle, Corridor, or Ramp Width<br>CFR(s): NFPA 101<br><br>Aisle, Corridor or Ramp Width<br>2012 EXISTING<br>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.<br>19.2.3.4, 19.2.3.5<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations and interview, the facility failed to maintain the required corridor width in the means of egress in accordance with National Fire Protection Association (NFPA) 101, Life Safety Code, 2012 edition, sections 19.2.3.4(5)<br><br>Finding include:<br><br>Observation, of exit corridors in the resident care wings during a facility tour on 02/18/2025 between 11:00 AM and 4:00 PM with the Director of Facilities and the Maintenance Employee present:<br><br>1. Unsecured chairs to the floor or wall in 1of 2 resident care wings measuring 8' width was reduced to 5 feet and 4 inches in width .<br><br>These findings were verified by the Director of Facilities and the Maintenance Employee at the | K 232 | | |

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| K 232 | Continued From page 10<br>time of observation on 02/18/2025 between 11:00 AM and 4:00 PM. | K 232 | | |
| K 355 SS=D | Portable Fire Extinguishers<br>CFR(s): NFPA 101<br><br>Portable Fire Extinguishers<br>Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers.<br>18.3.5.12, 19.3.5.12, NFPA 10<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation with the maintenance employee present, the long-term care facility failed to properly install and inspect portable fire extinguishers in accordance with NFPA 10, Standard for Portable Fire Extinguishers, 2010 edition, Section 7.2.2(2) as referenced by NFPA 101, Life Safety Code 2012 edition, Sections 19.3.5.12, and 9.7.4.1.<br><br>Finding include:<br><br>Observations and Interviews, of exits during a facility tour on 02/18/2025 between 11:00 AM and 4:00 PM with the Director of Facilities and the Maintenance Employee present:<br><br>1. The class "K" portable fire extinguisher in the kitchen was obstructed from view and restricted from access with signage and a garbage can.<br><br>This finding was verified by the Director of Facilities and the Maintenance Employee at the time of observation on 02/18/2025 between 11:00 AM and 4:00 PM. | K 355 | | |
| K 363 | Corridor - Doors | K 363 | | |

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| K 363<br>SS=D | Continued From page 11<br>CFR(s): NFPA 101<br><br>Corridor - Doors<br>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.<br><br>19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485<br>Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, | K 363 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 205176 | A. BUILDING **01**<br>B. WING _____ | **02/18/2025** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **FOREST HILL MANOR** | **25 BOLDUC AVE**<br>**FORT KENT, ME 04743** |

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|---|---|---|---|---|
| K 363 | Continued From page 12<br>etc.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, the long-term care facility failed to maintain the corridor doors to resist the passage of smoke in 3 resident rooms to and from the corridor as referenced by NFPA 101, Life Safety Code 2012 edition, Section 19.3.6.3.<br><br>Findings:<br><br>Observation and interview during a facility tour with the Management Director present on 02/18/2025, between 11:00 AM and 4:00 PM identified:<br><br>1. Resident rooms 16 and 22 have gaps measured more than 1/2" between the door and the door frame at the top latch side that is large enough to allow smoke to pass.<br><br>2. Resident room 10 door rubs on the floor, which does not allow it to close without extra effort.<br><br>The surveyor confirmed these findings with the Maintenance Director at the time of the observation on 02/18/2025, between 11:00 AM and 4:00 PM. | K 363 | | |
| K 521<br>SS=F | HVAC<br>CFR(s): NFPA 101<br><br>HVAC<br>Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications.<br>18.5.2.1, 19.5.2.1, 9.2 | K 521 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 205176 | A. BUILDING **01**<br>B. WING _____ | **02/18/2025** |

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|---|---|---|---|---|
| K 521 | Continued From page 13<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, records review, and interview, the facility failed to test all fire, smoke, and combination fire and smoke dampers in accordance with the NFPA Life Safety Code, 2012 Edition, Sections 9.2.1, and 19.5.2.1. Also reference NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems, 2012 edition, Section 5.4.8., NFPA Standard NFPA 80, Standard for Fire Doors and Other Opening Protectives, 2010 edition, Section 19.4, and NFPA 105 Standard for Smoke Door Assemblies and Other Opening Protectives, 2010 edition, Section 6.5.<br><br>Finding:<br><br>An interview and documentation review, on 01/21/2025 between 11:00 AM and 4:00PM with the Director of Facilities Management present:<br><br>1. Records review of the facility's fire damper testing records revealed the facility failed to test and inspect fire, smoke, and combination fire/ smoke dampers within one (1) year of installation and every four (4) years thereafter. The Director of Facilities was unable to provide documentation that the inspection and testing of the dampers had occurred within the past 4 years. The Director of Facilities stated that the facility had contacted the vendor to have the inspection performed, but the vendor has not performed the required inspection and testing as of 02/19/2025. The most recent date of the damper inspection | K 521 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 205176 | A. BUILDING **01**<br>B. WING _____ | **02/18/2025** |

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|---|---|---|---|---|
| K 521 | Continued From page 14<br>was 10/13/2020.<br><br>The finding was acknowledged by the Director of Facilities Management on 01/21/2025 between 11:00 AM and 4:00 PM. | K 521 | | |