STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205108	A. BUILDING 01 B. WING _____	C 06/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANDRE HEALTH CARE FACILITY	407 POOL ST BIDDEFORD, ME 04005

(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 Date of Survey 06/10/2025 St. Andre 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=D	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 | TITLE | (X6) DATE

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

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E 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 record 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 06.10.2025, between 9:30 am and 4:00 pm, a surveyor, with the Director of Plant Operations present, observed the following: 1. The annual review of the emergency preparedness plan had not been reviewed since 2017. The surveyor confirmed this finding with the Director of Plant Operations at the time of record review.	E 004		

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E 006 SS=D	Plan Based on All Hazards Risk Assessment CFR(s): 483.73(a)(1)-(2) §403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2), §441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §483.475(a)(1)-(2), §484.102(a)(1)-(2), §485.68(a)(1)-(2), §485.542(a)(1)-(2), §485.625(a)(1)-(2), §485.727(a)(1)-(2), §485.920(a)(1)-(2), §486.360(a)(1)-(2), §491.12(a)(1)-(2), §494.62(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach. (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. *[For LTC facilities at §483.73(a):] Emergency	E 006		

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E 006	Continued From page 3 Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment. *[For ICF/IIDs at §483.475(a):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the long term care facility failed to maintain a risk assessment for Emergency Preparedness Plan in accordance with 42 CFR 483.73 Finding: On 06.10.2025, between 9:30 am and 4:00 pm, a surveyor, with the Director of Plant Operations present, observed the following: 1. In the emergency preparedness plan the	E 006		

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E 006	Continued From page 4 facility-based and community-based risk assessment, utilizing an all-hazards approach, was not updated annually. The last update was May 30, 2024. The surveyor confirmed this finding with the Director of Plant Operations at the time of record review.	E 006		
E 015 SS=D	Subsistence Needs for Staff and Patients CFR(s): 483.73(b)(1) §403.748(b)(1), §418.113(b)(6)(iii), §441.184(b)(1), §460.84(b)(1), §482.15(b)(1), §483.73(b)(1), §483.475(b)(1), §485.542(b)(1), §485.625(b)(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm	E 015		

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E 015	Continued From page 5 systems. (D) Sewage and waste disposal. *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. This REQUIREMENT is not met as evidenced by: Based on observation, and 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 Findings: On 06.10.2025, between 9:30 am and 4:00 pm, a surveyor, with the Director of Plant Operations present, observed the following: 1. The was no documentation provided in the	E 015		

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E 015	Continued From page 6 emergency preparedness plan for: (i) an agreement for subsistence needs for food (i)The medical supplies memorandem of understanding with Mekesson Medical was not updated. The letter expired in 2019 (ii)The alternate source of energy memorandem of understanding for fuel was not updated The letter expired in 2019. (d)Sewage and waste disposal. The facility is not on city sewer but is on a septic tank and leach field. There was no momorandem of understanding or contract for waste disposal in the event of an emergency The surveyor confirmed these findings with the Director of Plant Operations at the time of record review.	E 015		
E 018 SS=D	Procedures for Tracking of Staff and Patients CFR(s): 483.73(b)(2) §403.748(b)(2), §416.54(b)(1), §418.113(b)(6)(ii) and (v), §441.184(b)(2), §460.84(b)(2), §482.15(b)(2), §483.73(b)(2), §483.475(b)(2), §485.542(b)(2), §485.625(b)(2), §485.920(b)(1), §486.360(b)(1), §494.62(b)(1). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the	E 018		

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E 018	Continued From page 7 following:] [(2) or (1)] A system to track the location of on-duty staff and sheltered patients in the [facility's] care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the [facility] must document the specific name and location of the receiving facility or other location. *[For PRTFs at §441.184(b), LTC at §483.73(b), ICF/IIDs at §483.475(b), PACE at §460.84(b):] Policies and procedures. (2) A system to track the location of on-duty staff and sheltered residents in the [PRTF's, LTC, ICF/IID or PACE] care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the [PRTF's, LTC, ICF/IID or PACE] must document the specific name and location of the receiving facility or other location. *[For Inpatient Hospice at §418.113(b)(6):] Policies and procedures. (ii) Safe evacuation from the hospice, 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. (v) A system to track the location of hospice employees' on-duty and sheltered patients in the hospice's care during an emergency. If the on-duty employees or sheltered patients are relocated during the emergency, the hospice must document the specific name and location of the receiving facility or other location.	E 018		

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E 018	Continued From page 8 *[For CMHCs at §485.920(b):] Policies and procedures. (2) Safe evacuation from the CMHC, 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 OPOs at § 486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records. *[For ESRD at § 494.62(b):] Policies and procedures. (2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and needs of the patients. This REQUIREMENT is not met as evidenced by: Based on observation, and record review, the long term care facility failed to maintain provision of tracking on duty staff for Emergency Preparedness Plan in accordance with 42 CFR 483.73 Finding: On 06.10.2025, between 9:30 am and 4:00 pm, a surveyor, with the Director of Plant Operations and Administrator present, observed the following: 1. The was no evidence in the emergency preparedness plan of a way to track the on-duty staff during and after an emergency.	E 018		

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E 018	Continued From page 9 The surveyor confirmed this finding with the Director of Plant Operations at the time of record review.	E 018		
E 025 SS=D	Arrangement with Other Facilities CFR(s): 483.73(b)(7) §403.748(b)(7), §418.113(b)(5), §441.184(b)(7), §460.84(b)(8), §482.15(b)(7), §483.73(b)(7), §483.475(b)(7), §485.625(b)(7), §485.920(b)(6), §494.62(b)(6). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] *[For Hospices at §418.113(b), PRFTs at §441.184,(b) Hospitals at §482.15(b), and LTC Facilities at §483.73(b):] Policies and procedures. (7) [or (5)] The development of arrangements with other [facilities] [and] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. *[For PACE at §460.84(b), ICF/IIDs at §483.475(b), CAHs at §486.625(b), CMHCs at §485.920(b) and ESRD Facilities at §494.62(b):] Policies and procedures. (7) [or (6), (8)] The development of arrangements with other [facilities] [or] other providers to receive patients	E 025		

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E 025	Continued From page 10 in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. *[For RNHCIs at §403.748(b):] Policies and procedures. (7) The development of arrangements with other RNHCIs and other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of non-medical services to RNHCI patients. This REQUIREMENT is not met as evidenced by: Based on observation, and record review, the long-term care facility failed to develop and implement emergency preparedness policies for LTC Facilities at §483.73(b):] Policies and procedures. (7) The development of arrangements with other [facilities] [and] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. 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 memorandum of understanding or contract addressing arrangements for transportation with the local EMA director in the event of a facility evacuation. And the memorandum for ambulance transportation with Northeast was outdated. The letter was last updated in 2018.	E 025		

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E 025	Continued From page 11 The surveyor confirmed these findings with the Director of Plant Operations at the time of record review.	E 025		
E 039 SS=D	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 §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:	E 039		

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E 039	Continued From page 12 (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. *[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	E 039		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANDRE HEALTH CARE FACILITY	**407 POOL ST** **BIDDEFORD, ME 04005**

(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 039	Continued From page 13 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: (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	E 039		

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E 039	Continued From page 14 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 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	E 039		

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E 039	Continued From page 15 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 (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	E 039		

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E 039	Continued From page 16 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. (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.	E 039		

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E 039	Continued From page 17 *[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 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	E 039		

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E 039	Continued From page 18 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 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	E 039		

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E 039	Continued From page 19 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 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,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	E 039		

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E 039	Continued From page 20 procedures in accordance with 42 CFR 483.73. Finding: On 06.10.2025, between 9:30 am and 4:00 pm, a surveyor, with the Director of Plant Operations present, observed the following: 1. There was no documentation provided to show evidence 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: The surveyor confirmed this finding with the Director of Plant Operations at the time of record review.	E 039		
K 000	INITIAL COMMENTS Federal Recertification Survey Survey Dates: 6/10/2025 St. Andre 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 211 SS=E	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11.	K 211		

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K 211	Continued From page 21 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation, the long-term care facility failed to maintain the Exit Corridor required width in the egress corridors per NFPA 101, Life Safety Code, 2012 Edition, Sections 18.2.1, 19.2.1, 7.1.10.1 Findings: On 06.10.2025, between 9:30 am and 4:00 pm, a surveyor, with the Director of Plant Operations and Administrator present, observed the following: 1. On the third floor east hallway, the nurse's kiosk in the corridor had a chair at the station which was not fixed and not in an alcove. 2. On the third floor north hallway, the nurse's kiosk in the corridor had a chair and a table which were not fixed and not in an alcove. 3. On the third floor across from the elevator doors, there was a lost and found rack with closes on them, a mobile blood pressure stand, and a dinning service cart stored in the corridor. 4. On the second floor across from the elevator doors, there was a dinning service cart stored in the corridor 5. On the second floor east hallway, the nurse's kiosk had a chair and table which were not fixed and not in an alcove. 6. On the second floor east hallway by room 204, there were to chairs in the corridor which were not fixed and were not in an alcove. 7. On the second floor Nurse's station, there were three nursing carts that were plugged into the wall for charging and being stored in the corridor. 8. On the first floor east hallway, there was a	K 211		

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K 211	Continued From page 22 mobile blood pressure cuff stand being charged in the corridor. These deficient practices could affect residents, guests and staff from proper egress in the event of an emergency. The surveyor confirmed these findings with the Director of Plant Operations and the Administrator at the time of facility walkthrough.	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 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	K 222		

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K 222	Continued From page 23 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 by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure that doors in a required means of egress met the latching/locking requirements of NFPA 101 Life Safety Code (2012 edition) 19.2.2.2.6 (2) and 7.2.1.6.2. This deficient practice could affect the patients/residents,	K 222		

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K 222	Continued From page 24 visitors, and members of facility staff in this location(s). Finding: On 06.10.2025, between 9:30 am and 4:00 pm, a surveyor, with the Director of Plant Operations and Administrator present, observed the following: 1. The facility failed to provide unobstructed exit access (employee entrance ground floor) in 1 of 5 exit discharges. The employee entrance was obstructed and not readily accessible to everyone, including the residences in the building, because of door having special locking arrangements (badge swipe to egress). Staff were the only people with access to exit regardless of resident independent cognitive ability which is not in accordance with LSC Section 19.2.2.2.4, 19.2.2.2.5, 19.2.2.2.5.2 and 7.2.1.6. Observation and Interview with the Director of Plant Operations and Administrator at the time of observation confirmed the exit door had proximity card readers that could only be accessed by staff with access cards. The facility failed to provide exit access that was readily accessible at all times by having special locking arrangements in accordance with LSC Section 19.2.2.2.4, 19.2.2.2.5, 19.2.2.2.5.2 and 7.2.1.6. The surveyor confirmed this finding with the Director of Plant Operations and the Administrator at the time of observation.	K 222		
K 271 SS=D	Discharge from Exits CFR(s): NFPA 101	K 271		

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K 271	Continued From page 25 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 NFPA 101 2012 edition Section 7.7, 7.1.7 and 7.1.6.2. Additionally, the exit discharge shall be a hard packed all-weather travel surface in accordance with survey and and certification letter 05-38 in 1 of the 5 exit discharges for the building. On 06.10.2025, between 9:30 am and 4:00 pm, a surveyor, with the Director of Plant Operations and Administrator present, observed the following: 1. The B-side exit discharge concrete pad was broken and cracked causing walking surface to have a greater than 1/4 in. elevation change in the exit discharge. The surveyor confirmed these findings with the Director of Plant Operations and the Administrator at the time of observation.	K 271		
K 293 SS=D	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING	K 293		

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	205108	A. BUILDING **01** B. WING _____	C **06/10/2025**

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K 293	Continued From page 26 Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observations, the long-term care facility failed to meet the requirements of the National Fire Protection Association (NFPA) 101, Life Safety Code, 2012 edition for exit and directional signs that are displayed in accordance with 7.10, 19.2.10.1, 19.2.10.2,19.2.10.3, and 19.2.10.4. Finding: On 06.10.2025, between 9:30 am and 4:00 pm, a surveyor, with the Director of Plant Operations and Administrator present, observed the following: 1. In the community room on the ground floor the exit to the lobby did not have an illuminated exit sign. This deficient practice could affect the occupants, visitors and staff while trying to exit the building under reduced visibility of the exit areas. The surveyor confirmed this finding with the Director of Plant Operations and the Administrator at the time of facility walkthrough.	K 293		
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities	K 324		

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K 324	Continued From page 27 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 by: Based on observation, the long-term care facility 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 9.3.2 and 19.3.2.5, 19.3.2.5.1.	K 324		

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K 324	Continued From page 28 Finding: On 06.10.2025, between 9:30 am and 4:00 pm, a surveyor, with the Director of Plant Operations and Administrator present, observed the following: 1. When commercial cooking appliances are on wheels, an approved method of marking the precise location for the appliance to be installed to ensure it is properly protected by the extinguishing system shall be applied. An approved method shall ensure that the appliance is returned to its position before cooking takes place. The surveyor confirmed this finding with the Director of Plant Operations and the Administrator at the time of facility walkthrough.	K 324		
K 346 SS=D	Fire Alarm System - Out of Service CFR(s): NFPA 101 Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 This REQUIREMENT is not met as evidenced by: Based on documentation review, the facility failed to ensure that a policy was in place in the event of an extended period of the fire alarm system being out of service. NFPA 101 2012	K 346		

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K 346	Continued From page 29 edition chapter 9.6.1.6 states where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated, or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. Finding: On 06.10.2025, between 9:30 am and 4:00 pm, a surveyor, with the Director of Plant Operations and Administrator present, observed the following: 1. The facility does not have a written policy in place in the event of their fire alarm system is out of service for more than 4 hours in a 24-hour period and implementation of a fire watch. The surveyor confirmed this finding with the Director of Plant Operations and the Administrator.	K 346		
K 354 SS=D	Sprinkler System - Out of Service CFR(s): NFPA 101 Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion	K 354		

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K 354	Continued From page 30 of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) This REQUIREMENT is not met as evidenced by: Based on record review, the long-term care facility failed to provide a plan in the event the sprinkler system was out of service. Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24 hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) Finding: On 06.10.2025, between 9:30 am and 4:00 pm, a surveyor, with the Director of Plant Operations and Administrator present, observed the following: 1. During the record review, no documentation was available stating the plan of a fire watch and proper AHJ notifications in the event of a long term sprinkler system shutdown. The surveyor confirmed this finding with the Director of Plant Operations and the Administrator.	K 354		

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K 355 SS=D	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the long-term care facility failed to comply with 2012 Life Safety Code sections 18.3.5.12, 19.3.5.12 Portable fire extinguishers shall be provided in all health care occupancies in accordance with 9.7.4.1. Where required by the provisions of another section of this Code, portable fire extinguishers shall be selected, installed, inspected, and maintained, in accordance with NFPA 10, Standard for Portable Fire Extinguishers, 2010 NFPA 10 6.1.3.8.1. Fire extinguishers having a gross weight not exceeding 40 lb (18.14 kg) shall be installed so that the top of the fire extinguisher is not more than 5 ft (1.53 m) above the floor. Failed to properly install a portable class K fire extinguisher applicable accessory sign above the Class K extinguisher in the kitchen in accordance with NFPA 10, Standard for Portable Fire Extinguishers, 2010 edition, Section 5.5.5.3, and 6.6.1 as referenced by NFPA 101, Life Safety Code 2012 edition, Sections 19.3.5.12, and 9.7.4.1. Findings: On 06.10.2025, between 9:30 am and 4:00 pm, a surveyor, with the Director of Plant Operations and Administrator present, observed the	K 355		

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K 355	Continued From page 32 following: 1. The fire extinguisher in the community room was found not mounted to the wall on the shelf. 2. 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, and the use and restriction of this extinguisher for grease laden fires only. There is no placard installed near the class K extinguisher in the kitchen. The surveyor confirmed this finding with the Director of Plant Operations and the Administrator at the time of facility walkthrough.	K 355		
K 541 SS=D	Rubbish Chutes, Incinerators, and Laundry Chu CFR(s): NFPA 101 Rubbish Chutes, Incinerators, and Laundry Chutes 2012 EXISTING (1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor shall be sealed by fire resistive construction to prevent further use or shall be provided with a fire door assembly having a fire protection rating of 1-hour. All new chutes shall comply with 9.5. (2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, shall be provided with automatic extinguishing protection in accordance with 9.7. (3) Any trash chute shall discharge into a trash collection room used for no other purpose and protected in accordance with 8.4. (Existing laundry chutes permitted to discharge into same room are protected by automatic sprinklers in	K 541		

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K 541	Continued From page 33 accordance with 19.3.5.9 or 19.3.5.7.) (4) Existing fuel-fed incinerators shall be sealed by fire resistive construction to prevent further use. 19.5.4, 9.5, 8.4, NFPA 82 This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to ensure in 2 of the 4 floors that per NFPA 101 2012 edition, section 19.5.4 any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor shall be sealed by fire resistive construction to prevent further use or shall be provided with a fire door assembly having a fire protection rating of 1-hour. All new chutes shall comply with 9.5, and that any rubbish chute or linen chute, including pneumatic rubbish and linen systems, shall be provided with automatic extinguishing protection in accordance with 9.7. Findings: On 06.10.2025, between 9:30 am and 4:00 pm, a surveyor, with the Director of Plant Operations and Administrator present, observed the following: 1. The laundry chute connecting all floors on Floor 1, the laundry chute door does not self-close and positive latch. 2. The trash chute connecting all floors on Floor 1 and Floor 2 trash chute doors does not positive latch. The surveyor confirmed these findings with the Director of Plant Operations and the Administrator at the time of observation.	K 541		

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K 712 K 712 SS=D	Continued From page 34 Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on documentation review, 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 Finding: On 06.10.2025, between 9:30 am and 4:00 pm, a surveyor, with the Director of Plant Operations and Administrator present, observed the following: 1. The facility failed to conduct the proper number of fire drills during the previous 12 months. The following fire drills for the facility were not completed or missing second shift drill conducted during the third quarter of 2024 The surveyor confirmed this finding with the Director of Plant Operations and the	K 712 K 712		

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K 712	Continued From page 35 Administrator.	K 712		
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 observation, the long-term care facility failed to ensure that proper hardware was installed in fire door assemblies as part of a 2-hour fire barrier were installed. Door holder/release devices shall be installed in accordance with the manufacturer's instructions and only in conformance with the individual manufacturer's published listings per NFPA 80-chapter 6.4.2. Finding: On 06.10.2025, between 9:30 am and 4:00 pm, a surveyor, with the Director of Plant Operations and Administrator present, observed the following:	K 761		

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K 761	Continued From page 36 1. The 2-hour separation located between the old building and the new building on the ground floor did not have the proper hardware providing 3 points of contact for a 90-minute fire rated door in a 2-hour fire rated assembly. The surveyor confirmed this finding with the Director of Plant Operations and the Administrator at the time of facility walkthrough.	K 761		
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 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, the facility, failed to ensure that inspect the retention force of	K 914		

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K 914	Continued From page 37 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 06.10.2025, between 9:30 am and 4:00 pm, a surveyor, with the Director of Plant Operations and Administrator present, 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 pose an electrical hazard to all residents, visitors, and members of facility staff in this locations. The surveyor confirmed these findings with the Director of Plant Operations and the Administrator at the time of observation.	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 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	K 918		

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K 918	Continued From page 38 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, interview and record review, the long term care facility failed to comply with the 2012 Life Safety Code 9.1.3.1 Emergency Generators and stand by power systems shall be installed, tested and maintained in accordance with NFPA 110 Standard for Emergency and Standby Power Systems, 2010 NFPA 110, Standard for Emergency and Standby Power Systems, Section 5.6.5.6 and 8.3.8 On 06.10.2025, between 9:30 am and 4:00 pm, a surveyor, with the Director of Plant Operations and Administrator present, observed the following: Findings:	K 918		

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	205108	A. BUILDING **01** B. WING _____	C **06/10/2025**

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ST ANDRE HEALTH CARE FACILITY	**407 POOL ST** **BIDDEFORD, ME 04005**

(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 918	Continued From page 39 1. The generator that is housed exterior of the facility does not have an emergency stop button located on the exterior of the housing. 2. No documentation showing an annual fuel quality test was provided on the generator testing and maintenance documentation. A fuel quality test shall be performed at least annually using appropriate ASTM standards or the manufacturer's recommendations. The Director of Plant Operations indicated that, he did not know that a fuel test needed to be performed. The surveyor confirmed these findings with the Director of Plant Operations and the Administrator at the time of the observation and record review.	K 918		
K 920 SS=D	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 standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure.	K 920		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205108	A. BUILDING **01** B. WING _____	C **06/10/2025**

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ST ANDRE HEALTH CARE FACILITY	**407 POOL ST** **BIDDEFORD, ME 04005**

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K 920	Continued From page 40 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, the long-term care facility failed to ensure that permanent dedicated wiring was provided for kitchen appliances in accordance with NFPA 99 Chapter 10, NFPA 70 chapter 4 {400.8(1)} Finding: On 06.10.2025, between 9:30 am and 4:00 pm, a surveyor, with the Director of Plant Operations and Administrator present, observed the following: 1. In the kitchen we observed an oven / cooktop grill plugged into an extension cord and no permanent outlet was noted in the area for use. 2. A ground unit air conditionor by the nurses station on the third floor was found to be plugged into a surge protector and not directly in to the wall outlet. The surveyor confirmed this finding with the Director of Plant Operations and the Administrator.	K 920		