

Cummings, Joanne

From: Cummings, Joanne
Sent: Wednesday, October 18, 2023 12:17 PM
To: 'bseekins@nhca.com'
Cc: Day, Gregory J; Peaslee, Ronald J
Subject: 205095 Kennebunk Center Statement of Deficiency
Attachments: 205095 Kennebunk Center Statement of Deficiency.pdf

Administrator Seekins,

On October 17, 2023, your facility was found not to be in substantial compliance with the participation requirements for Life Safety Code and Emergency Preparedness.

Please do not send your plan of correction to the office via US Mail or fax

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

**Joanne Cummings
Office Associate II
Maine State Fire Marshal's Office
45 Commerce Drive, Suite 1
Augusta, ME 04330
O (207) 626-3882
F (207) 287-6251**

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State of Maine
Department of Public Safety
Office of Fire Marshal
45 Commerce Drive, Suite 1
Augusta, ME 04330

JANET T. MILLS
GOVERNOR

MICHAEL SAUSCHUCK
COMMISSIONER

RICHARD MCCARTHY
STATE FIRE MARSHAL

October 18, 2023

Kennebunk Center For Health & Rehabilitation, LLC
Attn: Brett Seekins, Administrator
158 Ross Rd
Kennebunk, ME 04043

Provider ID#: 205095
Facility ID#: HF8073H
Event ID#: 8JML21

Administrator Seekins,

On October 17, 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 and Emergency Preparedness.

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.

PREVENTION * MITIGATION/ SUPPRESSION * LAW ENFORCEMENT
OFFICES LOCATED AT: 45 COMMERCE DRIVE, SUITE 1, AUGUSTA, MAINE 04330
(207) 626-3870 ADMINISTRATION/ INVESTIGATIONS (207) 287-3659 TDD
(207) 626-3880 INSPECTIONS/ PLANS REVIEW (207) 287-6251 FAX

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 **December 4, 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 **October 17, 2023**, the following remedy(ies) are being imposed:

The State Agency directs the plan of correction noted on the attached CMS-2567 for deficiencies E015(SS=C), K353(SS=D) & K761(SS=D) (Tags). [42 CFR 488.424]

If you do not achieve substantial compliance by January 18, 2024, 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 April 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 achieved. 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 **Assistant 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 207-441-0622.

Yours for Better Fire Prevention,



**Gregory J. Day
Assistant State Fire Marshal**

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

PRINTED: 10/18/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205095	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 10/17/2023
NAME OF PROVIDER OR SUPPLIER KENNEBUNK CENTER FOR HEALTH & REHABILITATION, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 158 ROSS RD KENNEBUNK, ME 04043		
(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: 10-17-23 Kennebunk Center for Health & Rehab, 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 015 SS=C	Subsistence Needs for Staff and Patients CFR(s): 483.73(b)(1) §403.748(b)(1), §418.113(b)(6)(iii), §441.184(b) (1), §460.84(b)(1), §482.15(b)(1), §483.73(b)(1), §483.475(b)(1), §485.542(b)(1), §485.625(b)(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting.	E 015			

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 015	Continued From page 1 (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal. *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, this facility failed to provide documentation to confirm the provision of subsistence needs for staff and patients whether they evacuate or shelter in place in the Emergency Preparedness Plan. On October 17, 2023, between 9:00 am and 11:15 am, a surveyor, with the Maintenance Director and Administrator present, observed the following:	E 015			

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E 015	Continued From page 2 Findings: 1. Documentation could not be provided to indicate there is a contract to provide emergency pharmaceutical supplies. 2. Documentation could not be provided to indicate there is a contract to provide emergency medical supplies. The surveyor confirmed these findings with the Maintenance Director and Administrator at the time of record review.	E 015		
K 000	INITIAL COMMENTS Federal Recertification Survey: Survey Date: 10-1-23 Kennebunk Center For Health & Rehabilitation, 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 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	K 353		

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K 353	Continued From page 3 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 interview, the long term care facility failed to maintain 2 sprinkler heads free of obstructions per NFPA 25, Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.1.1.1 and NFPA 101, Life Safety Code, 2012 Edition, Sections 19.3.5.1. and 9.7.6. Findings: On October 17, 2023, between 9:00 am and 11:15 am, a surveyor, with the Maintenance Director present, observed the following: 1. Fire sprinkler head in the left freezer of the kitchen found obstructed with storage. Maintain 18" of clearance. 2. Fire sprinkler head in the Activities Office closet found obstructed with storage. Maintain 18" of clearance. The surveyor confirmed these findings with the Maintenance Director at the time of the observation.	K 353			
K 761 SS=D	Maintenance, Inspection & Testing - Doors	K 761			

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K 761	Continued From page 4 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 interview, the facility failed to inspect and test fire door assemblies in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives, 2010 edition, Section 5.2.2, 5.2.3.1, 5.2.3.5.2(1), and NFPA 101, Life Safety Code, 2021 edition, sections 19.7.6, 4.6.12, 8.3.3.1, and 8.3.3.2.3 Findings: On 10/17/2023, between 09:00 AM and 11:15 AM, a surveyor, with the Maintenance Director, present, observed the following: 1. A record of all inspections and testing shall be signed by the inspector and kept for inspection and review. There were no records of an annual fire door inspection conducted at the facility by a qualified person.	K 761		

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K 761	Continued From page 5 2. Testing of fire door and window assemblies shall be performed by a qualified person with knowledge and understanding of the operating components of the type of assembly being subject to testing. No staff member at the facility has the required NFPA 80 certification, and no verification of inspection by an outside agency could be produced. The surveyor confirmed these findings with the Maintenance Director at the time of the observation.	K 761			