STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205124	A. BUILDING 01 RECEIVED NOV 18 2023 B. WING	10/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KNOX CENTER FOR LONG TERM CARE	6 WHITE STREET ROCKLAND, ME 04841

(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: 11/1/23 Breakwater Commons, located at 100 Commons Way Rockland a long term care facility, is not in substantial compliance with 42 Code of Federal Regulations Part 483.73- Emergency Preparedness Requirement for Long Term Care Facilities.	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	E 006	E 006 The facility requires a Hazard Vulnerability Analysis (HVA), to help understand environmental risks to safety and well-being of staff and residents. The facility's QAPI Committee identified the need to develop an HVA at its 10/24/2023 meeting. No residents were harmed by the identified deficient Practice. A Safety Committee meeting has been scheduled to complete the HVA (Community Band risk assessment). Education to staff will be completed highlighting the HVA and its' identified risks as part of the Emergency Operating Plan. The facility's Safety Committee will review outcomes of this Plan on a monthly basis, reporting to the QAPI Committee every 90 days x 6 months.	11/21/2023 12/14/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: ADMINISTRATOR | (X6) DATE: 11/15/2023

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205124	A. BUILDING 01 _____ B. WING _____ B.Y.	10/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KNOX CENTER FOR LONG TERM CARE	6 WHITE STREET ROCKLAND, ME 04841

(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 006	Continued From page 1 plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach. (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. *[For LTC facilities at §483.73(a):] Emergency 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, document review and interview, the facility failed to meet the	E 006		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205124	A. BUILDING 01 B. WING	10/31/2023

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KNOX CENTER FOR LONG TERM CARE	6 WHITE STREET ROCKLAND, ME 04841

(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 006	Continued From page 2 requirements of emergency preparedness for LTC Facilities §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. Findings: During records review and interview(s) on 10/31/23 between 10:00 AM and 2:00 PM with the facility administrator, the following was found: 1. No documentation was provided that the facility had conducted hazard risk assessment and had not identified emergency events that needed to be addressed These findings were verified by the facility administrator at the time of records review and exit interview on 10/31/23.	E 006		
E 022 SS=F	Policies/Procedures for Sheltering in Place CFR(s): 483.73(b)(4)	E 022		

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	205124	A. BUILDING 01 B. WING	10/31/2023

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(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 022	Continued From page 3 §403.748(b)(4), §416.54(b)(3), §418.113(b)(6)(i), §441.184(b)(4), §460.84(b)(5), §482.15(b)(4), §483.73(b)(4), §483.475(b)(4), §485.68(b)(2), §485.542(b)(4), §485.625(b)(4), §485.727(b)(2), §485.920(b)(3), §491.12(b)(2), §494.62(b)(3). (b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] [(4) or (2),(3),(5),(6)] A means to shelter in place for patients, staff, and volunteers who remain in the [facility]. *[For Inpatient Hospices at §418.113(b):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (i) A means to shelter in place for patients, hospice employees who remain in the hospice. This REQUIREMENT is not met as evidenced by: Based on observation, document review and interview, the facility failed to meet the requirements of emergency preparedness for LTC Facilities §403.748(b)(4), §416.54(b)(3), §418.113(b)(6)(i), §441.184(b)(4), §460.84(b)(5), §482.15(b)(4), §483.73(b)(4), §483.475(b)(4),	E 022		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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E 022	Continued From page 4 §485.68(b)(2), §485.542(b)(4), §485.625(b)(4), §485.727(b)(2), §485.920(b)(3), §491.12(b)(2), §494.62(b)(3). (b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] [(4) or (2),(3),(5),(6)] A means to shelter in place for patients, staff, and volunteers who remain in the [facility]. Findings: During records review and interview(s) on 10/31/23 between 10:00 AM and 2:00 PM with the facility administrator, the following was found: 1. No documentation was provided that the facility had a policy in place for sheltering in place for residents and/or staff. These findings were verified by the facility administrator at the time of records review and exit interview on 10/31/23	E 022	E 022 The facility requires a Shelter in Place policy as part of the Emergency Plan. The facility's QAPI Committee identified the need to continue development of its' Emergency Plan at its 10/24/2023 meeting. No residents were harmed by the identified deficient Practice. A special Safety Committee meeting has been scheduled to develop the Shelter in Place policy to be added to the facility's Emergency Plan. Education will be provided to staff highlighting the Shelter in Place policy and its location as part of the Emergency Plan. The facility's Safety Committee will review outcomes of this Plan on a monthly basis, reporting to the QAPI Committee every 90 days x 6 months.	11/21/2023 12/14/2023
E 033 SS=F	Methods for Sharing Information CFR(s): 483.73(c)(4)-(6) §403.748(c)(4)-(6), §416.54(c)(4)-(6), §418.113(c)(4)-(6), §441.184(c)(4)-(6), §460.84(c)(4)-(6), §441.184(c)(4)-(6), §460.84(c)(4)-(6), §482.15(c)	E 033		

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E 033	Continued From page 5 (4)-(6), §483.73(c)(4)-(6), §483.475(c)(4)-(6), §484.102(c)(4)-(5), §485.68(c)(4), §485.542(c)(4)-(6), §485.625(c)(4)-(6), §485.727(c)(4), §485.920(c)(4)-(6), §491.12(c)(4), §494.62(c)(4)-(6). [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following: (4) A method for sharing information and medical documentation for patients under the [facility's] care, as necessary, with other health providers to maintain the continuity of care. (5) A means, in the event of an evacuation, to release patient information as permitted under 45 CFR 164.510(b)(1)(ii). [This provision is not required for HHAs under §484.102(c), CORFs under §485.68(c)] (6) [(4) or (5)]A means of providing information about the general condition and location of patients under the [facility's] care as permitted under 45 CFR 164.510(b)(4). *[For RNHCIs at §403.748(c):] (4) A method for sharing information and care documentation for patients under the RNHCI's care, as necessary, with care providers to maintain the continuity of care, based on the written election statement made by the patient or his or her legal representative.	E 033		

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	205124	A. BUILDING 01 B. WING	10/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KNOX CENTER FOR LONG TERM CARE	6 WHITE STREET ROCKLAND, ME 04841

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E 033	Continued From page 6 "[For RHCs/FQHCs at §491.12(c):] (4) A means of providing information about the general condition and location of patients under the facility's care as permitted under 45 CFR 164.510(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, document review and interview, the facility failed to meet the requirements of emergency preparedness for LTC Facilities§403.748(c)(4)-(6), §416.54(c)(4)-(6), §418.113(c)(4)-(6), §441.184(c)(4)-(6), §460.84(c)(4)-(6), §441.184(c)(4)-(6), §460.84(c)(4)-(6), §482.15(c)(4)-(6), §483.73(c)(4)-(6), §483.475(c)(4)-(6), §484.102(c)(4)-(5), §485.68(c)(4), §485.542(c)(4)-(6), §485.625(c)(4)-(6), §485.727(c)(4), §485.920(c)(4)-(6), §491.12(c)(4), §494.62(c)(4)-(6). [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following: (4) A method for sharing information and medical documentation for patients under the [facility's] care, as necessary, with other health providers to maintain the continuity of care. (5) A means, in the event of an evacuation, to release patient information as permitted under 45 CFR 164.510(b)(1)(ii). [This provision is not required for HHAs under §484.102(c), CORFs under §485.68(c)] (6) [(4) or (5)]A means of providing information	E 033	E 033 The facility requires a Communications plan for Sharing Information and medical documentation as part of its' Emergency Plan. The facility's QAPI Committee identified the need to continue Development of its' Emergency Plan at its 10/24/2023 meeting. No residents were harmed by the identified deficient Practice. A special Safety Committee meeting has been scheduled to develop a Communications plan and policy to be added to the facility's Emergency Plan. Education will be provided to staff highlighting the Communication Plan Policy and its location as part of the Emergency Plan via staggered in-service schedule to meet with employees on all shifts in all departments. The facility's Safety Committee will review outcomes of this plan on a monthly basis, reporting to the QAPI Committee every 90 days x 6 months.	11/28/2023 12/14/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205124	A. BUILDING 01 B. WING BY:	10/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KNOX CENTER FOR LONG TERM CARE	6 WHITE STREET ROCKLAND, ME 04841

(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 033	Continued From page 7 about the general condition and location of patients under the [facility's] care as permitted under 45 CFR 164.510(b)(4). Findings: During records review and interview(s) on 10/31/23 between 10:00 AM and 2:00 PM with the facility administrator, the following was found: 1. No documentation was provided that the facility had developed a means of sharing information and medical documentation. These findings were verified by the facility administrator at the time of records review and exit interview on 10/31/23.	E 033		
E 036 SS=F	EP Training and Testing CFR(s): 483.73(d) §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.542(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d). *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, REHs at §485.542, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the	E 036		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205124	A. BUILDING 01 B. WING ____ SY: ____	10/31/2023

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E 036	Continued From page 8 emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient	E 036		

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E 036	Continued From page 9 orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years. This REQUIREMENT is not met as evidenced by: Based on observation, document review and interview, the facility failed to meet the requirements of emergency preparedness for LTC Facilities §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.542(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d).*[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. Findings: During records review and interview(s) on 10/31/23 between 10:00 AM and 2:00 PM with the facility administrator, the following was found: 1. No documentation was provided that the facility had developed a emergency preparedness	E 036	E 036 The facility requires a Testing program of its' Emergency Plan. The facility's QAPI Committee identified the need to continue Development of its' Emergency Plan at its 10/24/2023 meeting. No residents were harmed by the identified deficient Practice. A special Safety Committee meeting has been scheduled to develop a Testing program and policy to be added to the facility's Emergency Plan. Education will be provided to staff highlighting the Testing Plan Policy and its location as part of the Emergency Plan via staggered in-service schedule to meet with employees on all shifts in all departments. The facility's Safety Committee will review outcomes of this plan on a monthly basis, reporting to the QAPI Committee every 90 days x 6 months.	12/4/2023 12/14/2023

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E 036	Continued From page 10 testing program. These findings were verified by the facility administrator at the time of records review and exit interview on 10/31/23.	E 036		
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 procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures.	E 037		

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	205124	A. BUILDING 01 _____ B. WING _____	10/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KNOX CENTER FOR LONG TERM CARE	6 WHITE STREET ROCKLAND, ME 04841

(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 037	Continued From page 11 *[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 procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and	E 037		

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E 037	Continued From page 12 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 preparedness training. (iv) Demonstrate staff knowledge of emergency procedures.	E 037		

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E 037	Continued From page 13 *[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 roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training.	E 037		

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E 037	Continued From page 14 (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, document review and interview, the facility failed to meet the requirements of emergency preparedness for LTC Facilities at §483.73(d):] (1) Training Program. Findings: During records review and interview(s) on 10/31/23 between 10:00 AM and 2:00 PM with the facility administrator, the following was found: 1. No documentation was provided that any staff had received emergency preparedness training that was facility specific. These findings were verified by the facility administrator at the time of records review and exit interview on 10/31/23.	E 037	E037 The facility is required to provide facility specific Emergency Plan Education to staff on an annual basis and upon hire. The facility QAPI Committee identified the need to continue development of its' Emergency Plan at its 10/24/2023 meeting. No residents were harmed by the identified deficient Practice. Emergency Preparedness Training will be completed via staggered in-service schedule to meet with employees on all shifts in all departments. Documentation of education will include completion and signature of post in-service testing along with signed general attendance sheets. The facility's Safety Committee will review outcomes of this plan on a monthly basis, reporting to the QAPI Committee every 90 days x 6 months.	12/14/2023 12/14/2023

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K 000	INITIAL COMMENTS Federal Certification Survey Survey Date: 11/1/23 Breakwater Commons, located at 100 Commons Way Rockland, ME a long term care facility, is in not in substantial compliance with 42 Code of Federal Regulations Part 483.73 Requirement for Long Term Care Facilities Emergency Preparedness.	K 000		
K 211 SS=D	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 during facility tour, the facility failed to ensure that aisles,passageways, corridors,exit discharge,exit locations and accesses are in accordance with National Fire Protection Association(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 safety code, 2012 edition, sections 18.2., 18.2.2 through 18.2.11, and 7.1.10.1 Findings:	K 211		

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	205124	A. BUILDING 01 RECEIVED NOV 18 2023 B. WING	10/31/2023

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K 211	Continued From page 16 Observation(s) and Interview(s), during a facility tour on 10/31/23 between 10:00 AM and 2:00 PM with the Director of Environmental Services and a maintenance assistant, the following was found: 1. Nursing station in East wing had three medication carts that were not attended and stored in the exit corridor. 2. Maintenance/Service corridor had combustible storage on both side of the corridor that could be an obstruction to egress and contribute to the spread of smoke/fire. This exit corridor is also a required means for occupants/visitors in other areas of the healthcare facility. 3. West wing had a isolation cart with no wheels, stored in the exit coridoor. These findings were verified by the Director of Environmental Services and a maintenance assistant and facility administrator at the time of observations and exit interview on 10/31/23.	K 211		
K 222 SS=D	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the	K 222		

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K 222	Continued From page 17 rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a 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	K 222		

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K 222	Continued From page 18 Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on Observation and Interview, the facility failed to provide exit access that was readily accessible at all times by having special locking arrangements in accordance with LSC Section 18.2.2.2.4, 18.2.2.2.5, 18.2.2.2.5.2 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: Observation(s) and Interview(s), during a facility tour on 10/31/23 between 10:00 AM and 2:00 PM with the Director of Environmental Services and a maintenance assistant, the following was found: 1. The East wing exit door to the courtyard is labeled as a delayed egress door, but upon testing it did not function or release the door locking mechanism. 2. East wing and south wing exterior courtyard gates did not have pin pad code conspicuously posted to provide exit access that was readily available. The code was displayed on the back of a light pole located approximately 9-10' away from the pin pad/gate. 3. The delayed egress doors in east wing located near rooms 123 A/B, did not function or release	K 222	K222 Pin code postings have been relocated directly at gates to courtyards. Egress settings, performance and labeling of exit doors have been corrected and are in working order. No residents were harmed by the identified deficient practice Staff have received education and training on requirements of delayed egress and to report any issues to the facility maintenance staff. The Maintenance Director and/or designee will document inspections of exit doors and egress areas twice daily x 30 days then daily x 60 days. Results of inspections will be reported to the facility Safety Committee monthly x 3 months.	10/31/2023 11/20/2023

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K 222	Continued From page 19 the door locking mechanism. 4. A sample of all delayed egress doors were tested and found to be labeled to release in 30 seconds and they actually were programmed to release at the 15 second timeframe. These findings were verified by the Director of Environmental Services and a maintenance assistant and facility administrator at the time of observations and exit interview on 10/31/23.	K 222		
K 321 SS=F	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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K 321	Continued From page 20 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 facility failed to to ensure that hazardous areas were maintained or equipped with operational self-closing doors in accordance with National Fire Protection Association (NFPA) 101, Life Safety Code, 2012 edition, section(s) 8.7.1, 18.3.5.9, and 18.3.2.1. Findings include: Observation(s) and Interview(s), during a facility tour on 10/31/23 between 10:00 AM and 2:00 PM with the Director of Environmental Services and a maintenance assistant, the following was found: 1. The 1 hour rated Tel/Com room in the east wing had a section of gypsum missing on the wall (aprox. 4' wide x 1-1/2' high). 2. Sprinkler/Mechanical room had penetrations in the gypsum wall board. 3. Sprinkler/Mechanical room had a metal pipe above the door that had a section of missing fire stopping material. 4. The 60-minute fire rated door to the mechanical/electrical room did not self-close and	K 321	K321 Multiple findings were made relating to Hazardous Areas under this deficiency. 1. The section of Gypsum missing in the East Wing Tel/Com room has been replaced. 2.The sprinkler/mechanical room penetrations in gypsum wall board has been corrected. 3. The sprinkler/mechanical room missing fire stop material above the door has been corrected with the proper material. 4. The 60 minute fire-rated door to the mechanical/ Electrical room now positively latches upon release from fully open position. 5. The 60 minute fire-rated door to the laundry room door will be closed at all times as facility's general contractor (Allied Cook) have requested a schedule return from warranty sub-contractors (Granite Corp/Bennett Engineering to assess problem and expedite solution as soon as possible.	11/16/2023 11/16/2023 11/16/2023 11/16/2023

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K 321	Continued From page 21 positively latch upon release from the fully open position in the service wing. 5. The 60-minute fire rated door to the laundry room did not self-close and positively latch upon release from the fully open position in the service wing. 6. West wing janitor closet had a sprinkler pipe that penetrated the wall and no fire stopping material was present or system provided to maintain the 1 hour wall. These findings were verified by the Director of Environmental Services and a maintenance assistant and facility administrator at the time of observations and exit interview on 10/31/23.	K 321	6. West wing janitor closet sprinkler pipe penetration has been corrected with the proper fire stopping material. No residents were harmed by the identified deficient practice Further areas of concern were not and have not been identified related to penetrations and doors. As a new building that was recently commissioned, the construction management company has developed a plan of correction for all areas of concern. These identified areas of concerned are warranty items. The Maintenance Director and/or designee will document inspections of these areas monthly x 3 months upon completion of scope of work. Results of inspections will be reported to the facility Safety Committee monthly x 3 months.	11/16/2023
K 351 SS=D	Sprinkler System - Installation CFR(s): NFPA 101 Sprinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems.	K 351		

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K 351	Continued From page 22 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain sprinkler system in accordance with with NFPA 13, Standard for the Installation of Sprinkler Systems, 2010 Edition and NFPA 101, Life Safety Code, 2012 Edition, Section 18.3.5.1. Findings: Observation(s) and Interview(s), and document review during a facility tour on 10/31/23 between 10:00 AM and 2:00 PM with the Director of Environmental Services and a maintenance assistant, the following was found: 1. No documentation could be provided to indicate that CPVC sprinkler piping located in West wing janitor closet and in West wing storage room was permitted to be exposed and not covered. These findings were verified by the Director of Environmental Services and a maintenance assistant and facility administrator at the time of observations and exit interview on 10/31/23.	K 351	K351 Documentation to permit exposed CPVC sprinkler piping in West Wing Janitor closet was not available at time of survey. No residents were harmed by the identified deficient Practice. Further areas of concern were not and have not been identified related to exposed piping. Documentation of permissible exposure of CPUC piping has been obtained and is included with this plan of correction. The Maintenance Director and/or designee will document inspections of these areas monthly x 3 months upon Results of inspections will be reported to the facility Safety Committee monthly x 3 months.	11/16/2023
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	K 353		

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(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 353	Continued From page 23 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 interview, the facility failed to maintain sprinkler system in accordance with with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. and NFPA 101, Life Safety Code, 2012 Edition, Section 9.7.5, 9.7.7, 9.7.8, and NFPA 25. Findings: Observation(s) and Interview(s), and document review during a facility tour on 10/31/23 between 10:00 AM and 2:00 PM with the Director of Environmental Services and a maintenance assistant, the following was found: 1. West wing storage room had a painted sprinkler head that could cause improper sprinkler pattern development. These findings were verified by the Director of	K 353	K353 A painted sprinkler head was located in West Wing Storage room at time of inspection. Further areas of concern were not and have not been identified related to painted sprinkler heads. No residents were harmed by the identified deficient practice The sprinkler head has been replaced. Attestation has been included with this plan of correction. The Maintenance Director and/or designee will document inspections of these areas monthly x 3 months upon completion of scope of work. Results of inspections will be reported to the facility Safety Committee monthly x 3 months.	11/16/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205124	A. BUILDING 01 _____ B. WING _____	10/31/2023

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K 353	Continued From page 24 Environmental Services and a maintenance assistant and facility administrator at the time of observations and exit interview on 10/31/23.	K 353		
K 355 SS=C	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the long-term care facility failed to ensure that the portable fire extinguishers are inspected manually at least once per calendar month in addition to the annual maintenance per NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition, Section 7.2.1.2., and NFPA 101, Life Safety Code, 2012 edition, Section 18.3.5.12. Finding: On 10/31/2023 between 10:00 AM and 2:00 PM, a surveyor, with the Maintenance Director present, observed the following: 1. The facility opened in July and there were no monthly inspections documented on the attached tag or is a separate log for the months of July, and August on the portable fire extinguishers. The surveyor confirmed this finding with the Environmental Services Director at the time of the observation.	K 355	K355 Fire Extinguisher inspections were not completed in July and August of 2023. No residents were harmed by the identified deficient practice 10/31/2023 Fire Extinguisher monthly inspections are currently in compliance for the most recent completed months (September and October). The Maintenance Director and/or designee will continue to inspect the fire extinguishers monthly in accordance with regulations. ongoing Reports of compliance and concerns will be reported to the facility Safety Committee monthly x 3 months.	
K 363	Corridor - Doors	K 363		

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K 363 SS=D	Continued From page 25 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 protection ratings, automatics closing devices,	K 363	K363 Multiple self-closing doors were propped open at time of inspection. Corrections were made immediately upon discovery, staff were notified of non-compliance. 1.Therapy gym self closing door was no longer propped open upon discovery at time of survey. 2.Tel/Exam room self closing door was no longer propped open upon discovery at time of survey. 3. East Wing storage room door across from room 105 was no longer propped open upon discovery at time of surve 4.Salon self-closing door was no longer propped open upon discovery at time of survey. 5. The facility's general contractor (Allied Cook) has assessed room 322 for the ½ inch gap between door and frame on 11/16/2023. An update with proposed solution is forth-coming on date plan of correction is due. 6.Resident room doors 101 and 103 have been corrected and now positively latch. No residents were harmed by the identified deficient practice Staff has received education that propping open self-closing doors is a violation of the Life Safety Code. The Maintenance Director and/or designee will continue check For compliance as part of routine inspection program. Reports of compliance and concerns will be reported to the facility Safety Committee monthly x 3 months.	10/31/2023 10/31/2023 10/31/2023 10/31/2023 11/20/2023 11/16/2023 11/20/2023 ongoing

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 363	Continued From page 26 etc. This REQUIREMENT is not met as evidenced by: Based on observation and interview, during a facility tour, the facility failed to ensure that smoke doors were maintained in accordance with NFPA 101, Life Safety Code. 2012 edition Section 18.3.6.3. This deficient practice could affect the patients/residents, visitors, and members of facility staff in this location(s). These deficient practices have the potential of allowing the passage of smoke and/or fire from the hazardous area(s) into adjacent areas. Findings include: Observation(s) and Interview(s), during a facility tour on 10/31/23 between 10:00 AM and 2:00 PM with the Director of Environmental Services and a maintenance assistant, the following was found: 1. Therapy gym self closing door was propped open with a box. 2. Tel/exam room self closing door in east wing was propped open with a chair. 3. Storage room self closing door in east wing, located across from Room # 105, was propped open with boxes. 4. Salon self closing door was propped open with a chair. 5. Resident room # 322 had a gap over 1/2" between the door and frame (top half of the door/frame) and would not prevent the passage of smoke.	K 363		

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K 363	Continued From page 27 6. Resident rooms 101 and 103 in the East Wing did not latch when pulled closed. These findings were verified by the Director of Environmental Services and a maintenance assistant and facility administrator at the time of observations and exit interview on 10/31/23.	K 363		
K 511 SS=D	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the long-term care facility was drying mops and rags in the dryer, which is prohibited per NFPA 101, Life Safety Code, 2012 Edition, Sections 18.5.1.1, 9.1.1, 9.1.2 Finding: On 10/31/2023, between 10:00 AM and 2:00 PM, a surveyor, with the Maintenance Director present, observed the following: 1. The facility is drying mop heads and cleaning rags in the dryer after washing them despite the	K 511		

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K 511	Continued From page 28 warning labels directing otherwise on the appliance. The surveyor confirmed this finding with the Environmental Services Director at the time of the observation.	K 511		
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 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 observations, interview and records review the facility failed to ensure that combustible decorations were in accordance with NFPA 101: Life Safety Code, 2012 edition, 18.7.5.1, 18.3.5.11 Findings: Observation(s) and Interview(s),\ during a facility tour on 10/31/23 between 10:00 AM and 2:00 PM with the Director of Environmental Services and a maintenance assistant, the following was found: 1. No documentation could be provided to indicate that draperies located throughout all	K 751	K751 Documentation of flame retardant certification for corridor and common area draperies was obtained the day after inspection and provided to the Fire Marshall's office on 11/4/2023 and with this plan of correction. No residents were harmed by the identified deficient practi Further areas of concern were not identified during or following inspection. Families and staff will be educated on this requirement. The Maintenance Director and/or designee will assure flame retardant treatment or certification of flammable decorations at all times. Reports of compliance and concerns will be reported to the facility Safety Committee monthly x 3 months.	11/17/2023 ongoing

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K 753	Continued From page 30 tour on 10/31/23 between 10:00 AM and 2:00 PM with the Director of Environmental Services and a maintenance assistant, the following was found: 1. No documentation could be provided to indicate that decorations were flame retardant or had been treated with approved spray product. These findings were verified by the Director of Environmental Services and a maintenance assistant and facility administrator at the time of observations and exit interview on 10/31/23.	K 753		
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 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	K 918		

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K 751	Continued From page 29 corridors were flame retardant or had been treated with approved spray product. These findings were verified by the Director of Environmental Services and a maintenance assistant and facility administrator at the time of observations and exit interview on 10/31/23.	K 751		
K 753 SS=D	Combustible Decorations CFR(s): NFPA 101 Combustible Decorations Combustible decorations shall be prohibited unless one of the following is met: o Flame retardant or treated with approved fire-retardant coating that is listed and labeled for product. o Decorations meet NFPA 701. o Decorations exhibit heat release less than 100 kilowatts in accordance with NFPA 289. o 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). o 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 This REQUIREMENT is not met as evidenced by: Based on observations, interview and records review the facility failed to ensure that combustible decorations were in accordance with NFPA 101: Life Safety Code, 2012 edition, 18.7.5.6 Findings: Observation(s) and Interview(s),\ during a facility	K 753	K753 Decorations without flame retardant treatment or certification were removed at time of inspection. No residents were harmed by the identified deficient practice Further areas of concern were not identified during or following inspection. Families and staff will be educated on this requirement. The Maintenance Director and/or designee will assure flame retardant treatment or certification of flammable decorations at all times. Reports of compliance and concerns will be reported to the facility Safety Committee monthly x 3 months.	10/31/2023 ongoing

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K 918	Continued From page 31 components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the long-term care facility failed to provide the required documentation to indicate weekly and monthly generator testing per NFPA 110, Standard for Emergency and Standby Power Systems, 2010 Edition, Section 8.4.1 and NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.4.4.1.1.3. Findings: On 10/31/2023, between 10:00 AM and 2:00 PM, a surveyor, with the Maintenance Director present, observed the following: 1. Documentation could not be provided to indicate weekly inspections since the opening of the facility in July of 2023. 2. The only monthly load test documented was in October of 2023, no monthly load testing was documented for July, August, or September 2023. The surveyor confirmed these findings with the Environmental Services Director at the time of the observation.	K 918	K918 10/31/2023 Generator testing was not completed in July and August of 2023. Weekly and monthly generator testing are currently in compliance for the most recent completed months (September and October). No residents were harmed by the identified deficient practice The Maintenance Director and/or designee will continue to carry out and document weekly and full load monthly generator testing as required. Reports of compliance and concerns will be reported to the facility Safety Committee monthly x 3 months.	ongoing

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K 753	Continued From page 30 tour on 10/31/23 between 10:00 AM and 2:00 PM with the Director of Environmental Services and a maintenance assistant, the following was found: 1. No documentation could be provided to indicate that decorations were flame retardant or had been treated with approved spray product. These findings were verified by the Director of Environmental Services and a maintenance assistant and facility administrator at the time of observations and exit interview on 10/31/23.	K 753		
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 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	K 918		

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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 facility failed to maintain electrical system/components in accordance with NAPA 101 Life Safety Code 2012 section 18.5.1 and NFPA 70 The National Electrical Code section 126-A1 Findings: Observation(s) and Interview(s), during a facility tour on 10/31/23 between 10:00 AM and 2:00 PM with the Director of Environmental Services and a maintenance assistant, the following was found: 1. Tel/Com room in east wing had storage within 3' of electrical panel and which did not allow access to the panels. These findings were verified by the Director of Environmental Services and a maintenance assistant and facility administrator at the time of observations and exit interview on 10/31/23.	K 919	K919 10/31/2023 Items stored in the East Wing electrical room were removed upon conclusion of inspection. Additional electrical rooms were not found to contain storage at time of inspection. No residents were harmed by the identified deficient practice Only Maintenance and Administration have access to this room via access card system. The Maintenance Director and/or designee will assure electrical rooms remain free of storage in accordance with regulation requirements. ongoing Reports of compliance and concerns will be reported to the facility Safety Committee monthly x 3 months.	
K 923 SS=F	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet	K 923		

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K 923	Continued From page 33 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: Based on observation, and interview, the long-term care facility failed to maintain Gas Equipment - cylinder and Container Storage room	K 923		

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KNOX CENTER FOR LONG TERM CARE	6 WHITE STREET ROCKLAND, ME 04841

(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 923	Continued From page 34 per NFPA 99 Healthcare Facilities, Code 2012 Edition, Sections 11.3.2.1, 11.3.2.3, 11.3.4, 11.6.5 On 10/31/2023, between 10:00 AM and 2:00 PM, a surveyor, with the Maintenance Director present, observed the following: Findings: 1. Oxygen storage closet located on the East wing has greater than 300 cubic feet stored inside. Observation at time of inspection was 27 E cylinders, each containing 24 cubic feet (648 cubic feet of oxygen total) stored in closet. The combustible flooring tiles and baseboard was within 5 feet of the cylinders. 2. Empty oxygen cylinders were not segregated from full ones in the oxygen storage room. 3. Signage on the cylinders was not present to distinguish full cylinders from empty cylinders in a rapid manner. 4. A precautionary sign, readable from 5 feet away, was not displayed on the door of the storage room. The surveyor confirmed these findings with the Environmental Services Director at the time of the observation.	K 923	K923 Oxygen tanks have been separated from full and empty. Full tanks have been tagged as such. The Oxygen storage room has a display sign legible from 5 feet distance. No residents were harmed by the identified deficient practice There are no additional oxygen storage rooms. Staff have been educated on the proper storage of O2 tanks relating to cubic feet provided in facility O2 closet. The Maintenance Director/Designee will inspect the Oxygen storage room daily x 30 days and monthly x 3 months for compliance.	11/1/2023 11/20/2023 ongoing

Schneider Textile Finishing, Inc.
10537 King William Dr
Dallas, TX 75220
(214) 638-6511

SCHNEIDER

INVOICE

BILL TO	SHIP TO	
Gamache & Lessard Co., Inc. 995 Center Street Auburn, ME 04210	Gamache & Lessard Co., Inc. 995 Center Street Auburn, ME 04210	**INVOICE #** 32475 **DATE** 07/12/2023 **TERMS** Net 10

SHIP DATE	SHIP VIA	TRACKING NO.	PURCHASE ORDER NUMBER
07/12/2023	UPS	1Z8878E10395675872	01112023

DESCRIPTION	QTY	RATE	AMOUNT
Flame Retardant 701 Vance Vapor (Double Wide)	57	4.25	242.25

S/M: Breakwater

SUBTOTAL	242.25
TAX	0.00
SHIPPING	129.47
TOTAL	371.72
BALANCE DUE	**$371.72**

Certificate Of Flame Retardancy

This is to certify the following fabric(s) have
been treated with flame retardant chemicals.

pattern	color	yardage
Vance	Vapor	57

Meets: NFPA 701 Specifications

S/M: Breakwater

Customer **Gamache & Lessard Co., Inc.** **PO #01112023**

SCHNEIDER
TEXTILE FINISHING

P.O. Box 851711
Richardson, TX 75085
(214) 638-6511

date 7/12/23

number 32475

signed

RECEIVED
NOV 18 2023
BY: