State of Maine
Department of Public Safety
Office of Fire Marshal
52 State House Station
Augusta, ME 04333-005

JANET T. MILLS
GOVERNOR

MICHAEL SAUSCHUCK
COMMISIONER

RICHARD MCCARTHY
STATE FIRE MARSHAL

September 21, 2023

Aroostook Health Center
Attn: Kelly Lundeen, Administrator
15 Highland Ave
Mars Hill, ME 04758

Provider ID#: 205018
Facility ID#: 0313
Event ID#: 6OKA21

Administrator Lundeen,

On **September 19, 2023,** the Office of the Fire Marshal conducted a Life Safety Code and Emergency Preparedness survey to determine if your facility complies with Federal participation requirements for nursing facilities in the Medicare and/or Medicaid program (In which you will be receiving a Form CMS-2567 for Life Safety Code and Emergency Preparedness). Your facility was found not to be in substantial compliance with the participation requirements for Life Safety Code only.

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

PLAN OF CORRECTION

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

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- **Include dates when corrective action will be completed**. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility;
- Include documentation to support a waiver request (if appropriate).

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

Remedies will be recommended for imposition by the Centers for Medicare & Medicaid Services (CMS) Regional Office if your facility has failed to achieve substantial compliance by **November 3, 2023** (Opportunity to Correct). Informal dispute resolution for the cited deficiencies will not delay the imposition of the recommended enforcement actions. A change in the seriousness of the noncompliance may result in a change in the remedy selected. When this occurs, you will be advised of any change in remedy.

RECOMMENDED REMEDIES

Based on the deficiencies cited during the Life Safety Code and Emergency Preparedness Survey of **September 19, 2023,** the following remedy(ies) are being imposed:

The State Agency directs the plan of correction noted on the attached CMS-2567 for deficiencies K223(SS=C), K321(SS=C), K353(SS=D), K781(SS=D), K920(SS=D) & K923(SS=D) (Tags). [42 CFR 488.424]

If you do not achieve substantial compliance by **December 18, 2023,** the CMS Regional Office or State Medicaid Agency must deny payments for new (Medicare/Medicaid) admissions. In addition, we may recommend that **termination of your provider agreement be effective on March 18, 2024,** if substantial compliance is not achieved by that time. [42 CFR 488.456]. **Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination**.

ALLEGATION OF COMPLIANCE

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

INFORMAL DISPUTE RESOLUTION

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

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

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

Yours for Better Fire Prevention,

Gregory J. Day
Assistant State Fire Marshal

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205018	A. BUILDING **01** B. WING _____	**09/19/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AROOSTOOK HEALTH CENTER	**15 HIGHLAND AVE** **MARS HILL, ME 04758**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments Federal Recertification Survey Survey Date: 9/19/23 Aroostook Health Center, a long term care facility, is in substantial compliance with 42 Code of Federal Regulations Part 483.73 Requirement for Long Term Care Facilities Emergency Preparedness	E 000		
K 000	INITIAL COMMENTS Federeal Recertification Survey Survey Date: 9/19/23 Aroostook Health Center, a Long Term Care Facility, was surveyed to the National Fire Protection Association 101 Life Safety Code 2012 Edition as reference on 42 CFR 483.90 (a-b) physical environment and is not in substantial compliance.	K 000		
K 223 SS=C	Doors with Self-Closing Devices CFR(s): NFPA 101 Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8	K 223		

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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K 223	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on Observations the facility failed to ensure smoke doors in LTC corridor meet the requirement of NFPA 80 Clearances 6.3.1.7 Findings: Observed with the Maintenance Director and theAVP of facility managment on 09/19/2023 between 9 am and 12:30 pm the smoke door in the LTC corridor were warped 3/4 of a inch and would not seal properly This finding was observed with the Maintenance Director and the AVP of facility management on 9/19/23	K 223		
K 321 SS=C	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9	K 321		

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K 321	Continued From page 2 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: The facility failed to maintain fire resistive ratings of hazardous area in accordance with NFPA 101 Section 19.3.5.9. Finding: Observation(s) and Interview(s), during a facility tour on 09/19/23 between 09:00 AM and 12:30 PM with the Maintenance Director and the AVP of facilities management the following was found: 1) Penetrations in 1-hour fire rated ceiling in boiler room not properly fire stopped. 2) . Penetrations in 1 hr ceiling in the maintenance office area not properly fire stopped. These observations were observed by Maintenance Director and the AVP of facilities management	K 321		
K 353 SS=D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are	K 353		

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K 353	Continued From page 3 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 and interview, the facility failed to ensure that Sprinkler System was inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. This deficient practice could affect patients/residents, visitors, and members of facility staff in this location(s). Findings include: Observation(s) and Interview(s), during a facility tour on 09/19/23 between 09:00 AM and 12:30 PM with the Maintenance Director and the AVP of facilities management the following was found:	K 353		

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K 353	Continued From page 4 1. The physical therapy kitchen has a painted sprinkler head . These findings were verified by the Maintenance Director and the AVP of facilities management at the time of observations and exit interview on 09/19/23.	K 353		
K 781 SS=D	Portable Space Heaters CFR(s): NFPA 101 Portable Space Heaters Portable space heating devices shall be prohibited in all health care occupancies, except, unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8 This REQUIREMENT is not met as evidenced by: Based on observations and interview, the facility failed to ensure that portable space heaters were used in accordance with NFPA 101 section 19.7.8 and manufacturers recommendations. This deficient practice could affect patients/residents, visitors, and members of facility staff in this location(s). Findings include: 1. Clinical supervisor's office had two space heaters located under two separate desks, with combustible items within less that 3' which creates a hazardous condition that could lead to a fire. No documentation could be provided to indicate that the heating element was less than 212 degrees, but when operating on high setting	K 781		

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K 781	Continued From page 5 surveyor could not keep bare skin in front of element without risking getting burned. One of the space heaters did not have a automatic safety shutoff when the heater was tipped over. 2. Kitchen supervisor office had a portable space heater that was located under a desks, with combustible items within less that 3' which creates a hazardous condition that could lead to a fire. No documentation could be provided to indicate that the heating element was less than 212 degrees, but when operating on high setting surveyor could not keep bare skin in front of element without risking getting burned. The space heater was also plugged into a multi outlet power strip. These findings were verified by the Maintenance Director and the AVP of facilities management at the time of observations and exit interview on 09/19/23.	K 781		
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	K 920		

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K 920	Continued From page 6 (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. 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: The facility failed to ensure electrical equipment - Power Cords and Extension Cords installed and being used in accordance with their used use and in accordance with 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12 and manufacturers recommendations. Findings include: Observation(s) and Interview(s), during a facility tour on 0/19/23 between 09:00 AM and 12:30 PM with the Maintenance Director and the AVP of facilities management the following was found: 1. Activities office had a multi outlet power strip that was connected to a wall mounted multi outlet device (daisychained). There was a mini refrigerator plugged into the power strip. These findings were verified by the Maintenance	K 920		

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K 920	Continued From page 7 Director and the AVP of facilities management at the time of observations and exit interview on 09/19/23. The facility failed to ensure electrical equipment - Power Cords and Extension Cords installed and being used in accordance with their used use and in accordance with 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12 and manufacturers recommendations. Findings include: Observation(s) and Interview(s), during a facility tour on 0/19/23 between 09:00 AM and 12:30 PM with the Maintenance Director and the AVP of facilities management the following was found: 1) Air conditioner in dining room was connected to wall outlet with extension cord These findings were verified by the Maintenance Director and the AVP of facilities management at the time of observations and exit interview on 9/19/23	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	K 923		

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K 923	Continued From page 8 gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observations and interview, the facility failed to ensure that medical gas cylinders/ tanks in 2 of 4 smoke compartments were stored in accordance with NFPA 99, Health Care Facilities Code sections 11.3.2.3 (2), 11.6.2.3 (11) and 11.3.3.3. Cylinder and Container Storage Requirements. This deficient practice could affect the entire facility, patients/residents, visitors, and members of facility staff in this location(s). Findings include:	K 923		

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K 923	Continued From page 9 Observation(s) and Interview(s), during a facility tour on 0/19/23 between 09:00 AM and 12:30 PM with the Maintenance Director and the AVP of facilities management the following was found: 1. Two oxygen tank storage closets/ areas, both located in the physical therapy kitchen had a total of 18 E sized cylinders, which exceeds the allowable amount in a non rated room and allowable amount per smoke compartment. These findings were verified by the Maintenance Director and the AVP of facilities management at the time of observations and exit interview on 09/19/23.	K 923		