STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205086	A. BUILDING 01 B. WING	10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINNACLE HEALTH & REHAB AT N BERWICK	47 ELM ST NORTH BERWICK, ME 03906

(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:10.29.2024 Pinnacle Health North Berwick, 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 006 SS=F	Plan Based on All Hazards Risk Assessment CFR(s): 483.73(a)(1)-(2) §403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2), §441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §483.475(a)(1)-(2), §484.102(a)(1)-(2), §485.68(a)(1)-(2), §485.542(a)(1)-(2), §485.625(a)(1)-(2), §485.727(a)(1)-(2), §485.920(a)(1)-(2), §486.360(a)(1)-(2), §491.12(a)(1)-(2), §494.62(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:	E 006		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 11/14/24

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

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E 006	Continued From page 1 (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach. (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment. *[For ICF/IIDs at §483.475(a):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the long term care facility failed to maintain a risk assessment for Emergency	E 006		

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E 006	Continued From page 2 Preparedness Plan in accordance with 42 CFR 483.73 Finding: On October 29, 2024, between 09:00 AM and 12:00 PM, a surveyor, with the Administrator present, observed the following: 1. The was no evidence in the emergency preparedness plan of a risk assessment documented, facility-based and community-based risk assessment, utilizing an all-hazards approach. The surveyor confirmed this finding with the Administrator at the time of the observation.	E 006		
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. *	E 009		

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PINNACLE HEALTH & REHAB AT N BERWICK	47 ELM ST BY: NORTH BERWICK, ME 03906

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E 009	Continued From page 3 * [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 and interview, the long-term care facility failed to develop and implement the 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. Finding: On October 29, 2024, between 9:00 AM and 12:00 PM, a surveyor, with the Administrator present, observed the following: 1. The administrator was unable to provide documentation ensuring cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to ensure an integrated response during a disaster or emergency situation. The surveyor confirmed this finding with the Administrator at the time of the observation.	E 009		
E 013 SS=F	Development of EP Policies and Procedures CFR(s): 483.73(b)	E 013		

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E 013	Continued From page 4 §403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.102(b), §485.68(b), §485.542(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b). (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 at least every 2 years. *[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility 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 annually. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must	E 013		

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E 013	Continued From page 5 address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least every 2 years. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility 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. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the long-term care facility failed to 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 annually. Finding: On October 29, 2024, between 9:00 AM and 12:00 PM, a surveyor, with the Administrator present, observed the following:	E 013		

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E 013	Continued From page 6 1. There were no policies and procedures were developed based on the facility- and community-based risk assessment and communication plan, utilizing an all-hazards approach. The surveyor confirmed this finding with the Administrator at the time of the observation.	E 013		
K 000	INITIAL COMMENTS Federal Recertification Survey: Date: 10.29.2024 Pinnacle Health North Berwick, a Long Term Care Facility, was surveyed to the National Fire Protection Association 101 Life Safety Code 2012 Edition as reference on 42 CFR 483.90 (a-d) physical environment and is not in substantial compliance.	K 000		
K 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 7 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 8 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 provide exit access in 4 of 4 wings of the facility, that were readily accessible at all times by having special locking arrangements (coded key exit egress) with staff being the only people with access to exits 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. This deficient practice could affect exiting from all facility designated exits, as well as an indeterminable number of residents, staff and visitors. Findings Include: Observation on October 29, 2024, at approximately 9:00AM to 12:00PM during the facility tour identified the facility designated exits at all exits had a coded exit by key code controlled by staff without any means to provide visitors or oriented residents access to the means of exit. Interview on October 29, 2024, at approximately 9:00AM to 12:00PM during the facility tour with the Administrator and Maintenance Director stated the doors were all key code controlled, and residents did not have the codes. Observation and Interview with the Administrator and Maintenance Director at the time of observation confirmed the exit doors had key code that could only be accessed by staff. The facility failed to provide exit access that was readily accessible at all times by having special	K 222		

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K 222	Continued From page 9 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 findings were verified by the Administrator and Maintenance Director at the time of observation.	K 222		
K 321 SS=E	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 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	K 321		

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K 321	Continued From page 10 Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the long-term care facility failed to maintain the doors to the hazard areas in the basement level in accordance with NFPA 101, Life Safety Code, 2012 edition, Section 19.3.2.1 Findings: On October 29, 2024, between 9:00 AM and 12:00 PM, a surveyor, with the Maintenance Director present, observed the following: 1. The 90-minute door to the Nursing storage room didn't self-close and latch at it was held open with a rope. 2. The 90-minute door to the Business/General storage room did not self-close fully or positive latch as required. 3. The 90-minute door to the Business/General storage room is missing the center hinge assembly. The surveyor confirmed these findings with the Maintenance Director at the time of the observation.	K 321		
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire	K 353		

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K 353	Continued From page 11 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 observation, documentation review, and interview, the long-term care facility failed to maintain the sprinkler system in accordance with NFPA 25, Standard for Water-Based Fire Protection Systems, 2010 edition, Section Findings: On October 29, 2024, between 9:00 AM and 12:00 PM, a surveyor, with the Maintenance Director present, observed the following: 1. The tamper switch was damaged due to an over filled bathtub and it has been causing the fire alarm to be in a silenced, trouble mode since last Tuesday 10/22/2024 to present. 2. According to the sprinkler report and a telephone call from the sprinkler inspector the standard response heads dated 1965 have not had their 50-year testing. 3. According to the sprinkler report dated 06/11/2024, and a telephone call from the sprinkler inspector, the antifreeze loop was not	K 353		

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K 353	Continued From page 12 left in a serviceable condition due to the rating of the antifreeze in the administrative attic loop being zero degrees. 4. According to the sprinkler report dated 06/11/2024, and a telephone call from the sprinkler inspector, the antifreeze loop was not left in a serviceable condition due to the rating of the antifreeze in the boiler room loop being -4 degrees. 5. According to the sprinkler report dated 06/11/2024, and a telephone call from the sprinkler inspector, no signage was left on the piping for the antifreeze loop. The surveyor confirmed these findings with the Maintenance Director at the time of the observation.	K 353		
K 363 SS=F	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed	K 363		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205086	A. BUILDING 01 RECEIVED B. WING	10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINNACLE HEALTH & REHAB AT N BERWICK	47 ELM ST BY NORTH BERWICK, ME 03906

(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 363	Continued From page 13 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: Based on observation, documentation review, and interview, the long-term care facility failed to maintain the corridor doors to resist the passage of smoke in all three resident care wings per NFPA 101, Life Safety Code, 2012 Edition, Sections 19.3.6.3., and NFPA 80, Standard for Fire Doors and Other Opening Protectives, 2010 edition, Section 6.3.1.7.1. Findings: On 10/29/2024, between 09:00 AM and 12:00 PM, a surveyor, with the Maintenance Director present, observed the following: 1 Resident room #25, a 20-minute rated wood door in the A-wing has a ¾ gap on the top latch side.	K 363		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205086	A. BUILDING 01 B. WING	10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINNACLE HEALTH & REHAB AT N BERWICK	47 ELM ST NORTH BERWICK, ME 03906

(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 363	Continued From page 14 2. Resident Room #27, a 20-minute rated wood door in the A-wing doesn't latch and has a 7/16 gap on the top latch side. 3. Resident Room #28, a 20-minute rated wood door in the A-wing is delaminating on the bottom hinge side observed from the corridor side. 4. Resident Room #28, a 20-minute rated wood door in the A-wing has a 7/16-inch gap on the top latch side of the door. 5. Resident Room #28, a 20-minute rated wood door in the A-wing would not latch in the closed position. 6. Resident Room #31, a 20-minute rated wood door in the A-wing would not latch in the closed position. 7. Resident Room #18, in the B-Wing has a 3/8 gap at the top of the door on the top latch side. 8. Resident Room #19, in the B-Wing has a 3/8 gap at the top of the door on the top latch side. 9. Resident Room #13, in the C-Wing has a ½inch gap at the top of the door on the top latch side and a 5/16 gap on the latch side. 10. Resident Room #4 in the C-Wing is unable to fully close as it is contacting the floor. The surveyor confirmed these findings with the Maintenance Director at the time of the observation.	K 363		
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility	K 761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205086	A. BUILDING 01 B. WING	10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINNACLE HEALTH & REHAB AT N BERWICK	47 ELM ST NORTH BERWICK, ME 03906

(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 761	Continued From page 15 maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on observation, interview, and documentation review, the long-term care facility failed to conduct a fire door inspections program on all fire doors to ensure they are inspected, tested, and maintained by individuals with knowledge and understanding of the operating components of the type of door being subject to testing in accordance with NFPA 80, Standard for Fire Door and Other Opening Protectives, 2010 edition, Sections 5.2.1, and 5.2.3.1 and in accordance with NFPA 101, Life Safety Code, 2012 edition, sections 19.7.6, and 8.3.3.1, Findings: On 10/29/2024 between 09:00AM and 12:00 pm, the surveyor observed the following findings with the Maintenance Director Present: 1. The facility failed to complete the assessment of all fire doors in the facility. The 90-minute fire rated doors in the basement were omitted by the inspector conducting the annual door inspection. The conversation with the Maintenance Director revealed that the only doors inspected are in the resident area, and not all the fire-rated doors throughout the facility. 2. The facility had no documentation that the	K 761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205086	A. BUILDING 01 B. WING	10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINNACLE HEALTH & REHAB AT N BERWICK	47 ELM ST NORTH BERWICK, ME 03906

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K 761	Continued From page 16 doors had been inspected by a trained employee. Discussion with the maintenance director revealed that neither employee has had any training and only have the form to fill out. Avenues for training were provided during the exit interview with the Maintenance director and the Administrator. This surveyor confirmed these findings with the Maintenance Director at the time of the observation and review.	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:	K 914		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205086	A. BUILDING 01 B. WING	10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINNACLE HEALTH & REHAB AT N BERWICK	47 ELM ST NORTH BERWICK, ME 03906

(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 914	Continued From page 17 Based on observation and interview, the long-term care facility failed to maintain testing and maintenance of the electrical system in patient rooms NFPA 99, Healthcare Facilities Code, 2012 Edition, Sections 6.3.3, 6.3.3.1.5, 6.3.3.2, 6.3.4.1, 6.3.4.2 Finding: On October 29, 2024, between 9:00 AM and 12:00 PM, a surveyor, with the Administrator and Maintenance Director present, observed the following: 1. Patient bedroom duplex outlets are not hospital grade and have not been properly tested at annual intervals. The surveyor confirmed this finding with the Administrator and Maintenance Director at the time of the observation.	K 914		
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36	K 918		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205086	A. BUILDING 01 B. WING	10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINNACLE HEALTH & REHAB AT N BERWICK	47 ELM ST NORTH BERWICK, ME 03906

(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 18 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 generator inspection documentation review during the facility tour, the long-term care facility failed to maintain the Essential Electric System Generator per NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, sections 8.3.7. and 8.4.1, and NFPA 99, Healthcare Facilities Code, 2012 edition, section 6.4.4.1.1.3. Findings: On 10/29/2024, between 09:00 AM and 12:00 PM, a surveyor, with the Maintenance Director present, observed the following: 1. Emergency Power Supply Systems, including all appurtenant components, shall be inspected	K 918		

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	205086	A. BUILDING 01 B. WING	10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 918	Continued From page 19 weekly. No weekly inspections of the generator are being conducted. Documentation review only shows monthly inspections. 2. The monthly generator inspection reports did not show a voltage conductance test for sealed batteries or an electrolyte specific gravity reading for unsealed automotive batteries during the survey. The surveyor confirmed these findings with the Maintenance 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. Finding: On October 29, 2024, between 9:00 AM and 12:00 PM, a surveyor, with the Administrator and Maintenance Director present, observed the	K 919		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205086	A. BUILDING 01 B. WING	10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, ~~CITY, STATE, ZIP CODE~~
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K 919	Continued From page 20 following: 1. In A Wing, a wheelchair charging station is in the egress corridor. Currently there is one wheelchair being charged. Batteries shall not be charged in any area open to any path of egress or exit corridors per manufacturer specifications. Batteries are required to be charged in a rated room not open to the corridor. The risk is the release of combustible and/or toxic gases. Batteries should also be charged with the guidelines set forth by the manufacture's recommendations. The surveyor confirmed this finding with the Administrator and Maintenance Director at the time of the observation.	K 919		

Pinnacle Health & Rehabilitation – North Berwick

Fire Marshal Life Safety Code and Emergency Preparedness survey

October 29, 2024

E 006: Plan Based on All Hazards Risk Assessment

On 10/30/24, the facility All Hazards Risk Assessment was located and put in the Disaster Plan Book under tab "E 006".

The All Hazards Assessment is reviewed annually and is scheduled for review at least annually; next anticipated review date; 9/19/25. See copy enclosed.

E 009: Local, State, Tribal Collaboration Process

The North Berwick Fire Chief and members of the fire department will tour the facility on; 11/14/24. On 11/8/24, education was provided to the North Berwick fire Chief requesting routine communication for collaboration in efforts to ensure an integrated response during a disaster or emergency situation.

On 11/13/24, Administrator, Andrea Bouchard reached out to the Health Care Coalition of Maine and applied for membership. We will attend quarterly meetings, participate in planning and training exercises and agree to work with and support other members during emergencies.

The facility is not part of any tribal land.

On 11/13/24, Administrator, Andrea Bouchard reached out to the York County Emergency Management Agency; Arthur Cleaves, EMA Director and Chris McCall, Emergency Preparedness Coordinator. We will participate in training and support services from this organization.

E 013: Development of EP Policies and Procedures

On 10/30/24, the facility All Hazards Vulnerability Risk Assessment was located and put in the Disaster Plan Book under tab "E 006".

The All Hazards Vulnerability Assessment is reviewed annually and is scheduled for review at least annually; next anticipated review date; 9/19/25. See copy enclosed.

K 222: Egress Doors

On 11/8/24, the Maintenance Director or designee, labeled over all of the exit locking mechanisms the key code to exit the facility. These labels are plainly visible from 5 feet as required. This will allow exit from staff and visitors from the building.

The Maintenance Director, or designee, will add this to the weekly inspection report to verify code numbers are in place at all exit discharge locations.

K 321: Hazardous Areas-Enclosure

90-minute door to nursing storage room did not latch and was held open with a rope. The latch has been repaired and the rope removed. A sign indicating that the door must remain "closed" was posted.

90-minute door to the Business/General storage room did not self-close fully or latch.

90-minute door to the Business/General storage room is missing center hinge. The latch and hinge were replaced/repaired on; 11/8/24.

K 353: Sprinkler System-Maintenance and Testing

1: Tamper switch damage; causing fire alarm to be silenced; "trouble mode": Hampshire Fire Protection was on-site on; 11/11/24; to address this issue. Everon Tech will be on-site on; 11/13/24 to clear the alarm.

2. Standard response heads from 1965 need 50-year testing: Heads sampled and passed required testing see Hampshire Fire Protection Report; page 14, resolution date; 11/8/24

3. Antifreeze loop not left in serviceable condition from 6/11/24 inspection report. Hampshire Fire Protection was on-site on; 11/11/24; and corrected the issue. See enclosed report from Hampshire Fire Protection.

4. Antifreeze loop not left in serviceable condition from 6/11/24 inspection report in the boiler room. Hampshire Fire Protection was on-site on; 11/11/24; and corrected the issue. See enclosed report from Hampshire Fire Protection.

5. No signage was left on the piping for the antifreeze loop from 6/11/24 inspection. Hampshire Fire Protection was on-site on; 11/11/24; and corrected this issue. See enclosed report from Hampshire Fire Protection.

K 363: Corridor- Doors

Resident room #25: ¾ gap on the top latch side

Resident room #27: doesn't latch and has a 7/16 gap on top latch side

Resident room #28: is delaminating on the bottom hinge side observed from the corridor side

Resident room #28: 7/16 gap on top latch side

Resident room #28: would not latch in closed position

Resident room #31: would not latch in closed position

Resident room #18: 3/8 gap on top latch side

Resident room #19: 3/8 gap on top latch side

Resident room #13: ½ inch gap on top latch side and 5/16 gap on latch side

Resident room #4: unable to close, contacting the floor

All resident room doors will be inspected by; 11/22/24, using a door gap tool. All doors will be able to close and any gaps will be within compliance by 12/2/24.

Beginning the week of 12/2/24; the Director of Maintenance or designee will conduct weekly audits of 5-randomly selected resident room doors for 4 weeks and then monthly audits for 3 months to assure doors are within compliance.

Results will be reported at the quarterly QAPI meetings.

12/2/24

K 761: Maintenance, Inspection & Testing – Doors

By 11/15/24, the Maintenance Director and Assistant Maintenance Director, will participate in a 1-hour, on-line training specific to door inspecting.

https://ihfea.mylearnworlds.com/course/door-inspection-training

By 11/15/24, the basement fire rated doors will be inspected by the Maintenance Director. These doors will be added to the routine inspection checklist.

K 914: Electrical Systems- Maintenance and Testing

On 11/4/24, duplex outlets were removed from resident rooms.

On 11/4/24, a walkthrough of all resident rooms was conduct to remove any additional duplex outlets.

On 11/4/24, resident and employee education was provided related to the restriction of duplex outlets.

Beginning the week of 11/4/24; the Director of Maintenance or designee will conduct weekly audits for 4 weeks and then monthly audits for 3 months to assure duplex outlets are not in use in resident rooms.

Results will be reported at the quarterly QAPI meetings.

11/29/24

K 918: Electrical Systems-Essential Electrical System Maintenance and Testing

Beginning the week of; 11/4/24, the Maintenance Director or designed will conduct weekly generator inspections. The inspection will include all appurtenant components.

Results will be reviewed at monthly Safety Meetings.

Beginning in November, monthly generator inspections reports will show voltage conductance test for sealed batteries or an electrolyte specific gravity reading for unsealed automotive batteries.

Results will be reviewed at monthly Safety Meetings.

11/29/24

(*) **K 919: Electrical Equipment- Other**

On 10/29/24, the charging electric wheelchair was removed from the hallway.

A designated non-resident area; (the back "living room")has been assigned for charging the electric wheelchair.

Staff education was provided on; 11/13/24. A policy will be written and reviewed at our next Safety Meeting on

Audits will be conducted weekly for 4 weeks, then monthly for 3 months to assure electric wheelchair are not being charged in the hallway, egress area. Results will be reviewed during quarterly QAPI Meetings.

11/29/24