STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205063	A. BUILDING 01 B. WING	05/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLOVER HEALTH CARE	440 MINOT AVE AUBURN, ME 04210

(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 Dates: 05/05/2025 Clover Health Care 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 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), §485.542(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		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Megan Stevenson
TITLE: Administrator
(X6) DATE: 5-22-2025

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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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 observation,interview and documentation review, the long-term care facility failed to conduct the annual review of the Emergency Preparedness Plan in accordance with 42 CFR §483.73(a). Finding: On May 05, 2025 between 9:30 AM and 400 PM, a surveyor, with the Plant Operations Director present, observed the following: 1. The annual review of the emergency preparedness plan has not been reviewed since 2021. The surveyor confirmed this finding with the Plant Operations Director at the time of the observation These findings were acknowledged by the Plant	E 004		

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E 004	Continued From page 2 Operations Director at the time of observations and document review.	E 004		
E 009 SS=F	Local, State, Tribal Collaboration Process CFR(s): 483.73(a)(4) §403.748(a)(4), §416.54(a)(4), §418.113(a)(4), §441.184(a)(4), §460.84(a)(4), §482.15(a)(4), §483.73(a)(4), §483.475(a)(4), §484.102(a)(4), §485.68(a)(4), §485.542(a)(4), §485.625(a)(4), §485.727(a)(5), §485.920(a)(4), §486.360(a)(4), §491.12(a)(4), §494.62(a)(4) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years [annually for LTC facilities]. The plan must do the following:] (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation. * * [For ESRD facilities only at §494.62(a)(4)]: (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation. The dialysis facility must contact the local emergency preparedness agency at least annually to confirm that the agency is aware of the dialysis facility's needs in the event of an emergency. This REQUIREMENT is not met as evidenced by: Based on observation, interview and documentation review, the long-term care failed	E 009		

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E 009	Continued From page 3 to provided a documented plan for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation. Findings: On May 05, 2025, between 9:30 AM and 400 PM, a surveyor, with the Plant Operations Director present, observed the following: 1. There was no evidence in the emergency preparedness plan of a policy developed for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation. These findings were acknowledged by the Plant Operations Director at the time of observations and document review.	E 009		
E 015 SS=F	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	E 015		

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E 015	Continued From page 4 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. (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.	E 015		

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E 015	Continued From page 5 (C) Sewage and waste disposal. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the long-term care facility failed to maintain provision of subsistence needs for staff and patients for Emergency Preparedness Plan in accordance with 42 CFR 483.73 Finding: On May 05, 2025, between 9:30 AM and 400 PM, a surveyor, with the Plant Operations Director present, observed the following: 1. The was no documentation provided in the emergency preparedness plan for: (a) Temperatures to protect resident health and safety. (b) Emergency lighting (c) Fire Detection, extinguishing, and alarm systems This finding was acknowledged by the Plant Operations Director at the time of observation and document review.	E 015		
E 020 SS=F	Policies for Evac. and Primary/Alt. Comm. CFR(s): 483.73(b)(3) §403.748(b)(3), §416.54(b)(2), §418.113(b)(6)(ii), §441.184(b)(3), §460.84(b)(3), §482.15(b)(3), §483.73(b)(3), §483.475(b)(3), §485.68(b)(1), §485.542(b)(3), §485.625(b)(3), §485.727(b)(1), §485.920(b)(2), §491.12(b)(1), §494.62(b)(2) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness	E 020		

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E 020	Continued From page 6 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 [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] [(3) or (1), (2), (6)] Safe evacuation from the [facility], which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. *[For RNHCIs at §403.748(b)(3) and ASCs at §416.54(b)(2) and REHs at §485.542(b)(3):] Safe evacuation from the [RNHCI or ASC or REHs] which includes the following: (i) Consideration of care needs of evacuees. (ii) Staff responsibilities. (iii) Transportation. (iv) Identification of evacuation location(s). (v) Primary and alternate means of communication with external sources of assistance. * [For CORFs at §485.68(b)(1), Clinics, Rehabilitation Agencies, OPT/Speech at §485.727(b)(1), and ESRD Facilities at §494.62(b)(2):] Safe evacuation from the [CORF; Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology	E 020		

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E 020	Continued From page 7 Services; and ESRD Facilities], which includes staff responsibilities, and needs of the patients. * [For RHCs/FQHCs at §491.12(b)(1):] Safe evacuation from the RHC/FQHC, which includes appropriate placement of exit signs; staff responsibilities and needs of the patients. This REQUIREMENT is not met as evidenced by: Based on observation, interview and documentation review, the long-term care facility failed to maintain an evacuation plan for its residents and staff for Emergency Preparedness Plan in accordance with 42 CFR 483.73 Finding: On May 05, 2025, between 9:30 AM and 400 PM, a surveyor, with the Plant Operations Director present, observed the following: 1. The was no evidence in the emergency preparedness plan for a MOU for transportation services during and evacuation. This finding was acknowledged by the Plant Operations Director at the time of observation and document review.	E 020		
E 026 SS=F	Roles Under a Waiver Declared by Secretary CFR(s): 483.73(b)(8) §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). [(b) Policies and procedures. The [facilities] must	E 026		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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E 026	Continued From page 8 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 [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] (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. *[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. This REQUIREMENT is not met as evidenced by: 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). Finding: On May 05, 2025, between 9:30 AM and 400 PM, a surveyor, with the Plant Operations Director present, observed the following:	E 026		

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E 026	Continued From page 9 1. There are no policies or procedures in the 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 alternate care site identified by emergency management officials. This finding was acknowledged by the Plant Operations Director at the time of observation and document review.	E 026		
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 10 On May 05, 2025, between 9:30 AM and 400 PM, a surveyor, with the Plant Operations Director present, observed the following: 1. In the emergency preparedness plan of a communications plan there was no evidence the plan has been updated. The call tree was no personell, the state fire marshal's office phone number was incorrect and there was no physician contact. 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. This finding was acknowledged by the Plant Operations Director at the time of observation and document review.	E 029		
E 036 SS=F	EP Training and Testing CFR(s): 483.73(d) §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.542(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d). *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, REHs at §485.542, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the	E 036		

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E 036	Continued From page 11 emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient	E 036		

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E 036	Continued From page 12 orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the long term care facility failed to develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually in accordance with 42 CFR 483.73. On May 05, 2025, between 9:30 AM and 400 PM, a surveyor, with the Plant Operations Director present, observed the following: 1. There was no evidence in the emergency preparedness plan of a policy developed for a training and testing program that is based on the emergency plan, risk assessment, procedures at paragraph, and the communication plan. The training and testing program must be reviewed and updated at least annually. This finding was acknowledged by the Plant Operations Director at the time of observation and document review.	E 036		
E 037 SS=D	EP Training Program	E 037		

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205063	A. BUILDING 01 B. WING	05/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLOVER HEALTH CARE	440 MINOT AVE AUBURN, ME 04210

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E 037	Continued From page 13 CFR(s): 483.73(d)(1) §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.542(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, REHs at §485.542, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their	E 037		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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E 037	Continued From page 14 expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following:	E 037		

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E 037	Continued From page 15 (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. (v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent	E 037		

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E 037	Continued From page 16 with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures.	E 037		

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E 037	Continued From page 17 *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interviews the long-term care facility failed to maintain a training and testing program for Emergency Preparedness Plan in accordance with 42 CFR 483.73 Finding: On May 05, 2025, between 9:30 AM and 400 PM and May 06, 2025, between 8:45 AM and 5:15 PM, a surveyor, with the Plant Operations Director, Regional Director of Plant operations and the Regional Operations Specialist present, observed the following: 1. The training records that were reviewed did meet the requirements for training the staff in the entire emergency preparedness plan. And there was no documented policy or plan on required training in initial hiring and annual refresher training. 2. An interview was conducted with a charge nurse in the Belfast wing on May 05, 2025, at the nurse's station. The surveyor asked if the charge nurse could find the emergency preparedness	E 037		

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E 037	Continued From page 18 plan book. The charge nurse pulled out the employee policy book instead. The surveyor showed the charge nurse the location of the book. Then the surveyor asked if there was an emergency for a power outage, could they take me to the correct area in the book. The nurse was not able to find the correct area. Then the surveyor asked if they had to find the contact numbers to notify the administration. The nurse was able to find the call tree and noticed it was outdated. The surveyor thanked the charge nurse for their assistance. 3. An interview was conducted with a nurse at the nurse's station in the Galway wing on May 06,2025. The surveyor asked if the nurse could find the emergency preparedness plan book. The nurse was not able to find the book and stated she does not work at this station and wing. The surveyor asked if the nurse could find where to go in the book if there was an emergency and she stated she unfortunately could not. The surveyor thanked nurse for their assistance. The finding was acknowledged by the Plant Operations Director at the time of observation and document review.	E 037		
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), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(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, REHs at §485.542, OPO, "Organizations" under	E 039		

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E 039	Continued From page 19 §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 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.	E 039		

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E 039	Continued From page 20 *[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, 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:	E 039		

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E 039	Continued From page 21 (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):] (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	E 039		

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E 039	Continued From page 22 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 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	E 039		

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E 039	Continued From page 23 (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 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.	E 039		

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E 039	Continued From page 24 (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 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	E 039		

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E 039	Continued From page 25 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 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	E 039		

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E 039	Continued From page 26 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 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	E 039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205063	A. BUILDING 01 B. WING	05/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLOVER HEALTH CARE	440 MINOT AVE AUBURN, ME 04210

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E 039	Continued From page 27 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 observation, interview and record review, the long-term care facility failed to conduct exercises to test the emergency plan annually. The facility must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures in accordance with 42 CFR 483.73. On May 05, 2025, between 9:30 AM and 400 PM, a surveyor, with the Plant Operations Director present, observed the following: 1. Documentation provided for one tabletop drill that did not contain evidence that the drill presented a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. 2. No documentation provided showed evidence	E 039		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	205063	A. BUILDING 01 BY: _____ B. WING _____	05/06/2025

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E 039	Continued From page 28 that the facility conducted exercises to test the emergency plan at least twice per year including unannounced staff drills using emergency procedures doing any of 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. These findings were acknowledged by the Plant Operations Director at the time of observation and document review.	E 039		
K 000	INITIAL COMMENTS Federal Recertification Survey Date of Survey 05/05/2025 Clover Health Care, 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 133 SS=D	Multiple Occupancies - Construction Type CFR(s): NFPA 101 Multiple Occupancies - Construction Type Where separated occupancies are in accordance with 18/19.1.3.2 or 18/19.1.3.4, the most stringent construction type is provided throughout the building, unless a 2-hour separation is provided in accordance with 8.2.1.3, in which case the	K 133		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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K 133	Continued From page 29 construction type is determined as follows: * The construction type and supporting construction of the health care occupancy is based on the story in which it is located in the building in accordance with 18/19.1.6 and Tables 18/19.1.6.1 * The construction type of the areas of the building enclosing the other occupancies shall be based on the applicable occupancy chapters. 18.1.3.5, 19.1.3.5, 8.2.1.3 This REQUIREMENT is not met as evidenced by: Based on plans review, observation and interview during the facility tour, the long-term care facility failed to maintain penetrations and wall construction requirements of the 2-hour separation walls for inspection per NFPA 101, Life Safety Code, 2012 Edition, Sections 8.2.1.3., and 19.1.3.5. Finding: On 05/05/2025, between 9:30 AM and 5:15 PM, a surveyor, with the Plant Operations Director and Regional Director of Plant Operations present observed the following: 1. Upon inspection of the 2-hour fire wall between the long-term care side and the residential care side, as identified on the life safety drawings, penetrations into the wall were not sealed with an approved system. a. Above the door between the main corridor and Carlow Common had penetrations for wires and cables that were not protected, which was observed on both sides of the wall. b. Above the door by the fire alarm panel from the Carlow side, it was observed that the on the Carlow side that wires and cables were going	K 133		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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K 133	Continued From page 30 through the wall without an approved firestop system. c. On the Carlow is by the fire alarm panel, it was also observed that steel structural members were going into the cinder block, with no fire stopping This finding was verified by the Plant Operations Manager and the Regional Director of Plant Operations at the time of the observation.	K 133		
K 163 SS=D	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 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 ensure that the openings required to have a fire protection rating shall be protected by approved, listed, labeled fire door assembly with their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives as referenced in NFPA 101, the Life Safety Code, 2012 edition, section 8.3.3.1and 8.3.4.2.	K 163		

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K 163	Continued From page 31 Findings: On 05/06/2025, between 8:30AM and 4:00 PM, a surveyor, with the Plant Operations Director and the Regional Operations Specialist, observed the following: 1. During the inspection it was observed that in the Limerick unit, the access door to the utility crawl space has a wooden, non fire-rated door. The wall, according to the life safety plans, is a 2-hour fire wall. The surveyor confirmed this finding with the Plant Operations Director and Regional Operations Specialist 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 by: Based on observation and interview the facility failed to ensure that aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with NFPA 101, Life Safety Code, 2012 edition, Chapter 7, and that the means of egress is continuously maintained free of all obstructions to full use in case of emergency unless modified by NFPA 101, Life Safety Code, 2012 edition, sections 19.2.2	K 211		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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K 211	Continued From page 32 through 19.2.11, 19.2.1, and 7.1.10. Finding: On 05/06/2025, between 8:30AM and 4:00 PM, a surveyor, with the Plant Operations Director and the Regional Operations Specialist, observed the following: 1. The exit prior to Dublin, on the Minot Ave side of the building, had PPE storage in the exit enclosure. This deficient practice could affect all occupants including residents, employees, and visitors to the facility. 2. In the Galway unit at door #8, storage of carts and blankets were observed in the exit enclosure. This deficient practice could affect all occupants including residents, employees, and visitors to the facility. 3. A med cart was observed stored in the corridor the Belfast unit nurses station. This deficient practice could affect all occupants including residents, employees, and visitors to the facility. 4. Soiled linen and trash bins was observed stored in the corridor by room 88. This deficient practice could affect all occupants including residents, employees, and visitors to the facility. 5. Clean linen cart was observed stored in the corridor by room 23. This deficient practice could affect all occupants including residents, employees, and visitors to the facility. 6. Soiled linen bins and trash bins were observed stored in the Dublin unit corridor by rooms 29-36. This deficient practice could affect all occupants including residents, employees, and visitors to the facility. This deficient practice could affect all occupants including residents, employees, and visitors to the facility. 7. Soiled linen bins and trash were observed	K 211		

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K 211	Continued From page 33 stored in the Dublin unit corridor by rooms 37-44. This deficient practice could affect all occupants including residents, employees, and visitors to the facility. 8. A med cart was observed stored in the corridor in the atrium corridor in the Dublin unit. This deficient practice could affect all occupants including residents, employees, and visitors to the facility. 9. In the basement service corridor, storage of delivery packages, racks, and boxes were observed stored in the corridor by the maintenance office and back delivery entrance. This deficient practice could affect all occupants including residents, employees, and visitors to the facility. The surveyor confirmed this finding with Plant Operations Director and Regional Operations Specialist at the time of the observation.	K 211		
K 222 SS=D	Egress Doors CFR(s): NFPA 101 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	K 222		

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K 222	Continued From page 34 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 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	K 222		

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K 222	Continued From page 35 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 Observations the facility failed to ensure doors at the means of egress meet the requirement of NFPA 101 life safety code 2012 edition 7.2.1.6.1 for requirements for delayed egress. Findings: On May 05, 2025, between 9:30 AM and 400 PM, a surveyor, with the Plant Operations Director present, observed the following: 1. The Belfast wing cross corridor exit door and the single exit door off the hallway of the Carlow wing to the Belfast wing were equipped with delayed egress and not signed. 7.2.1.6.1.1. Approved, listed, delayed-egress locking systems shall be permitted to be installed on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6 or an approved, supervised automatic sprinkler system in accordance with Section 9.7, A readily visible, durable sign in letters not less than 1 in. (25 mm) high and not less than 1/8 in. (3.2 mm) in stroke width on a contrasting background that reads as follows shall be located on the door leaf adjacent to the release device in the direction of egress: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS. These findings were acknowledged by the Plant	K 222		

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K 222	Continued From page 36 Operations Director at the time of observation.	K 222		
K 271 SS=D	Discharge from Exits CFR(s): NFPA 101 Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to ensure that exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Findings: On May 05, 2025, between 9:30 AM and 400 PM and May 06, 2025, between 8:45 AM and 5:15 PM, a surveyor, with the Plant Operations Director, Regional Director of Plant operations and the Regional Operations Specialist present, observed the following: 1. The exit door #10 in the Belfast wing has a change in elevation of 1". The door does not meet the ¼ to ½ of elevation. 2. The exit discharge path outside exit door #10 in the Belfast wing is not a level travel surface. There are various block pavers missing as well. 3. The exit discharge of the exit door by the fire alarm panel in the Carlow wing is not a level	K 271		

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K 271	Continued From page 37 travel surface all the way to the public way. There are holes in the concrete pads in various places. 4. The exit door in the Dublin wing by rooms 37-44 has a 3" change in elevation. The door does not meet the ¼ to ½ of elevation. These findings were acknowledged by the Plant Operations Director at the time of observation.	K 271		
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 This REQUIREMENT is not met as evidenced	K 324		

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K 324	Continued From page 38 by: Based on observation, the long-term care facility failed to properly install a portable class K fire extinguisher applicable accessory sign, failed to mark the wheel location of the gas stove, ovens and soup cooker and failed to install an exhaust system and extinguishing system over the stove/oven in the recreation room in accordance with NFPA 96, Standard for ventilation control and fire protection, commercial cooking operations, 2011 edition, section 10.2.2 and section 12.1.2.2*, 12.1.2.3, 12.1.2.3.1 as referenced by NFPA 101, Life Safety Code 2012 edition, Sections 19.3.5.12, and 9.3.2 and 19.3.2.5, 19.3.2.5.1. Findings: On May 05, 2025, between 9:30 AM and 400 PM and May 06, 2025, between 8:45 AM and 5:15 PM, a surveyor, with the Plant Operations Director, Regional Director of Plant operations and the Regional Operations Specialist present, observed the following: 1. A placard shall be conspicuously placed near the class K extinguisher that states that the fire protection system shall be activated prior to using the fire extinguisher. There is no placard installed near the class K extinguisher in the kitchen. 2. Not provided with an approved method that would ensure that the appliances were returned The wheeled, gas-fired stove/oven and wheeled gas-soup cooker located on the cooking line in the kitchen were to an approved design location after they had been moved for maintenance and cleaning.	K 324		

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K 324	Continued From page 39 3. In the Carlow wing in the recreation room the stove and oven being used does not have an extinguishing system and a exhaust system above it. These findings were acknowledged by the Plant Operations Director at the time of observation.	K 324		
K 351 SS=D	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the long-term care facility failed to install the water-based fire protection system in 3 of 4 smoke compartments in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, 2010 edition, Sections 9.2.1.3.3.2 and 8.15.1.2.18.1 as referenced by NFPA 101, Life	K 351		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205063	A. BUILDING 01 B. WING	05/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLOVER HEALTH CARE	440 MINOT AVE AUBURN, ME 04210

(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 351	Continued From page 40 Safety Code, 2012 edition, Section 19.3.5. This deficient practice could affect the response of the facility, and the sprinkler in case of activation of the sprinkler system. Findings: On 05/05/2025, between 09:30 AM and 5:15 PM and on 05/06/2025, between 8:30 AM and 4:00, a surveyor with the Plant Operations Manager, Regional Director of Plant Operations and the Regional Operations Specialist present observed the following: 1. The awning attached to the building, outside of Belfast, is required to have sprinkler protection or provdie documention that the fabric meets NFPA 701. 2. At the Clare unit nurse's station, around the air handling unit, there is missing ceiling tiles 3. In the Clare unit janitor's closet, is broken/missing ceiling tiles. 4. In the kitchen, over the door by the sink, is missing a ceiling tile. 5. In the Dublin unit storage room, is missing ceiling tiles. 6. In the Dublin unit nurse's station, around the air handling unit, are missing ceiling tiles. 7. In the laundry, clean linen room, all the ceiling tiles were missing. This finding was verified by the Plant Operations Manager, Regional Director of Plant Operations and the Regional Operations Specialist at the time of the observation.	K 351		
K 353 SS=D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101	K 353		

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K 353	Continued From page 41 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 _____ 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, interview and document review, the facility failed to ensure that Sprinkler System was inspected and maintained in 3 of 4 smoke compartments in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. This deficiency does not meet the minimum requirements of maintaining a sprinkler system in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-based Fire Protection Systems, 2011 edition, sections 4.3.1, 5.2.1.1.1, and 5.2.2.2. Findings: On 05/05/2025, between 09:30 AM and 5:15 PM and on 05/06/2025, between 8:30 AM and 4:00, a surveyor with the Plant Operations Manager,	K 353		

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K 353	Continued From page 42 Regional Director of Plant Operations and the Regional Operations Specialist present observed the following: 1. During the walk-through inspection several sprinkler heads were observed covered with dust and debris. These sprinkler head locations include, but are not limited to: a. Belfast unit corridor, by the bathroom - corrected on site b. Belfast unit nurse's station - corrected on site c. Belfast unit corridor, outside of Rehab - corrected on site d. In the Kitchen above the dishwash and in the freezer. e. In the kitchen by the commercial cooking appliance, these heads were also covered with grease and dust. f. In the Laundry by the phone. 2. The exit prior to Dublin, on the Minot Ave side of the building, communication lines were observed zipped tied to the sprinkler pipe. This finding was verified by the Plant Operations Manager, Regional Director of Plant Operations and the Regional Operations Specialist at the time of the observation.	K 353		
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	K 355		

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K 355	Continued From page 43 by: Based on observation, the long-term care facility failed to properly install the marking sign for the portable fire extinguisher in accordance with NFPA 10, Standard for Portable Fire Extinguishers, 2010 edition, Section 6.1.3.3.2, as referenced by NFPA 101, Life Safety Code 2012 edition, Sections 19.3.5.12, and 9.9. Findings: On May 05, 2025, between 9:30 AM and 400 PM, a surveyor, with the Plant Operations Director present, observed the following: 1. The fire extinguisher wall sign was located behind the refrigerator in the recreation room. The fire extinguisher was located several feet to the left of the sign by the doorway. This finding was acknowledged by the Plant Operations Director at the time of observation.	K 355		
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	K 363		

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K 363	Continued From page 44 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. 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: On 05/05/2025, between 09:30 AM and 5:15 PM and on 05/06/2025, between 8:30 AM and 4:00, a surveyor with the Plant Operations Manager, Regional Director of Plant Operations and the Regional Operations Specialist present observed the following: Findings: 1. The Enviro Room door, in the Belfast unit, had a louver in the door, not making the door smoke tight. 2. The Clare unit linen closet door is not a	K 363		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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K 363	Continued From page 45 solid-bonded wood core door. 3. The Clare unit Activities Office door is not a solid-bonded wood core door and has been modified with the placement of a storm window. 4. The Dublin Activities Office door is not a solid-bonded wood core door and has been modified with the placement of a storm window. 5. Patient room 82 has a gap greater than ½" with visible light seen at the upper latch side corner of the door. 6. Patient room 24 would not close due to the curtain interfering with the latching. 7. There were items observed impeding the door's ability to close at the following locations: a. Room 88, trash can b. Room 83, trash can c. Room 20, trash can d. Room 21, wedges e. Room 23, gallon water bottle This finding was verified by the Plant Operations Manager, Regional Director of Plant Operations and the Regional Operations Specialist at the time of the observation.	K 363		
K 372 SS=D	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier.	K 372		

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K 372	Continued From page 46 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation the facility failed to meet the requirements of the National Fire Protection Association (NFPA) 101, Life Safety Code, 2012 edition for smoke barrier enclosures in accordance with 19.3.7.3. Findings: On May 05, 2025, between 9:30 AM and 400 PM and May 06, 2025, between 8:45 AM and 5:15 PM, a surveyor, with the Plant Operations Director, Regional Director of Plant operations and the Regional Operations Specialist present, observed the following: 1. The wall above the activities office door in Clare wing had a bathroom dryer vent fan penetrating through the wall. The wall was not smoke tight, just above the door in the smoke barrier wall. 2. The wall above the activities office door in Dublin wing had a bathroom dryer vent fan penetrating through the wall. The wall was not smoke tight, just above the door in the smoke barrier wall. These findings were acknowledged by the Plant Operations Director at the time of observation.	K 372		
K 712 SS=D	Fire Drills CFR(s): NFPA 101 Fire Drills	K 712		

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K 712	Continued From page 47 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, document review and interview, the long-term care facility failed to ensure that fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift per NFPA 101, Life Safety Code, 2012 Edition, Section 19.7.1.4 through 19.7.1.7 Findings: On 05/05/2025, between 9:30 AM and 5:15 PM, the surveyor, with the Plant Operations Director: 1. The facility failed to conduct the proper number of fire drills during the previous 12 months. The first shift failed to conduct fire drills in the third quarter of 2024. Second shift failed to conduct fire drills in the third quarter of 2024 and first quarter of 2025. Third shift failed to conduct fire drills in the second quarter of 2024. This deficient practice could affect all occupants including residents, employees, and visitors to the facility. The surveyor confirmed this finding with the Plant Operations Director at the time of the	K 712		

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K 712	Continued From page 48 observation.	K 712		
K 741 SS=D	Smoking Regulations CFR(s): NFPA 101 Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 This REQUIREMENT is not met as evidenced by: Based on observation, documentation review the facility failed to maintain compliance with the facility's smoking policy was enforced in accordance with NFPA 101, Life Safety Code, 2012 edition, Section 19.7.4	K 741		

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K 741	Continued From page 49 Findings: On May 05, 2025, between 9:30 AM and 400 PM and May 06, 2025, between 8:45 AM and 5:15 PM, a surveyor, observed the following: 1. Observed a female resident on May 05, 2025 seated on her walker smoking a cigarette by the mulch area nearest the road in the visitor parking lot. There was evidence of cigarette butts all over the ground in the mulch and there was not a non-combustible butt container present. 2. Observation of a male resident on May 06, 2025 seated on his walker smoking a cigarette at the end of the front entrance exit discharge path at the start of the parking lot next to the bench and trash can. There was evidence of cigarette butts on the ground and there was not a non-combustible butt container present. The facilities smoking policy indicates the residents can smoke in designated areas laid out in the policy handbook. And these were not designated areas.	K 741		
K 753 SS=E	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 100 kilowatts in accordance with NFPA 289. o Decorations, such as photographs, paintings	K 753		

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K 753	Continued From page 50 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 ensure that combustible decorations shall be prohibited unless one of the following is met: Flame retardant or treated with approved fire-retardant coating that is listed and labeled for product. Decorations meet NFPA 701 (2010). Decorations exhibit heat release less than 100 kilowatts in accordance with NFPA 289 (2009). 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). 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. Findings: On May 05, 2025, between 9:30 AM and 400 PM and May 06, 2025, between 8:45 AM and 5:15 PM, a surveyor, with the Plant Operations Director, Regional Director of Plant operations and the Regional Operations Specialist present, observed the following: 1. It was observed on the residents' room doors in Clare Wing, Dublin Wing and Galway wing had decorations on them. No evidence could be provided to show that it had been sprayed with a	K 753		

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K 753	Continued From page 51 fire-retardant coating, or that it met the requirements of NFPA 701 (2010) or NFPA 289 (2009). 2. In the Doublin wing by rooms 29-36 had a large blanket hanging in the egress corridor and no evidence could be provided to show that it had been sprayed with a fire-retardant coating, or that it met the requirements of NFPA 701 (2010) or NFPA 289 (2009). An interview was completed with the hospice nurse on duty on 5/6/2025. The nurse stated they could not verify the blanket was in compliance with NFPA 701 and also had a similar blank in the corridor of the Clare wing. These findings were acknowledged by the Plant Operations Director at the time of observation.	K 753		
K 761 SS=D	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 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 interview and documentation review, the long-term care facility failed to conduct an	K 761		

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K 761	Continued From page 52 annual fire door inspection that ensures that all fire rated doors and hardware are inspected, tested, and maintained by individuals performing the door inspections that possess knowledge, training or experience that demonstrates ability in accordance with NFPA 80, Standard for Fire Door and Other Opening Protectives, 2010 edition Section 5.2 as referenced by NFPA 101, Life Safety Code, 2012 Edition, Sections 19.7.6, 4.6.12.1, and 8.3.3.1 Findings: On 05/06/2025, between 8:450 AM and 4:00 PM, the surveyor, with the Plant Operations Director and Regional Operations Specialist: 1. The facility had no documentation that the doors had been inspected by a trained employee or a qualified outside vendor in the last year. This deficient practice could affect all occupants including residents, employees, and visitors to the facility. 2. The double doors to Clare rooms 19-26, the self-closers are out of adjustment and slamming shut. This deficient practice could affect all occupants including residents, employees, and visitors to the facility. 3. The double doors to Dublin rooms 37-44, the right left self-closer is leaking oil and slamming shut.This deficient practice could affect all occupants including residents, employees, and visitors to the facility. The surveyor confirmed this finding with the Plant Operations Director and Regional Operations Specialist at the time of the observation.	K 761		

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(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 911 SS=E	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 observations, the facility failed to meet the requirements of NFPA 70, National Electrical Code, 2011 edition, Section 314.25, 110.7 as referenced by NFPA 99, Healthcare Facilities Code, 2012 edition, section 6.3.2.1. Finding: On May 05, 2025, between 9:30 AM and 400 PM and May 06, 2025, between 8:45 AM and 5:15 PM, a surveyor, with the Plant Operations Director, Regional Director of Plant operations and the Regional Operations Specialist present, observed the following: 1. The electrical panel box in the Clare wing was not labeled. 2. The electrical junction box in the Clare wing at the center atrium was missing a cover. (fixed on site) 3. The dirty utility room by room 26 in the Clare wing was missing a cover. 4. The bathrooms in the Clare wing leading to the Dublin wing, they both were missing covers on the light switches. (fixed on site) 5. The exit enclosure in Clare wing where the PPE storage is located is missing outlet cover.	K 911		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205063	A. BUILDING 01 BY:_____ B. WING _____	05/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 920	Continued From page 59 standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the long-term care facility failed to ensure that power strips are not used for non-PCREE (Patient-care-related electrical equipment) and that power strips are not used as a substitute for fixed wiring in accordance with NFPA 99 Chapter 10, NFPA 70 chapter 4 {400.8(1)} On May 05, 2025, between 9:30 AM and 400 PM, a surveyor, with the Plant Operations Director, Regional Director of Plant operations present, observed the following: Findings: 1. In Belfast wing nurse station, a mini fridge was found plugged into a multi-port adaptor as a permanent power source. (this was removed on site) 2. In Belfast wing by the fish tank, the tank was plugged into a 3 to 1 adapter. (this was removed on site) 3. In Belfast wing the rehab room, there were 2 power strips and one multi-port adaptor being used as a permanent power source. (this was removed on site) 4. In Clare wing room 23, there was a power strip	K 920		

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K 920	Continued From page 60 in the resident room being used as a permanent power source. (this was removed on site) 5. In Clare wing in the atrium by room 81, there was television plugged into a multi-port adaptor being used as a permanent source of power. 6. In Clare wing by room 25, a multi-port adaptor had a battery charger plugged into it being used as a permanent source of power. These findings were acknowledged by the Plant Operations Director at the time of observation.	K 920		
K 923 SS=D	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage 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,	K 923		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205063	A. BUILDING 01 B. WING	05/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 911	Continued From page 54 6. The storage room just prior to the Dublin entrance there was an outlet cover missing. 7. The Dietary office, there was a 4 gang outlet box with no cover, a junction box with no cover, and a home made pig tail cord being used in place of permanent wiring. 8. The eletrical panel outside the kitchen by the basment entrance there was a tapped GFCI breaker in the panel holding it in the on position. When the surveyor touched the tape, the beaker then tripped to the off position. The surveyor left the breaker in the off position. These findings were acknowledged by the Plant Operations Director at the time of observation.	K 911		
K 914 SS=D	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 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	K 914		

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K 914	Continued From page 55 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 documentation review and interview the facility, failed to ensure that inspection of the retention force of receptacles not listed as hospital-grade are tested at intervals not exceeding 12 months in accordance with NFPA 99, Healthcare Facilities Code, 2012 edition, Section 6.3.3.2.4. Finding: On 05/05/2025, between 9:30AM and 5:15PM, the surveyor, with the Plant Operations Director observed the following: 1. The annual testing of the receptacles did not include the retention force of the grounding blade of each electrical receptacle to ensure it is not less than 4 oz. This deficient practice could affect all occupants including residents, employees, and visitors to the facility. The surveyor confirmed these findings with the Administrator and Director of Maintenance at the time of the observation and record review..	K 914		
K 918 SS=D	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	K 918		

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K 918	Continued From page 56 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) This REQUIREMENT is not met as evidenced by: Based on observation and record review, the long-term care facility failed to complete and document the weekly and monthly required checks as required by NFPA 99, Health Care Facilities Code, 2012 edition, section 6.4.4.1.1.3 and NFPA 110, Standard for Emergency and Standby Power, 2010 edition, section 8.3 and 8.4. Findings:	K 918		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 918	Continued From page 57 On 05/05/2025, between 9:30 AM and 5:15 PM, the surveyor, with the Plant Operations Director present observed the following: 1. During record review for the weekly generator checks it was observed that prior to April 18th all the checks sheets were incomplete and lacked the required information. Stating that engine hours, fuel, water temperature, coolant system, lubricating oil and oil pressure were all "NA". 2. During the record review, there was no documentation that the generator was tested to 30% of the generator's rating. The surveyor confirmed this finding with the Plant Operations Director at the time of the 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 failed to comply with NFPA 99, Healthcare Facilities Code, 2012 sections 10.5.2.7, 10.5.3.1, & NFPA 101, Life Safety Code, 2012 Edition in 1 of 4 smoke compartments.	K 919		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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K 919	Continued From page 58 Finding: On 05/05/2025, between 9:30 AM and 5:15 PM, a surveyor, with the Plant Operations Director and Regional Director of Plant Operations present observed the following: 1. A wheel chair charging unit was observed in the Clare unit corridor under the television, and one was observed in the corridor by room 25. The facility could not provide manufactures instructions to prove if charging of the battery is a safety issue. The risk is the release of combustible and/or toxic gases. Batteries should also be charged with the guidelines set forth by the manufacturer's recommendations. This finding was verified by the Plant Operations Manager and the Regional Director of Plant Operations at the time of the observation.	K 919		
K 920 SS=E	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL	K 920		

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K 923	Continued From page 61 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, the long-term care facility failed to ensure that Gas Equipment - Cylinder and Container Storage 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 that Gas Equipment, storage of empty and full oxygen cylinders in the Oxygen Room were separated and marked to avoid confusion from full and empty cylinders as referenced in NFPA 99 the health care facilities code section 11.6.5.3 Finding: On May 05, 2025, between 9:30 AM and 400 PM, a surveyor, with the Plant Operations Director present, observed the following: 1. It was observed the in the oxygen room in the Clare wing atrium, the 'E' size oxygen cylinders in the Oxygen Room had no marked signs to indicate empty or full cylinders and they were	K 923		

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K 923	Continued From page 62 collected all together and not separated ot avoid confusion between empty and full. This finding was acknowledged by the Plant Operations Director at the time of observation.	K 923		

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E004:

All residents and staff had the potential to be harmed by this practice. No residents or staff were impacted by this practice.

This facility has completed a comprehensive Emergency Preparedness Plan developed to address identified risks and facility-specific emergencies.

A quarterly review of the Emergency Preparedness Plan will be conducted at the facility's

Safety Meeting.

The Maintenance Director, or designee will review and audit the EPP and update as needed based upon any changes of requirements.

Results of audits will be reported to the facilities Quality Assurance Performance Improvement committee until the QA Committee determines sustained compliance has been achieved.

Completion Date: 06/16/2025

E-009

All residents and staff had the potential to be impacted by this practice. No residents or staff were affected.

Immediate action taken:

- The facility contacted the Androscoggin EMA to initiate coordination and collaboration.
- The facility contacted Auburn FD to request a meeting to review our EPP.

The Maintenance Director, or designee, will maintain a Community Coordination Log, documenting all outreach and collaborative activity with emergency officials.

- The log and status of collaboration efforts will be reviewed quarterly by the facility's QA Committee.

Completion Date: 06/16/2025

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E015

All residents and staff had the potential to be impacted by this practice. No residents or staff were impacted by this practice.

The Emergency Preparedness Plan was immediately updated and revised to include detailed provisions for subsistence needs during an emergency.

- Procedures for maintaining safe indoor temperatures (heating/cooling) during power outages.
- Back-up systems for emergency lighting in resident rooms, halls, and critical care areas.
- Functionality checks for fire alarms, smoke detectors, and sprinkler systems during outages.

The Maintenance Director, or designee, will conduct a quarterly audit of all subsistence-related systems.

Results will be reviewed during the Quality Assurance Committee until compliance has been achieved.

Completion Date: 06/16/2025

E020

All residents had the potential to be impacted by this deficient practice. No residents were impacted by this deficient practice.

Memorandums of Understanding were obtained to ensure that residents and staff can be transported safely in the event of an evacuation or emergency.

Those MOU's have been added to the facilities' EPP.

The Maintenance Director, or designee, will audit MOUs related to transportation quarterly. Results of the audit will be presented during the facilities Quality Assurance Committee.

Completion Date: 06/16/2025

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E026

The facility has updated their Emergency Preparedness program. The program includes a policy for providing care and treatment at alternate care sites under the1135 waiver.

The facility has identified all residents as having the potential to be affected by this deficient practice.

The Administrator or their designee will inform the facilities QAPI committee of any changes in alternate care sites under 1135 waiver to assure that facility remains in compliance.

Completion date: 06/16/2025

E029

The facility has updated their Emergency Preparedness program. The program includes a written communication plan that has been reviewed by the committee and scheduled for an annual review.

The facility has identified all residents as having the potential to be affected by this deficient practice.

Emergency Preparedness manuals have been placed on each nursing unit, all staff has been educated on the plan.

The Plant Operations Director or their designee will perform random monthly audits for accurate contact information.

The Plant Operations Director or their designee will ensure that all EPP binders have up to date phone trees.

Audits will be conducted for a period of 4 months or until the facility's QAPI committee determines sustained compliance.

The QA committee will be notified of any changes in communication should they occur between annual reviews to ensure that the facility remains in compliance.

Completion date: 06/16/2025

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E036

The facility has updated their Emergency Preparedness plan, to reflect a written testing and training program.

The facility has identified all residents as having the potential to be affected by this deficient practice.

The Plant Operations Director, and Administrator or their designee(s) will review the Emergency Plan education at a minimum annually, or as needed to ensure the training is aligned with the EPP.

The Plant Operations Director or their designee will inform QAPI committee of any changes in the education plan should they occur between annual reviews to ensure that the facility remains in compliance.

Completion date: 06/16/2025

E037

The facility has an Emergency Preparedness plan has a written testing and training program.

The facility has identified all residents as having the potential to be affected by this deficient practice.

Staff will be educated on the Emergency Plan. This training will be provided for new hires, and quarterly, or as needed to ensure staff are able to identify and utilize the plan in the event of an emergency.

The Plant Operations Director or their designee, will inform the QAPI committee of any changes in the plan should they occur between annual reviews to assure that the facility remains in compliance.

Completion Date: 06/16/2025

E039

The facility has updated their emergency plan to include documentation of events that required activation of its emergency plan.

All residents and staff had the potential to be impacted by this practice. No residents or staff were affected.

*The facility will document attempts to coordinate with the local EMA for full-scale community-based exercises.

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*The facility will document any events that require activation of its plan and place in the EPP binder.

The Plant Operations Director or their designee, will schedule at least 1 mock disaster drill or tabletop exercise semi-annually.

The Plant Operations Director or their designee will present any changes to the requirements of this requirement as needed to the facilities' QA Committee.

Completion 06/16/2025

K133

All residents and staff had the potential to be impacted by this practice.

An audit has been conducted of all penetrations inclusive of those identified during survey.

All penetrations identified have fire rated caulking applied.

Monthly audits will be conducted by the Plant Operations Director or their designee, for a period of 3 months. The results of the audits will be presented to the QA Committee.

Random monthly audits will be conducted for a period of 3 months to the QA committee, or until the facility's QA committee determines sustained compliance.

Completion date: 06/16/2025

K163

All residents and staff had the potential to be impacted by this practice.

The identified access door will have a fire rating.

Audits will be conducted quarterly to ensure that all access doors required to be in the community are fire-rated.

Results of the audits will be presented by The Plant Operations Director or designee at the facility's quarterly QA meeting.

Completion date: 06/16/2025

K211

All residents, visitors and staff had the potential to be impacted by this deficient practice.

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Education will be conducted regarding appropriate storage of linen, waste bins, medication carts, improper storage practices including shipments and boxes. With a focus on safety and not blocking egresses for safe passage.

The Plant Operations Director or their designee will conduct daily audits for a period of x 1 week, then weekly audits for a period of 3 weeks, then random monthly audits for a period of 2 months.

The results of the audits will be presented to the facility's QA Committee for a period of 3 months or until substantial compliance is achieved.

Completion date: 06/16/2025

K222

All residents, visitors and staff had the potential to be impacted by this deficient practice.

Corrective action taken:

Education was provided to the Maintenance personnel on ensuring signage is in place for egress doors that visibly state "PUSH until alarm sounds, doors can be opened in 15 seconds."

Appropriate signage was ordered for egress doors.

The Plant Operations Director or their designee will audit weekly for appropriate signage on the egress doors.

The Plant Operations Director will present audits that exits locked with a delayed egress device and have proper signage, monthly to QAPI committee for a period of 3 months.

The QAPI Committee will review the effectiveness of the plan to ensure compliance is sustained

Completion Date: 06/16/2025

K271

All residents, visitors and staff had the potential to be impacted by this deficient practice.

Quotes and signed work orders will be obtained to address ensuring an even, unobstructed surface to the public way.

The Plant Operations Director or their designee will do a complete audit of all surfaces to ensure that they meet requirements for variance in elevation.

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The Plant Operations Director or their designee will audit quarterly and report the results of the on-going audits for a period of 1 year or until the facility's QA Committee determines sustained compliance is achieved.

Completion Date: 06/16/2025

K324

All residents had the potential to be impacted by this deficient practice.

- Stove identified in Recreation room has been deemed for training purposes only, and signage indicating its purpose has been displayed
- An outline of the cooking equipment under the ventilation hood has been outlined to ensure that equipment, if moved, would be returned to its appropriate position under the hood.
- Signage indicating the K class for the extinguisher to be utilized secondary to the suppression system.

Education will be provided to the maintenance and dietary employees by the Plant Operations Director or designee.

The Plant Operations Director or designee will conduct quarterly audits to ensure compliance is sustained. Results of the quarterly audits will be presented to the facility's Quarterly QA Committee until substantial compliance is achieved.

Completion date: 06-16-2025

K 351

All residents had the potential to be impacted by this deficient practice.

1) Awning identified has been removed

2) Ceiling tiles identified on the units Clare, Dublin, and Belfast, and laundry room have been installed.

An audit will be conducted to ensure that all ceiling tiles are in place.
Any identified ceiling tiles in the audit will be installed.

Education will be conducted for the maintenance and housekeeping employees related to this deficient practice.

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The Plant Operations Director or their designee will conduct monthly audits for a period of 4 months. The results of the monthly audits will be presented at the facility's QA meeting.

Completion Date: 06/16/2025

K353

All residents had the potential to be impacted by this deficient practice.

a-c: corrected on site

2: Zip tie removed from identified sprinkler pipe

An audit of all sprinkler heads will be conducted, and all sprinkler heads will be cleaned.

Education will be conducted for housekeeping and maintenance on proper cleaning procedures of sprinkler heads.

The Plant Operations Director or designee will audit daily for a one-week period, then a weekly audit for 3 weeks, and random monthly audits for 2 months or until sustained compliance is achieved.

The results of the audits will be presented to the facilities QA Committee.

Completion Date: 06/16/2025

K355

All residents, visitors and staff had the potential to be impacted by this deficient practice.

Pronounced signage will be installed

Fire Extinguishers will be moved to have signage line up

The Plant Operations Director or designee will conduct quarterly audits for signage related to portable extinguishers.

The results of the quarterly audit will be presented to the facility's QA Committee for a period of 2 quarters or until the QA Committee determines compliance is sustained.

Completion date: 06/16/2025

K363

All residents and staff had the potential to be impacted by this deficient practice.

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Education will be provided to staff regarding safety procedures with doors, including not propping doors open, using other items to keep doors open.

Doors identified will be removed and replaced.

Doors identified that are not smoke tight have astragal installed

The Plant Operations Director or designee will conduct daily audits for a period of 2 weeks, then weekly audits for a period of 3 months or until substantial compliance is sustained.

Results of these audits will be presented to the facility's QA Committee.

Completion date: 06/16/2025

K372

All residents and staff had the potential to be impacted by this deficient practice.

The smoke barriers were properly repaired using materials that can restrict the transfer of smoke.

The identified areas that were not smoke-tight have been sealed.

The Plant Operations Director or their designee will perform audits on smoke barriers throughout the building weekly for 1 month and then monthly for 3 months or until the facilitys' QA Committee determines substantial compliance is achieved.

Completion Date: 06/16/2025

K712

All residents and staff had the potential to be impacted by this deficient practice.

Fire drills will be conducted on all 3 shifts at random times.

Life safety code K712 reviewed, and Fire Drills are to be performed on 1st, 2nd, and 3rd shift every quarter. Drills are to be performed at varied times and conditions as to not be predictable. Director of Plant operations and Assistant Director of Plant Operations has reviewed and been educated on K712 to ensure compliance.

Monthly audits will be conducted by the Plant Operations Director, or their designee for a period of 4 months or until the facility's' QA Committee has determined substantial compliance has bene achieved.

Completion Date: 06/16/2025

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K741

All residents and staff had the potential to be impacted by this deficient practice.

Education to staff regarding designated smoking areas for residents.

Signage has been ordered and will be installed upon arrival

Information packets will be provided to the residents who smoke on the AL/Res Care side of the community as well as the residents on the NF side of the community, this information will include Designated areas, proper disposal of their smoking materials, and safety.

The Plant Operations Director, or their designee will audit for safe smoking, and compliance with the policy. Daily audits for a period of 1 week, then weekly audits for a period of 3 weeks, then random monthly audits for a period of 3 months.

The results will be presented to the facilitys' QA Committee until the committee determines substantial compliance is achieved.

Completion Date: 06/16/2025

F753

All residents had the potential to be impacted by this practice.

An audit of all combustible decorations will be conducted, and identified items have been treated with a fire rated spray.

The Plant Operations Director or designee will audit monthly for a period of 3 months. To monitor ensuring combustible decorations are treated on resident doors.

The Maintenance staff and housekeeping staff will be educated regarding combustible decorations.

The Plant Operations Director or designee will audit monthly and report any noncompliance findings to the facilitys' QA Committee for a period of three months or until substantial compliance is achieved.

Completion date: 06/16/2025

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F761

All residents had the potential to be impacted. No residents were harmed as a result of this deficient practice.

All fire-rated doors throughout the facility were audited.

- The Plant Operations Director or their designee will ensure annual inspections are performed and documented for all fire-rated doors.
- A monthly random sample of fire-rated doors will be checked by the Maintenance Director for functionality for a period of three months.
- Findings will be documented and reviewed at the facility's Quarterly Quality Assurance and Performance Improvement (QAPI) meeting.

Completion Date: 06/16/2025

K911

All residents had the potential to be impacted by this practice. No residents were harmed as a result of this deficient practice.

An audit was conducted of the following:

- All panels/junction boxes
- Outlet covers
- Light switches

Education to the Maintenance and Housekeeping team will be conducted around identifying, communicating, labeling, and addressing electrical panel systems related to this citation.

A random weekly audit will be conducted for a period of one month, then a monthly audit will be conducted for a period of two months or until the facility's' QA Committee determines substantial compliance has been achieved.

Completion date: 06/16/2025

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K914

All residents had the potential to be impacted by this practice.

1) The receptacle identified was repaired on 5/7/2025

The facility will implement a tracking mechanism to ensure that testing requirements of receptacles are conducted.

The Plant Operations Director or their designee will conduct monthly audits for a period of 3 months. The results of the audits will be presented to the facility's QA Committee.

Completion date: 06/16/2025

K918

All residents have the potential to be impacted by this deficient practice.

On 05/21/2025 the facility's emergency generator was tested under load for 30 continuous minutes.

The Plant Operations Director will verify completion and documentation of monthly generator testing by the 10th of each month.

The Administrator or designee will review the generator log quarterly.

The generator testing schedule and records will be reviewed at the QAPI committee meetings on a quarterly basis or until substantial compliance is achieved.

Completion Date: 06/16/2025

K919

All residents had the potential to be impacted by this practice. No residents were harmed due to this practice.

On 05/06/2025 all residents' chairs with electrical components were inspected to ensure that they were being charged in designated areas as per manufacturer guidelines.

Nursing staff were educated on location designated for charging motorized chairs.

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The Plant Operations Director, The Assistant Plant Operations Director, and Facility Administrator, or their designee(s) will conduct monthly inspections to ensure that electrical chairs are properly charged in designated areas and not in resident rooms.

Quarterly audits will be conducted by the Safety Committee to ensure adherence to charging policies and to review the safety of electrical equipment. The results of the quarterly audit will be presented to the facility's' QA Committee until substantial compliance is achieved.

Completion Date: 06/16/2025

K920

This deficient practice did not affect any residents, staff or visitors but had the potential to affect all residents, staff and visitors.

Corrective action taken:

Items 1-4: Were removed in the moment

Maintenance personnel were re-educated on power strips and extension cords are prohibited beyond temporary installation

The Plant Operations Director or their designee will audit to ensure there is no presence of unapproved power strips or extension cords utilized.

The audit schedule is as follows:

Weekly for a period of one month, then monthly for a period of 3 months.

The results of the audits will be reviewed and presented to the facility's QA Committee to ensure sustained compliance is achieved.

Completion Date: 06/16/2025

K923

All residents and staff had the potential to be impacted by this deficient practice. No residents or staff were impacted.

Corrective action taken:

Signage installed indicating full and empty cylinders were placed in all oxygen storage rooms.

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The Plant Operations Director, or their designee will conduct random weekly audits to ensure signs are in place for a period of 3 months.

The results of the audits will be presented to the QA committee to ensure sustained compliance is achieved.

Completion Date: 06/16/2025