STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205159	A. BUILDING 01 B. WING _____	06/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEDGEWOOD COMMONS	22 NORTHBROOK DR FALMOUTH, ME 04105

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments Federal Recertification Survey Survey Dates: 6/3/2025 Sedgewood Commons, 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 037 SS=F	EP Training Program CFR(s): 483.73(d)(1) §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.542(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, REHs at §485.542, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and	E 037		

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 037	Continued From page 1 procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency	E 037		

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

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	205159	A. BUILDING 01 B. WING	06/03/2025

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E 037	Continued From page 2 procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. (v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency	E 037		

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E 037	Continued From page 3 preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected	E 037		

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E 037	Continued From page 4 roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the long term care facility failed to provide Emergency Preparedness training annually in accordance with 42 CFR 483.73 Finding: Based on interview and document review on 06.03.2025 between the hours of 9:30 AM and 2:30 PM. The surveyor accompanied the Director of Maintenance, Administrator, administrator in training, and the senior maintenance supervisor did observe the following: 1. No documenttation of initial training in	E 037		

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E 037	Continued From page 5 emergency preparedness policies and procedures to staff with their expected roles. 4 randomly selected staff had no documentation of of any training in emergency preparedness. The surveyor confirmed this finding with the Director of Maintenance, Administrator, administrator in training, and the senior maintenance supervisor at the time of the observation.	E 037		
K 000	INITIAL COMMENTS Federal Recertification Survey Date of Survey 06/3/2025 Sedgewood Commons, a long-term care facility, was surveyed pursuant to the National Fire Protection Association, 101 Life Safety Code, 2012 Edition as referenced in Part 483.90(a-d) - Physical Environment is not in substantial compliance.	K 000		
K 133 SS=D	Multiple Occupancies - Construction Type CFR(s): NFPA 101 Multiple Occupancies - Construction Type Where separated occupancies are in accordance with 18/19.1.3.2 or 18/19.1.3.4, the most stringent construction type is provided throughout the building, unless a 2-hour separation is provided in accordance with 8.2.1.3, in which case the construction type is determined as follows: * The construction type and supporting construction of the health care occupancy is based on the story in which it is located in the building in accordance with 18/19.1.6 and Tables 18/19.1.6.1 * The construction type of the areas of the building enclosing the other occupancies shall be	K 133		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 133	Continued From page 6 based on the applicable occupancy chapters. 18.1.3.5, 19.1.3.5, 8.2.1.3 This REQUIREMENT is not met as evidenced by: Based on plans review, observation and interview during the facility tour, the long-term care facility failed to maintain the clear locations of the 2-hour seperation walls for inspection per NFPA 101, Life Safety Code, 2012 Edition, Sections 8.2.1.3. Finding: Based on interview and observation on 06.03.2025 between the hours of 9:30 AM and 2:30 PM. The surveyor accompanied the Director of Maintenance, Administrator, administrator in training, and the senior maintenance supervisor did observe the following: 1. During the facility tour the inspection team was unable to effectively identify compartment separations without a set of life safety drawings. The locations annotated on the blueprint plans we looked at versus the building layout did not match. The inspection performed on 03.29.2024 identified the walls between wings as 2-hour fire walls. The surveyor identified the attic space was sprinkled but was unable to determine the construction type because the roof hips. Diretor of Maintenance states there is a wall and hatch but was unable to confirm construction type and rating of the wall. The surveyor confirmed this finding with the Director of Maintenance, Administrator, administrator in training, and the senior maintenance supervisor at the time of the observation.	K 133		

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

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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. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the Long Term Care facility in 4 of 4 smoke compartments failed to ensure that aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with NFPA 101, Life Safety Code, 2012 edition, Chapter 7, and that the means of egress is continuously maintained free of all obstructions to full use in case of emergency unless modified by NFPA 101, Life Safety Code, 2012 edition, sections 19.2.2 through 19.2.11, 19.2.1, and 7.1.10. Findings: On 06.03.2025 between the hours of 9:30 AM and 2:30 PM. The surveyor accompanied the Director of Maintenance, Administrator, administrator in training, and the senior maintenance supervisor did observe the following: In the Millay Wing 1. Two soiled linen containers, approximately 32 gallons each, were found in the corridor across from the soiled linen storage room.	K 211		

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K 211	Continued From page 8 2. A standing fan was found in the corridor. This was removed on site. 3. A gate was found across the nurses managers office in the door way. These deficient practices could affect residents, guests and staff from proper egress in the event of an emergency. In the Longfellow Wing 1. Two soiled linen containers, approximately 32 gallons each, were found in the corridor across from the soiled linen storage room. 2. A recliner was found in the corridor by the nurses station not mounted to the floor or wall, reducing the egress width. 3. A nurses computer stand and a monitor stand were found in the corridor These deficient practices could affect residents, guests and staff from proper egress in the event of an emergency. In the Hauthorne Wing 1. A blood pressure cuff stand, a floor fan, a table and radio were being stored in the corridor. 2. The nurses aid cart was found stored in the corridor These deficient practices could affect residents, guests and staff from proper egress in the event of an emergency. Outside the Multipurpose Room 1. There were two folding tables with itmes being stored under them in the corridor. This deficient practice could affect residents, guests and staff from proper egress in the event of an emergency.	K 211		

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K 211	Continued From page 9 The the Coorridor by the laundry 1. Storage of clothing on racks and an enclosed storage unit with clothes was stored 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 Maintenance, Administrator, administrator in training, and the senior maintenance supervisor at the time of the observation.	K 211		
K 321 SS=D	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)	K 321		

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	205159	A. BUILDING 01 B. WING _____	06/03/2025

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K 321	Continued From page 10 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: Based on observation and interview the long-term facility failed to ensure that hazardous areas are protected per the requirements of NFPA 101 2012 edition 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. Finding: Based on interview and observation on 06.03.2025 between the hours of 9:30 AM and 2:30 PM. The surveyor accompanied the Director of Maintenance, Administrator, administrator in training, and the senior maintenance supervisor did observe the following: 1. Penetrations in 1-hour rated fire wall in boiler room was patched with residential euthorane spray foam. The penetration had numerous wires and category 5 wire ran through the wall in the area above the fire alarm panel. The surveyor confirmed this finding with the Director of Maintenance, Administrator,	K 321		

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	205159	A. BUILDING 01 B. WING	06/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEDGEWOOD COMMONS	22 NORTHBROOK DR FALMOUTH, ME 04105

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K 321	Continued From page 11 administrator in training, and the senior maintenance supervisor at the time of the observation.	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 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 observation and document review, the long-term care facility failed to ensure that Automatic sprinkler systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems sections 13.4.4.2.9 Finding: Based on interview and observation and	K 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 353	Continued From page 12 document review on 06.03.2025 between the hours of 9:30 AM and 2:30 PM. The surveyor accompanied the Director of Maintenance, Administrator, administrator in training, and the senior maintenance supervisor did observe the following: 1. Discrepancy between the sprinkler documentation and sprinkler riser sticker was found during inspection. The dry sprinkler system failed it's 3-year air leak test on 04.09.2025 per sticker on the sprinkler riser. The senior maintenance supervisor consulted the sprinkler company and confirmed the 3-year leak test did fail. The sprinkler company replaced 21' of sprinkler piping to correct the issue but the system has not been retested. The surveyor confirmed this finding with the Director of Maintenance, Administrator, administrator in training, and the senior maintenance supervisor at the time of the observation.	K 353		
K 355 SS=E	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 in 4 of 4 smoke compartments failed to comply with 2012 Life Safety Code sections 18.3.5.12, 19.3.5.12	K 355		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 355	Continued From page 13 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 10:6.1.3.3.2 In large rooms and in certain locations where visual obstructions cannot be completely avoided, means shall be provided to indicate the extinguisher location. Findings: On 06.03.2025 between the hours of 9:30 AM and 2:30 PM. The surveyor accompanied the Director of Maintenance, Administrator, administrator in training, and the senior maintenance supervisor did observe the following: In the Millay, Longfellow, and Hawthorn Wings 1. In each corridor, there were two fire extinguisher signs indicating there were fire extinguishers below the sign. There were no extinguishers below the signs. They extinguishers were in the corridor around in a cross corridor with no fire extinguisher indicating signs. This could impact the ability of finding an extinguisher easily in an emergency. The surveyor confirmed these findings with the Director of Maintenance, Administrator, administrator in training, and the senior maintenance supervisor at the time of the observation.	K 355		

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	205159	A. BUILDING 01 B. WING _____	06/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEDGEWOOD COMMONS	22 NORTHBROOK DR FALMOUTH, ME 04105

(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	K 363		
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire	K 363		

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K 363	Continued From page 15 protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the long-term care facility failed to maintain the corridor doors to resist the passage of smoke to and from the corridor as referenced by NFPA 101, Life Safety Code 2012 edition, Section 19.3.6.3 Finding: On 06.03.2025 between the hours of 9:30 AM and 2:30 PM. The surveyor accompanied the Director of Maintenance, Administrator, administrator in training, and the senior maintenance supervisor did observe the following: 1. Room 46 corridor door did not prevent the passage of smoke . There was a gap greater than 1/2" at tbe bottom right on the latch side of the door. The Interior weather stripping was bent and not mounted to the frame. The surveyor confirmed this finding with the Director of Maintenance, Administrator, administrator in training, and the senior maintenance supervisor at the time of the observation.	K 363		
K 751 SS=D	Draperies, Curtains, and Loosely Hanging Fabr CFR(s): NFPA 101 Draperies, Curtains, and Loosely Hanging Fabrics Draperies, curtains including cubicle curtains and loosely hanging fabric or films shall be in accordance with 10.3.1. Excluding curtains and	K 751		

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K 751	Continued From page 16 draperies: at showers and baths; on windows in patient sleeping room located in sprinklered compartments; and in non-patient sleeping rooms in sprinklered compartments where individual drapery or curtain panels do not exceed 48 square feet or total area does not exceed 20 percent of the wall. 18.7.5.1, 18.3.5.11, 19.7.5.1, 19.3.5.11, 10.3.1 This REQUIREMENT is not met as evidenced by: Based on observation, the long-term care facility in 2 of 4 smoke compartment failed to ensure that combustible decorations shall be prohibited unless one of the following is met: Flame retardant or treated with approved fire-retardant coating that is listed and labeled for product. Decorations meet NFPA 701 (2010). Decorations exhibit heat release less than 100 kilowatts in accordance with NFPA 289 (2009). Decorations, such as photographs, paintings and other art are attached to the walls, ceilings and non-fire-rated doors in accordance with 18.7.5.6(4) or 19.7.5.6(4). The decorations in existing occupancies are in such limited quantities that a hazard of fire development or spread is not present. 19.7.5.6. Findings: Based on interview and observation on 06.03.2025 between the hours of 9:30 AM and 2:30 PM. The surveyor accompanied the Director of Maintenance, Administrator, administrator in training, and the senior maintenance supervisor did observe the following: 1. Observed in a room attached to the dining area in the Millay Wing a projector screen in use. No	K 751		

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K 751	Continued From page 17 documentation or markings were observed showing the screen had been treated for flame retardance. 2. Observed in a room attached to the dining area in the Longfellow Wing a projector screen in use. No documentation or markings were observed showing the screen had been treated for flame retardance. The surveyor confirmed these findings with the Director of Maintenance, Administrator, administrator in training, and the senior maintenance supervisor at the time of the observation.	K 751		
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 and inspection in two of four smoke compartments, the long term care facility failed to meet the requirements of the	K 761		

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K 761	Continued From page 18 National Fire Protection Association (NFPA) 101, Life Safety Code, 2012 edition, section 8.3.3.1 and NFPA 80, Standard for Fire Doors and Other Opening Protectives, 2010 edition, Section 5 Findings: Based on interview and observation on 06.03.2025 between the hours of 9:30 AM and 2:30 PM. The surveyor accompanied the Director of Maintenance, Administrator, administrator in training, and the senior maintenance supervisor did observe the following: 1. Cross corridor 90 minute fire-rated doors separating the main lobby area and the Millay wing had 6 holes in the bottom latch side of both the left and right leaf. Pre-existing hardware was removed and replaced with a fire pin leaving penetrations in door. 2. Cross corridor 90 minute fire-rated doors separating the main lobby area and the Longfellow Wing had 4 holes in the bottom latch side of both left and right leaf. Pre-existing hardware was removed and replaced with a fire pin leaving penetrations in door. The surveyor confirmed these findings with the Director of Maintenance, Administrator, administrator in training, and the senior maintenance supervisor at the time of the observation.	K 761		
K 911 SS=D	Electrical Systems - Other CFR(s): NFPA 101 Electrical Systems - Other List in the REMARKS section any NFPA 99	K 911		

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K 911	Continued From page 19 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observations and inspection, in 1 of 4 smoke compartments the long-term care facility failed to meet the requirements of NFPA 70, as referenced by NFPA 99, Healthcare Facilities Code, 2012 edition, section 6.3.2.1. Findings: Based on interview and observation on 06.03.2025 between the hours of 9:30 AM and 2:30 PM. The surveyor accompanied the Director of Maintenance, Administrator, administrator in training, and the senior maintenance supervisor did observe the following: 1. Observed an electrical junction box on the wall above the generator missing a cover, exposing wires and electrical connections. 2. Observed an alarm panel wiring junction box above the panel in the boiler room was missing a cover exposing wiring and electrical connections. The surveyor confirmed these findings with the Director of Maintenance, Administrator, administrator in training, and the senior maintenance supervisor at the time of the observation.	K 911		
K 923 SS=E	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101	K 923		

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K 923	Continued From page 20 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, 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:	K 923		

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K 923	Continued From page 21 Based on observation and interview, the long-term care facility in 4 of 4 smoke compartments failed to ensure that Gas Equipment - Cylinder and Container Storage in a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in that Gas Equipment, storage of empty and full oxygen cylinders in the Oxygen Room were separated and marked to avoid confusion from full and empty cylinders as referenced in NFPA 99 the health care facilities code section 11.6.5.3 Findings: On 06.03.2025 between the hours of 9:30 AM and 2:30 PM. The surveyor accompanied the Director of Maintenance, Administrator, administrator in training, and the senior maintenance supervisor did observe the following: In the Millay, Longfellow and Hawthorn Wings 1. It was observed in the oxygen rooms in all wings had 'E' size oxygen cylinders in the Oxygen Room, these cylinders had no marked signs to indicate empty or full cylinders and they were all together and not separated. The surveyor confirmed these findings with the Director of Maintenance, Administrator, administrator in training, and the senior maintenance supervisor at the time of the observation.	K 923		