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

PRINTED: 03/14/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205076	A. BUILDING 01 B. WING	03/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARKET SQUARE HEALTH CARE CENTER, LLC	3 MARKET SQUARE SOUTH PARIS, ME 04281

(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: 03.04.2025 Market Square Health Care, a long-term care facility, is in substantial compliance with 42 Code of Federal Regulations Part 483.73 Requirement for Long Term Care Facilities for Emergency Preparedness.	E 000		
K 000	INITIAL COMMENTS Federal Recertification Survey: Date: 03/04/2025 Market Square Health Care Center, a Long Term Care Facility, was surveyed to the National Fire Protection Association 101 Life Safety Code 2012 Edition as reference on 42 CFR 483.90 (a-d) physical environment and 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 based on the applicable occupancy chapters.	K 133		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Administrator 4/2/25

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

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K 133	Continued From page 1 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 penetrations and wall construction requirements of the 2-hour separation walls for inspection per NFPA 101, Life Safety Code, 2012 Edition, Sections 8.2.1.3., and 19.1.3.5. Finding: On 03.04.2025, between 9:30 AM and 4:00 PM, a surveyor, with the environmental services director and administrator present on 03.04.2025 from 09:30 AM to 4:00 PM identified: 1. During the facility tour the inspection team was unable to effectively inspect the two-hour fire rated separating wall between residential care, and the long-term care facilities. Surveyors were unable to determine 2-hour fire wall location and orientation using the life safety drawings the facility provided. The life safety drawings did not contain a wall detail or description of how the fire wall was constructed and several areas inspected were questionable if they would meet the required 2 hour wall construction requirements. The inspectors were unable to completely inspect the wall from start to termination of the wall. 2. The 2-hour rated fire barrier above the ceiling between Residential care and Long-term Care a 2" round hole on the West Wing Side above the cross corridor doors. This finding was verified by the environmental services director and administrator at the time of	K 133		

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K 133	Continued From page 2 interview and document review on 03.04.2025 from 09:30 AM to 4:00 PM.	K 133		
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 evidericed by: Based on observation and interview, the long-term care facility failed to maintain the Exit Corridor required width in 2 of 3 egress corridors per NFPA 101, Life Safety Code, 2012 Edition, Sections 18.2.1, 19.2.1, 7.1.10.1 Findings: On 03.04.2025, between 9:30 AM and 4:00 PM, a surveyor, with the environmental services director and administrator present on 03.04.2025 from 09:30 AM to 4:00 PM identified: 1. The basement egress corridor had (2) 64 gallon wheeled carts with cardboard stored in the hallway. This deficient practice could effect staff from proper egress in the event of an emergency. 2. IT cabinet and paint cans were stored in the egress corridor outside the locker room. This deficient practice could effect residents, guest and staff from proper egress in the event of an emergency.	K 211		

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K 211	Continued From page 3 These findings were verified by the environmental services director and administrator at the time of interview and document review on 03.04.2025 from 09:30 AM to 4:00 PM.	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 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	K 222		

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K 222	Continued From page 4 and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout 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 Observations the facility failed to ensure doors at the means of egress meet the requirement of NFPA 101 life safety code 2012 edition 7.2.1.6.1 for requirements for delayed egress. 7.2.1.4.5.1 in 2 of the 5 egress doors. Findings: On 03.04.2025, between 9:30 AM and 4:00 PM,	K 222		

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K 222	Continued From page 5 surveyor, with the environmental services director and administrator present on 03.04.2025 from 09:30 AM to 4:00 PM identified: 1. Res Care exit doors and Activities Room are equipped with delayed egress and not signed. 7.2.1.6.1.1 Approved, listed, delayed-egress locking systems shall be permitted to be installed on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6 or an approved, supervised automatic sprinkler system in accordance with Section 9.7, A readily visible, durable sign in letters not less than 1 in. (25 mm) high and not less than 1/8 in. (3.2 mm) in stroke width on a contrasting background that reads as follows shall be located on the door leaf adjacent to the release device in the direction of egress: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS. This deficient practice could effect residents, guest and staff from proper egress in the event of an emergency. 2. The egress door located outside the locker room required greater than 30 lbf to set the leaf in motion. This deficient practice could effect residents, guest and staff from proper egress in the event of an emergency. These findings were verified by the environmental services director and administrator at the time of interview and document review on 03.04.2025 from 09:30 AM to 4:00 PM.	K 222		
K 223 SS=D	Doors with Self-Closing Devices CFR(s): NFPA 101	K 223		

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K 223	Continued From page 6 Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to ensure that doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of required manual fire alarm system, and local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and automatic sprinkler system, if installed; and loss of power per the requirements of NFPA 101 2012 edition. In 1 of 3 smoke compartments. Findings: On 03/04/2025 between hours of 9:30 am and 4:00 pm. this surveyor accompanied with Enviromental Services Director and the	K 223		

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K 223	Continued From page 7 Administrator did observe the following: 1. The elevator room door, adjacent to the maintenance room, had a kick down door stop located at the bottom of the interior latch side of the door. The door stop prevents the fire rated door from self closing and self latching. The surveyor confirmed this finding with the Maintenance Director and the Administrator at the time of the observation.	K 223		
K 291 SS=D	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on observation, document review and interview the facility failed to conduct operational emergency light testing in accordance with NFPA 101, Life Safety Code, 2012 edition, sections 19.2.9.1, and 7.9.3.1.1(3). Finding: Observations, document review and Interviews during a facility tour with the Administrator and Enviromental Serivices Director present on 03/04/2025 from 9:30 AM to 4:00PM identified: 1) The emergency light test log did not indicate that the required 90 minute tests have been conducted within the last 12 months. The maintenance staff member, who conducts the	K 291		

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K 291	Continued From page 8 tests, stated that he did not know that the 90 minute test needed to be concuted annually. This finding was verified by the Administrator and the Enviromental Services Director at the time of observations and interview on 03/04/2025 from 9:30AM to 4:00PM.	K 291		
K 293 SS=D	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observations and interview with the Administrator, and EVS Manager the facility failed to meet the requirements of the National Fire Protection Association (NFPA) 101, Life Safety Code, 2012 edition for exit and directional signs that are displayed in accordance with 7.10, 19.2.10.1, 19.2.10.2,19.2.10.3, and 19.2.10.4. In 2 of 3 smoke compartments. Findings: Observations and Interviews, of exits signage during a facility tour on 03.04.2025 between 9:30 AM and 4:00 PM with the environmental services director and administrator present on 03.04.2025 from 09:30 AM to 4:00 PM identified: 1. The area of the Activities Room requires exit	K 293		

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K 293	Continued From page 9 signage outside Patient Room 38 on Activities Room side of the cross corridor doors displaying the proper egress out. 2. The area of the Res Care front desk area requires exit signage with directional displaying the proper egress out for the Residential Care and Activities Room corridors. 3. The cross corridor doors separating Residential-Care and West Wing requires exit signage displaying the proper egress out. This deficient practice could affect the occupants, visitors and staff while trying to exit the building under reduced visibility of the exit areas. These findings were verified by the environmental services director and administrator at the time of interview and document review on 03.04.2025 from 09:30 AM to 4:00 PM.	K 293		
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	K 321		

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K 321	Continued From page 10 hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation, the 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. In 1 of 3 smoke compartments. Findings: On 03.04.2025, between 9:00 AM and 4:00 PM, a surveyor, with the environmental services director and administrator present on 03.04.2025 from 09:30 AM to 4:00 PM identified: 1. The elevator room had penetrations around piping through ceiling and wall.	K 321		

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K 321	Continued From page 11 2. The boiler room had penetrations in ceiling around 3 pipes. This finding was verified by the environmental services director and administrator at the time of interview and document review on 03.04.2025 from 09:30 AM to 4:00 PM.	K 321		
K 331 SS=D	Interior Wall and Ceiling Finish CFR(s): NFPA 101 Interior Wall and Ceiling Finish 2012 EXISTING Interior wall and ceiling finishes, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and have a flame spread rating of Class A or Class B. The reduction in class of interior finish for a sprinkler system as prescribed in 10.2.8.1 is permitted. 10.2, 19.3.3.1, 19.3.3.2 Indicate flame spread rating(s). This REQUIREMENT is not met as evidenced by: Based on observation and interview, the long-term care facility failed to maintain the interior wall and ceiling finishes, including exposed interior surface per NFPA 101, Life Safety Code, 2012 Edition, Sections 19.3.3.1, 19.3.3.2 Finding: On 03.04.2025, between 9:00 AM and 4:00 PM, a surveyor, with the environmental services director and administrator present on 03.04.2025 from	K 331		

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K 331	Continued From page 12 09:30 AM to 4:00 PM identified: 1. The Soiled Utility Room across from the Res Care front desk had a 12"x12" penetration in the wall around sink piping. 2. The Sprinkler Room off the Activities Room had exposed wooden studs and no interior walls. 3. The Compressor Room had yellow spray foam around refrigeration piping. This finding was verified by the environmental services director and administrator at the time of interview and document review on 03.04.2025 from 09:30 AM to 4:00 PM.	K 331		
K 351 SS=D	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler 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. 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)	K 351		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205076	A. BUILDING 01 B. WING	03/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARKET SQUARE HEALTH CARE CENTER, LLC	3 MARKET SQUARE SOUTH PARIS, ME 04281

(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 351	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the long-term care facility failed to install the water-based fire protection system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, 2010 edition, Section 6.2.9.7., 8.5.7 as referenced by NFPA 101, Life Safety Code, 2012 edition, Section 19.3.5. This deficient practice could affect the response of the facility, and the sprinkler in case of activation of the sprinkler system. Finding: On 03.04.2025, between 09:30 AM and 4:00 PM, a surveyor with the environmental services director and administrator present on 03.04.2025 from 09:30 AM to 4:00 PM identified: 1. A list of the spare sprinklers shall be posted in the sprinkler cabinet that includes the Sprinkler Identification Number, General description, Quantity of each type to be contained in the cabinet, and issue or revision date of the list. 2. The Sprinkler Room off the activities room had numerous ceiling tiles missing. 3. The Soiled Utility Room across from Patient Room 15 had ceiling tiles missing. 4. The Kitchenette in the Res Care wing had a ceiling tile missing above the coffee machine. This finding was verified by the environmental services director and administrator at the time of interview and document review on 03.04.2025 from 09:00 AM to 4:00 PM.	K 351		

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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 interview, the long-term care facility failed to maintain the water-based fire protection system piping free of external loads in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 edition, Section 5.2.2.2. and Section 5.2.1.1.1 as referenced by NFPA 101, Life Safety Code, 2012 edition, Section 19.3.5.1 and 9.7.5. This deficient practice could affect the facility, and the sprinkler in case of activation of the sprinkler system. Findings: On 03.04.2025, between 09:30 AM and 4:00 PM,	K 353		

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K 353	Continued From page 15 a surveyor with the environmental services director and administrator present on 03.04.2025 from 09:30 AM to 4:00 PM identified: 1. Sprinkler piping shall not be subjected to external loads by materials either resting on the pipe or hung from the pipe. The sprinkler piping has cord ziptied to the pipe and hangers in the maintenance room. 2. Sprinkler piping shall not be subjected to external loads by materials either resting on the pipe or hung from the pipe. The sprinkler piping has a braided steel hose on the pipe in the generator shed. 3. A sprinkler head located in the laundry room above the dryers had paint on the deflector. These findings were verified by the environmental services director and administrator at the time of interview and document review on 03.04.2025 from 09:30 AM to 4:00 PM.	K 353		
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	K 363		

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K 363	Continued From page 16 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, etc. This REQUIREMENT is not met as evidenced by: Based on observation, 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 Findings: Observation and interview during a facility tour with the environmental services director and administrator present on 03.04.2025 from 09:30 AM to 4:00 PM identified:	K 363		

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K 363	Continued From page 17 1. Patient Room 28 latch side has a 1/2-inch gap on the latch side of the door that allows light through and does not resist the passage of smoke. 2. Patient Room 47 latch side has a 1/2-inch gap on the latch side of the door that allows light through and does not resist the passage of smoke. 3. Biohazard Room across from Front desk in Res Care wing has hollow core door. The door is required to be 1-3/4 in. thick, solid-bonded core wood or material that resists fire for a minimum of 20 minutes and resist the passage of smoke. 4. West wing corridor door across from Patient Room 30 latch side has a 1/2-inch gap on the latch side of the door that allows light through and does not resist the passage of smoke. These findings were verified by the environmental services director and administrator at the time of interview and document review on 03.04.2025 from 09:00 AM to 4:00 PM.	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	K 511		

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K 511	Continued From page 18 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, 19.5.1.1, 9.1.1, 9.1.2 Finding: On 03.04.2025, between 9:00 AM and 4:00 PM, a surveyor, with the environmental services director and administrator present on 03.04.2025 from 09:30 AM to 4:00 PM identified: 1. The facility was drying rags in the dryer after washing them, This deficient practice could effect residents, guest and staff if this practice lead to the rags or mops catching fire while in the dryer. This finding was verified by the environmental services director and administrator at the time of interview and document review on 03.04.2025 from 09:30 AM to 4:00 PM.	K 511		
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of	K 712		

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K 712	Continued From page 19 established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on observation, document review and interview, the long-term care facility failed to ensure that fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift per NFPA 101, Life Safety Code, 2012 Edition, Section 19.7.1.4 through 19.7.1.7 Findings: On 03/04/2025, between 9:30 AM and 4:00 PM, the surveyor, with the Enviromental Services Director and Adminsitrator present, observed the following: 1. The facility failed to conduct the proper number of fire drills during the previous 12 months. The second shift only conducted fire drills in second quarter of 2024 and first quarter of 2025. Third shift fire drills were not completed to the facilities emergency plan. In interviewing the staff member who conducts the thrid shift drills, he stated that silent drills did not use coded annoucements and that the staff would just gather around and discuss the procedures but don't actually go through the montions. 2. According to the Adminstrator, the emergency action plan does not direct staff to remove wheeled equipemnt out of the egress corridor. The surveyor confirmed this finding with the	K 712		

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K 712	Continued From page 20 Enviromental Service Director and Administrator at the time of the observation.	K 712		
K 741 SS=D	Smoking Regulations CFR(s): NFPA 101 Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 This REQUIREMENT is not met as evidenced by: Based on observation, documentation review and interview the facility failed to maintain compliance with the facility's smoking policy was enforced in accordance with NFPA 101, Life	K 741		

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K 741	Continued From page 21 Safety Code, 2012 edition, Section 19.7.4 Finding: Observation, documentation review and interview during a facility tour on 03.04.2025, between 9:00 AM and 4:00 PM, a surveyor, with the environmental services director and administrator present on 03.04.2025 from 09:30 AM to 4:00 PM identified: 1. Observed a female resident in the smoking area seated in a wheelchair smoking a cigarette with a D size oxygen cylinder attached to the wheelchair. The oxygen tank was within the 20 foot designated smoking area. The facility policy states there shall be no smoking allowed with 20 feet of any oxygen use. The Administrator stated she has had discussions with the resident in the past and she continues this behavior. The facilities smoking policy indicates that any resident found to not follow the policy would be restricted to possessing smoking materials and this was not followed. This finding was verified by the environmental services director and administrator at the time of interview and document review on 03.04.2025 from 09:30 AM to 4:00 PM.	K 741		
K 753 SS=C	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.	K 753		

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K 753	Continued From page 22 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 observation, the health care facility 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. In 1 of 3 smoke compartments. Findings: On 03.04.2025, between 9:30 AM and 4:00 PM, a surveyor, with the environmental services director and administrator present on 03.04.2025 from 09:30 AM to 4:00 PM identified: 1. Patient Room 54 egress corridor side of door has a decorative wreath hung and no evidence	K 753		

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K 753	Continued From page 23 could be provided to show that it had been sprayed with a fire-retardant coating, or that it met the requirements of NFPA 701 (2010) or NFPA 289 (2009). 2. Patient Room 62 egress corridor side of door has a decorative wreath hung and no evidence could be provided to show that it had been sprayed with a fire-retardant coating, or that it met the requirements of NFPA 701 (2010) or NFPA 289 (2009). These findings were verified by the environmental services director and administrator at the time of interview and document review on 03.04.2025 from 09:30 AM to 4:00 PM.	K 753		
K 754 SS=D	Soiled Linen and Trash Containers CFR(s): NFPA 101 Soiled Linen and Trash Containers Soiled linen or trash collection receptacles shall not exceed 32 gallons in capacity. The average density of container capacity in a room or space shall not exceed 0.5 gallons/square feet. A total container capacity of 32 gallons shall not be exceeded within any 64 square feet area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gallons shall be located in a room protected as a hazardous area when not attended. Containers used solely for recycling are permitted to be excluded from the above requirements where each container is less than or equal to 96 gallons unless attended, and containers for combustibles are labeled and listed as meeting FM Approval Standard 6921 or equivalent. 18.7.5.7, 19.7.5.7 This REQUIREMENT is not met as evidenced	K 754		

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K 754	Continued From page 24 by: Based on observation and interview, the long-term care facility failed to maintain mobile soiled linen collection receptacles in room protected as a hazard area in 1 of 8 wings per NFPA 101, Life Safety Code, 2012 Edition, Sections 19.7.5.7 Finding: On 03.04.2025, between 9:00 AM and 4:00 PM, a surveyor, with the environmental services director and administrator present on 03.04.2025 from 09:30 AM to 4:00 PM identified: 1. Outside Patient Room 11, a 32 gallon trash container was stored in exit corridor. This deficient practice could effect residents, guest and staff from proper egress in the event of an emergency. 2. Soiled utility room across from Patient Room 15 is missing a ceiling tile. This finding was verified by the environmental services director and administrator at the time of interview and document review on 03.04.2025 from 09:30 AM to 4:00 PM.	K 754		
K 911 SS=D	Electrical Systems - Other CFR(s): NFPA 101 Electrical Systems - Other List in the REMARKS section any NFPA 99 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.	K 911		

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

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K 911	Continued From page 25 Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the long-term care facility failed to provide and maintain access and working space about all electrical equipment to permit ready and safe operation and maintenace per NFPA 70, National Electric Code, 2011 edition, section 110.26(A), NFPA 99, Health Care Facilities Code, 2012 edition, section 6.3.2.1, and NFPA 101, Life Safety Code, 2012 edition, section 9.1.2. Finding: Based on observation and interview on 3/04/2025, between 09:30 AM and 4:00 AM, the surveyor, with the Enviromental Services Director and the Administrator present, observed the following: 1. In the boiler room, storage was found in front of the electrical panels preventing ready access to the panels. The surveyor confirmed this finding with the Envirmental Services Director and the Administrator at the time of the observation.	K 911		
K 914 SS=D	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not	K 914		

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K 914	Continued From page 26 listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on documentation review and interview the facility, failed to ensure that inspect the retention force of receptacles not listed as hospital-grade are tested at intervals not exceeding 12 months in accordance with NFPA 99, Healthcare Facilities Code, 2012 edition, Section 6.3.3.2.4. Finding: Documentation review and interview during a facility tour with the environmentalservices director and administrator present on 03.04.2025 from 09:30 AM to 4:00 PM identified: 1. The annual testing of the receptacles did not include the retention force of the grounding blade of each electrical receptacle to ensure it is not less than 4 oz. This deficient practice could pose an electrical hazard to all residents, visitors, and members of facility staff in this locations.	K 914		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205076	A. BUILDING 01 B. WING	03/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARKET SQUARE HEALTH CARE CENTER, LLC	3 MARKET SQUARE SOUTH PARIS, ME 04281

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K 914	Continued From page 27 This finding was verified by the environmental services director and administrator at the time of interview and document review on 03.04.2025 from 09:30 AM to 4:00 PM.	K 914		
K 918 SS=D	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 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	K 918		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205076	A. BUILDING 01 B. WING	03/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 918	Continued From page 28 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, and interview, and generator inspection documentation review during the facility tour, the long-term care facility failed to maintain the Essential Electric System Generator per NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, sections 8.3.8, and 8.4.2, and NFPA 99, Healthcare Facilities Code, 2012 edition, section 6.4.4.1.1.3.This deficient practice could affect the patients/residents, visitors, and members of facility staff in this location. Findings: Review of documentation and interview with the Enviromental Services Director and the Administrator present on 03/04/2025 between 9:30 AM and 4:00 PM identified the following deficiencies: 1) The provided generator inspection reports did not show that the generators were tested under the 30% rated load or to the manufactures recommended exhaust tempratures. 2) No documentation showing an annual fuel quality test was provided on the generator testing and maintenance documentation. A fuel quality test shall be performed at least annually using appropriate ASTM standards or the manufacturer ' s recommendations. These findings were verified by the Enviromental Services Director and the Administrator at the	K 918		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205076	A. BUILDING 01 B. WING	03/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARKET SQUARE HEALTH CARE CENTER, LLC	3 MARKET SQUARE SOUTH PARIS, ME 04281

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K 918	Continued From page 29 time of observation on 03/04/2025 between 9:30 AM and 4:00 PM.	K 918		
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the long-term care facility failed to ensure that extension cords are not used as a substitute for fixed wiring of a structure in accordance with NFPA 99 Chapter 10, section 10.2.4, NFPA 70 chapter 4 {400.8(1)}	K 920		

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	205076	A. BUILDING 01 B. WING	03/04/2025

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K 920	Continued From page 30 On 03/04/2025, between 9:30 AM and 4:00 PM, the surveyor with the Enviromental Services Director and Adminstrator present observed the following: 1. In the dining room room an extension cord was observed connected to a "disco ball," on the ceiling. The cord ran across the ceiling which was zipped tied to the suspended ceiling structure. It then ran behind the upper cabinets, to an outlet located above the counter. 2. In the patio area, outside of the dinning room, extension cords were observed in use running through the snow. It was noted that the label on the extension cord stated it was not for use in wet conditions. The surveyor confirmed this finding with the Enviromental Services Director and Adminstrator at the time of the observation.	K 920		

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Market Square Health Care Center
3 Market Square, South Paris, ME 04281 Tel. (207) 743-7086 Fax (207) 743-2395

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

April 2, 2025

Dear Mr. Day,

Please find attached my Plan of Correction related to the Office of Fire Marshal Life Safety Code and Emergency Preparedness Survey conducted at Market Square Health Care Center on March 2, 2025. If you have any questions, please do not hesitate to contact me via phone at (207) 743-7086 or email at tnute@ncaltc.com.

Respectfully Submitted,

Tabatha Nute, MHA, MLA
Administrator
Market Square Health Care Center
3 Market Square
South Paris, ME 04281

Market Square Health Care Center SFMO POC 4/2/35

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K133 Multiple Occupancies

1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice:

1. The life safety drawings were located and contained proper wall orientation and detail.

These will be included with POC.

2. The 2" hole was plugged.

2. How will you identify other residents having the potential to be affected by the same deficient practice, and what corrective action will be taken.

A complete set of life safety drawings was located, which show the proper orientation and wall location of the two-hour separation. This area was inspected to ensure proper construction requirements were met.

3. Indicate how the facility plans to monitor its performance to make sure that the solutions are sustained.

All life safety drawings have been placed in a binder, with one copy located in the maintenance room and the other in the administrator's office. This should alleviate any future issues of presenting them when they are requested.

Audits on fire barriers and location of life safety drawings will be conducted monthly for 3 months. These audits will be incorporated into weekly, monthly, and quarterly QAPI meetings

4. Completion Date: 4/8/25

K211 Means of Egress

1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice:

1a. The (2) 64-gallon wheeled carts were removed from the hallway. Education will be provided to housekeeping, laundry, maintenance, and dietary staff regarding this regulation by April 7, 2025.

2a. The IT Cabinet will be relocated by Retirement Home TV into an enclosed room adjacent to its current location, ensuring it does not interfere with egress.

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2. How will you identify other residents who may be affected by the same deficient practice, and what corrective action will be taken?

2a. All means of egress in the building were checked for obstructions or barriers limiting access to exiting. No other issues were detected, if subsequent issues are identified, objects will be removed.

3. Indicate how the facility plans to monitor its performance to make sure that the solutions are sustained.

Audits will be conducted twice per week for at least 3 months to ensure compliance. Audits will be reviewed at weekly, monthly, and quarterly QAPI meetings to determine if further auditing or action is necessary.

Completion Date: 4/8/25

K222-Egress Doors

1. What corrective action will be accomplished for those residents to have been affected by the deficient practice:

Finding 1: Appropriate signs indicating delayed egress instructions were posted on the Activity Room and Residential Care exit doors.

Finding 2: The door closure device will be adjusted on April 8, 2025.

Education will be provided to the maintenance department on April 3, 2025, regarding this regulation.

2. How will you identify other residents having the potential to be affected by the same practice and what corrective action will be taken:

Finding 1: All egress doors were reviewed for appropriate signage. Signage was updated on all doors for consistency purposes.

Finding 2: The effort needed to open all other egress doors will be reviewed. Any doors that need adjustments to the amount of effort to set the leaf in motion will be adjusted.

3. Indicate how the facility plans to monitor its performance to make sure the solutions are sustained:

Audits will be conducted weekly for three months to assess egress signage and the effort required to initiate egress on doors. Audits will be reviewed at weekly, monthly, and quarterly QAPI meetings to determine if further action or auditing is necessary.

4. Completion Date: 4/10/25

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K223-Doors with Self-Closing Devices

1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice:

The kick-down door stop on the elevator room door adjacent to the maintenance room was removed. Education will be provided to the maintenance department regarding this regulation on March 4, 2025.

2. How will you identify other residents who may be affected by the same deficient practice, and what corrective action will be taken?

All other doors with self-closing devices were checked for door stops or other items that prevent self-closing or self-latching.

None were found.

3. Indicate how the facility plans to monitor its performance to make sure that the solutions are sustained.

Environmental audits were created for monthly review of self-closing and self-latching doors to ensure they do not include items that would prevent proper operation. POC and audits will be reviewed weekly, monthly, and quarterly

QAPI meetings to determine whether further action or auditing is necessary.

Completion Date: 4/4/25

K291 Emergency Lighting

1. What corrective action will be accomplished for those residents found to have been affected by this deficient practice:

90 minute tests will be completed on 4/4/25.

Education will be provided to the maintenance department on 4-3-15 on this regulation.

90-minute tests have been added to the annual checklists. 90-minute tests have been scheduled for the next 12 months to establish a pattern of compliance with this regulation.

2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:

NFPA 101 Life Safety Code 2012 edition sections 19.2.9.1 and 7.9.3.1(3) will be

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reviewed to ensure compliance with the full regulation. If any other areas of noncompliance are discovered, they will be remedied by adding the practice into already existing weekly or monthly tests accordingly.

3. Indicate how you the facility plans to monitor its performance to make sure solutions are sustained.

Audits will be completed monthly x3 months to ensure compliance is sustained. Audits will be reviewed at weekly, monthly, and quarterly QAPI meetings to determine whether further auditing or action is needed.

Completion Date: 4/9/25

K293 Exit Signage

1. What corrective action will be accomplished?

Exit signage was ordered for those three areas and will be placed in the proper places per this regulation.

Education on this regulation will be provided to the maintenance department on 4-3-25.

2. How will you identify other residents having the potential to be affected by the same deficient practice, and what corrective action will be taken:

The building was checked for proper exit signage. No other issues were identified.

3. Indicate how the facility plans to monitor its performance to make sure that the solutions are sustained.

Audits related to emergency exits will be conducted monthly for 3 months to ensure compliance with this regulation. These audits will be reviewed at the weekly, quarterly, and monthly QAPI meetings to determine if further auditing or action is necessary.

Completion Date: 4/15/25

K321 Hazardous Areas Enclosure

1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice.

The elevator room and boiler room penetrations were fixed with fire-rated caulking. Education on this regulation will be provided to the maintenance department on 4-3-25.

2. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:

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Other hazardous areas will be checked to ensure there are no penetrations. If other penetrations exist, they will be fixed.

3. Indicate how the facility plans to monitor its performance to make sure that the solutions are sustained.

Audits will be conducted monthly for a period of three months to ensure compliance. This will be reviewed at weekly, monthly, and quarterly QAPI for 3 months to determine whether further action or auditing is needed.

Completion Date: 4/15/25

K331 Interior Wall and Ceiling Finish

1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice.

Finding 1: The 12x12 penetration in the soiled utility room was fixed with drywall.

Finding 2: The walls in the sprinkler room adjacent to the Activity Room were enclosed with sheetrock over the wooden studs to form full walls.

Finding 3: The spray foam in the compressor room was removed and replaced with proper materials.

Education was provided to the Maintenance Department on this regulation on 4-3-25.

2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:

Interior walls and ceiling finishes will be inspected. Any deficiencies will be immediately remedied.

3. Indicate how the facility plans to monitor its performance to make sure that the solutions are sustained.

Audits will be conducted monthly for a period of three months to ensure compliance. This will be reviewed at weekly, monthly, and quarterly QAPI for 3 months to determine whether further action or auditing is needed.

Date of Completion 4/9/25

K351 Sprinkler System Installation

1. What corrective action will be accomplished for those residents having the potential to be affected by the same deficient process.

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Finding 1: We requested Maine Fire to update the list of spare sprinklers in the sprinkler room to include the Sprinkler Identification Number, general description, and quantity of each time contained in the cabinet. A table was requested for issue and revision date documentation.

Finding 2: The missing tiles in the sprinkler room were replaced.

Finding 3: The missing tiles in the soiled utility room were replaced.

Finding 4. The missing tile in the Res Care kitchenette was replaced.

Education will be provided to the maintenance department on 4-3-25.

2. How will you identify other residents having the potential to be affected by the same deficient practice, and what corrective action will be taken?

Finding 1: A monthly audit of the spare sprinklers will be conducted to determine if compliance is met. If not, the deficient aspects will be remedied.

Findings 2, 3, & 4: An environmental audit of ceiling tiles will be conducted. Missing ones will be replaced.

3. Indicated how the facility plans to monitor its performance to make sure that the solutions are sustained.

Finding 1: Monthly audits of the spare sprinkler storage and list will be conducted. Findings 2, 3, & 4: Weekly ceiling tile audits will be conducted to ensure all are present. These audits will continue for three months, at which time they will be reviewed to determine if further auditing or action is needed.

Completion Date: 4/15/25

K353 Sprinkler System Maintenance and Testing

1. What corrective action will be accomplished for those residents having the potential to be affected by the same deficient process.

Finding 1: The cord on the sprinkler pipe was removed on 3/18/25.

Finding 2: The braided steel hose on the sprinkler pipe was removed on 3/18/25.

Finding 3: The sprinkler head located in the laundry room was replaced by Maine Fire on 3/18/25.

Education will be provided to the Maintenance Department on 4/3/25

2. How will you identify other residents having the potential to be affected by the same deficient practice, and what corrective action will be taken?

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Environmental rounds were conducted on all sprinkler piping in the building to ensure that nothing else was hanging from or attached to the pipes. All sprinkler head deflectors were inspected for paint.

3. Indicated how the facility plans to monitor its performance to make sure that the solutions are sustained.

Audits will be conducted monthly for three months and reviewed at weekly, monthly, and quarterly QAPI meetings to determine if further auditing or action is needed.

Completion Date: 4/15/25

F363-Corridor Doors

1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice:

Doors to patient rooms 28 and 47 were measured for replacement. The door to the biohazard room has been measured for replacement. Door Company has been called for the corridor door on the west wing-if the door cannot be adjusted, it will be replaced. All door replacements will be ordered from exactitude by 4-3-25. Door gap education will be provided to the Maintenance Dept on 4-3-25.

2. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:

The Environmental Services Director will complete NFPA 80 Fire Door training by 4-8-25 and will inspect all doors by 4-12-25. Any doors found to be deficient will be adjusted or replaced.

3. Indicated how the facility plans to monitor its performance to make sure that the solutions are sustained.

Monthly audits will be completed on doors to ensure compliance. Audits will be reviewed at weekly, monthly, and quarterly QAPI meetings to determine if furthering auditing or action is needed.

Completion date: 4/15/25

K511-Utilities-Gas and Electric

1. What corrective action will be accomplished for those residents found to have been affected by this deficient practice:

Procedures were updated to include using drying racks to dry rags-as is currently the practice for mops.

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Education will be provided to all maintenance, housekeeping, and laundry staff on 4-3-25.

2. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:

A review of washing/drying instructions on other housekeeping equipment was conducted. No other deficient practices of this regulation were identified.

3. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.

Audits will be conducted twice weekly for three months to ensure compliance with the washing and drying of housekeeping rags. Audits will be reviewed at weekly, monthly, and quarterly QAPI meetings to determine if further action or auditing is needed.

Completion Date: 4/9/25

F712-Fire Drills

1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice.

Finding 1: All fire drills have been scheduled for the following 12 months. A third-shift procedure has been created to utilize coded drills and follow the proper motions.

Finding 2: The Emergency Action Plan will be updated to direct staff to remove wheeled equipment from the egress corridor. Education on this regulation will be provided to the maintenance department on 4-3-25.

2. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:

Finding 1: All fire drills will be scheduled for the next 12 months to ensure they occur as required.

Finding 2: The EAP will be reviewed for other procedural disciplines. Any missing procedures will be added.

3. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.

Fire drill schedules will be audited monthly for a period of three months. Education on the removal of wheeled equipment from egress corridors will be provided on April 16, 2025. Monthly drills on the procedure will be performed for 3 months. All audits will be reviewed weekly, monthly, and quarterly QAPI to determine if further action or auditing are necessary

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Completion Date: 4/17/25

K741-Smoking Regulations

1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?

All residents who smoke and have oxygen will be required to keep smoking materials in medication carts so that oxygen tanks are removed before residents go outside to smoke.

Education will be provided to all staff on this regulation on April 16, 2025.

2. How will you identify other residents having the potential to be affected by the same deficient practice, and what corrective action will be taken:

An audit was conducted on all residents who smoke. No other residents who smoke also use oxygen at this time. In the event this occurs, those residents will follow the corrections outlined above.

3. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.

Weekly audits of residents who smoke and the smoking policy will be conducted over three months. These audits will be reviewed at weekly, monthly, and quarterly QAPI meetings to determine if further auditing or action is needed.

Completion Date: 4/17/25

K753 Combustible Decorations

1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice:

The decorations on these rooms were removed. Procedures were implemented for the use of a fire-retardant spray for all decorations and a log of sprayed materials was created.

Education will be provided to staff on 4-16-25 and residents on 4-7-25.

2. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken.

A facility-wide inspection will be conducted on April 4, 2025. Any decorations that have not been sprayed with a fire-retardant coating will be removed or sprayed and logged.

3. Indicate how the facility plans to monitor its performance to ensure that solutions are sustained.

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A QAPI project will be implemented following this regulation. Weekly audits will be conducted for 3 months. Audits will be reviewed at weekly, monthly, and quarterly QAPI meetings to determine if further action or auditing is necessary.

Completion Date: 4/17/25

K 754 Soiled Linen and Trash Containers

1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice.

Finding 1: The 32-gallon trash can stored outside room 11 was removed.

Finding 2: The ceiling tile in the soiled utility room across from patient room 15 was replaced.

2. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.

An Environmental inspection will be conducted on 4-7-25 and any deficiencies discovered will be remedied in the same manner as listed above.

3. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.

Audits will be conducted on egress corridors and ceiling tiles weekly for three months. Audits will be reviewed at weekly, monthly, and quarterly QAPI meetings to determine if further action or auditing is necessary.

Completion Date 4/8/25

K911 Electrical Systems-Other

1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice:

The storage in front of the electrical panels was removed.

Education will be provided to the maintenance department on 4/3/25 on this regulation.

2. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:

All electrical panels were inspected to ensure no storage was present. In the event any is found in the future, it will be immediately removed.

3. How the facility plans to monitor its performance to make sure that solutions are sustained.

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A QAPI project was implemented on this regulation. Audits will be conducted twice a week for three months. Audits will be reviewed on a weekly, monthly, and quarterly basis through the QAPI to determine if further action or auditing is needed.

Completion Date: 4/7/25

K914 Electrical Systems-Maintenance and Testing

1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice:

The annual testing on receptacles will be completed by 4/5/25.

Education will be provided to the maintenance department on 4/3/25.

2. How will you identify other residents who may be affected by the same deficient practice, and what corrective action will be taken?

Other annual electrical systems will be reviewed for compliance. Any testing that has not been completed within 12 months will be completed by 4/15/25.

3. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.

Annual electrical systems auditing will be audited monthly for the next three months. These audits will be reviewed at weekly, monthly, and quarterly QAPI meetings to determine if further action or auditing is needed.

Completion date: 4/15/25

K918 Electrical Systems

1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice.

Finding 1. The generator has been tested under the 30% rated load tests. These tests have been scheduled monthly for the next 12 months.

Finding 2: CN Brown will provide the fuel testing information by April 16, 2025. Education will be provided to the maintenance department on 4/3/25 regarding this regulation.

Education will be provided to the maintenance department on 4/3/25.

2. How will you identify other residents having the potential to be affected by the same deficient practice, and what corrective action will be taken:

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All activity related to the generators will be reviewed for compliance with this regulation. Any further infractions will be remedied as described above.

3. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.

Generator testing regulations will be audited monthly for three months to determine if compliance has been met. After 3 months, audits will be reviewed at the quarterly QAPI meeting to determine if further auditing or action is necessary.

Date of Completion: 4/17/25

K920 Electrical Equipment-Power Cords and Extension Cords.

1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice:

The disco ball and extension cord were removed from the dining room. The extension cords were removed from the patio area.

Education will be provided to Maintenance, Activities, and Managerial

staff on this regulation on 4-3-25.

2. How you will identify other residents having been affected by the same deficient practice and what corrective action will be taken.

An environmental inspection of the facility occurred on 3-20-25. No other extension cords were found. If extension cords are found on future inspections, they will be removed per this regulation.

3. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.

Weekly environmental inspections will occur for the next 3 months. After 3 months, the results of these inspections will be reviewed at the quarterly QAPI meeting to determine if further action or auditing is needed.

Completion Date: 4/10/25