Cummings, Joanne

From: Cummings, Joanne
Sent: Friday, September 22, 2023 8:26 AM
To: beth.berands@genesishcc.com
Cc: Peaslee, Ronald J; Day, Gregory J
Subject: 205072 Marshwood Center SOFD
Attachments: 205072 Marshwood Center SOFD.pdf

Good Morning Administrator Berands,

On September 19, 2023, your facility was found not to be in substantial compliance with the participation requirements for Life Safety Code and Emergency Preparedness.

Please see the attached Statement of Deficiencies, you must also sign, date and affix your signature.

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

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

Joanne Cummings
Office Associate II
Maine Fire Marshal's Office
State House Station 52
45 Commerce Drive
Augusta, ME 04333-0052
O (207) 626-3882
F (207) 287-6251

State of Maine
Department of Public Safety
Office of Fire Marshal
52 State House Station
Augusta, ME 04333-0052

JANET T. MILLS
GOVERNOR

MICHAEL SAUSCHUCK
COMMISIONER

RICHARD MCCARTHY
STATE FIRE MARSHAL

September 22, 2023

Marshwood Center
Attn: Beth Berands, Administrator
33 Roger Street
Lewiston, ME 04240

Provider ID#: 205072
Facility ID#: 0108
Event ID#: AP0521

Administrator Berands,

On **September 19, 2023**, the Office of the Fire Marshal conducted a Life Safety Code and Emergency Preparedness survey to determine if your facility complies with Federal participation requirements for nursing facilities in the Medicare and/or Medicaid program (In which you will be receiving a Form CMS-2567 for Life Safety Code and Emergency Preparedness). Your facility was found not to be in substantial compliance with the participation requirements for Life Safety Code and Emergency Preparedness.

The Federal regulatory requirements referenced in this letter are found in Title 42, Code of Federal Regulations (CFR) and in the National Fire Protection Association (NFPA)101 Life Safety Code Standard, 2012 Edition.

PLAN OF CORRECTION

Attached is Form CMS-2567 "Statement of Deficiencies" which enumerates the deficiencies found as a result of the survey. A Plan of Correction (POC) must be submitted by the **tenth (10th) calendar day** from your receipt of this letter. **Please note that a POC is not needed for isolated deficiencies which cause no harm (S/S of A).** Your POC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- **Include dates when corrective action will be completed**. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility;

- Include documentation to support a waiver request (if appropriate).

You are required to record your plan of correction in the appropriate column on the enclosed Form(s) CMS-2567. **Sign, date, and indicate your title in the blocks provided on page one.** Return the forms(s) with the POC to **State of Maine, Department of Public Safety, Office of State Fire Marshal, 45 Commerce Drive, 52 State House Station, Augusta, ME 04330-0052**.

Remedies will be recommended for imposition by the Centers for Medicare & Medicaid Services (CMS) Regional Office if your facility has failed to achieve substantial compliance by **November 3, 2023** (Opportunity to Correct). Informal dispute resolution for the cited deficiencies will not delay the imposition of the recommended enforcement actions. A change in the seriousness of the noncompliance may result in a change in the remedy selected. When this occurs, you will be advised of any change in remedy.

RECOMMENDED REMEDIES

Based on the deficiencies cited during the Life Safety Code and Emergency Preparedness Survey of **September 19, 2023**, we are recommending to CMS the imposition of the following remedy(ies):

A Civil Monetary Penalty per day to be determined by CMS.

Directed Plan of Correction (DPOC) effective immediately. The State Agency directs the plan of correction noted on the attached CMS-2567 for deficiencies E029(SS=E), K211(SS=D), K324(SS=D), K345(SS=E), K353(SS=A), K361(SS=D), K363(SS=E), K372(SS=F), K754(SS=F), K761(SS=F), K911(SS=A) & K923(SS=D) (Tags). [42 CFR 488.424]

If you do not achieve substantial compliance by **December 18, 2023,** the CMS Regional Office or State Medicaid Agency must deny payments for new (Medicare/Medicaid) admissions. In addition, we may recommend that **termination of your provider agreement be effective on March 18, 2024,** if substantial compliance is not achieved by that time. [42 CFR 488.456]. **Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.**

INFORMAL DISPUTE RESOLUTION

In accordance with 42 Code of Federal Regulations §488.331, you have one opportunity to question cited deficiencies through an IDR process. You may also contest scope and severity assessments for deficiencies, which may have resulted in a finding of substandard quality of care (SQC) or immediate jeopardy. To be given such an opportunity, you are required to send your written request, along with the specific deficiencies (or why you are disputing the scope and severity assessments of deficiencies which have been found to constitute SQC or immediate jeopardy) to **Asst. Fire Marshal Gregory J. Day** at the address below. This request must be sent during the same 10 calendar days you have for submitting a POC for the cited deficiencies. An incomplete IDR process will not delay the effective date of any enforcement action. IDR in no way is to be construed as a formal evidentiary hearing. It is an informal administrative process to discuss deficiencies. If counsel will accompany you, you must indicate this in your request for IDR so that we may also have counsel present.

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

If you have any questions, please contact me at (207) 441-0622.

Yours for Better Fire Prevention,

Gregory J. Day
Assistant State Fire Marshal

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205072	A. BUILDING 01 B. WING _____	09/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARSHWOOD CENTER	33 ROGER STREET LEWISTON, ME 04240

(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: 09.19.2023 Marshwood Center, a Long-Term Care facility, is not in substantial compliance with 42 Code of Federal Regulations Part 483.73 Requirement for Long Term Care Facilities for Emergency Preparedness.	E 000		
E 029 SS=E	Development of Communication Plan CFR(s): 483.73(c) §403.748(c), §416.54(c), §418.113(c), §441.184(c), §460.84(c), §482.15(c), §483.73(c), §483.475(c), §484.102(c), §485.68(c), §485.542(c), §485.625(c), §485.727(c), §485.920(c), §486.360(c), §491.12(c), §494.62(c). (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]. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the long-term care facility failed to ensure that the communication plan has been reviewed and updated at least annually. Finding: On September 19, 2023, between 9:15 AM and 1:45 PM, a surveyor, with the Maintenance Director present, observed the following: 1. Documentation could not be provided that the	E 029		

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

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

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E 029	Continued From page 1 communication plan has been reviewed and updated by the facilitywithin the last year. The surveyor confirmed this finding with the Maintenance Director at the time of the observation.	E 029		
K 000	INITIAL COMMENTS Federal Recertification Survey Survey Date: 09.19.2023 Marshwood Center, a Long Term Care Facility was surveyed pursuant to the National Fire Protection Association 101 Life Safety Code, 2012 Edition as referenced in 42 CFR 483.90 (a - d) - Physical Environment is not in substantial compliance.	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 and interview, the long-term care facility failed to maintain the exit corridors and exit discharges free of obstructions per NFPA 101, Life Safety Code, 2012 Edition, Sections 19.2.1., 7.2.1.10.1., 7.1.6.2, and 7.2.1.4.5. Findings:	K 211		

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K 211	Continued From page 2 On 09/19/2023, between 09:15 AM and 1:45 PM, a surveyor, with the Maintenance Director, present, observed the following: 1. During the inspection of the courtyard serving Adams Wing, and Carter Wing, the maintenance director and the staff in the immediate area were not able to provide the keypad code for the gate preventing instant egress to the public way from the courtyard. 2. The exterior exit door leading to the courtyard from Buchanan Wing was obstructed by the threshold at the bottom of the door and required excessive force to open this exit door. 3. The courtyard exterior exit discharge paths to the public way has pavement that is excessively cracking, uneven and has ridges greater than 1/4 inch in height. The surveyor confirmed these findings with the Maintenance Director at the time of the observation.	K 211		
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke	K 324		

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K 324	Continued From page 3 compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on observation, the long-term care facility failed to properly install and maintain equipment protected by the kitchen hood extinguishing system NFPA Standard: NFPA 101, Life Safety Code (2012) Sections 19.3.2.5.2*, 9.2.3, NFPA Standard: NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations (2011) Sections 12.1.2.2*, 12.1.2.3, 12.1.2.3.1 Finding: On September 19, 2023, between 9:15 AM and 1:45 PM, a surveyor, with the Maintenance Director present, observed the following: 1. The wheeled, gas-fired stove/oven and wheeled, gas-fired griddle located on the cooking line in the kitchen were not provided with an approved method that would ensure that the appliances were returned to the correct location	K 324		

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K 324	Continued From page 4 after being removed for maintenance and or cleaning. The surveyor confirmed this finding with the Maintenance Director at the time of the observation.	K 324		
K 345 SS=E	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the long-term care facility failed to ensure that the fire alarm was maintained in accordance with NFPA 101, Life Safety Code, 2012 Edition, Sections 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 On September 19, 2023, between hours of 9:15 AM and 1:45 PM. this surveyor accompanied with Maintenance Director did observe the following: 1. The facility could not provide documentation that the smoke detection sensitivity testing had been completed within the past five years. The surveyor confirmed this finding the Maintenance Director at the time of the observation.	K 345		
K 361	Corridors - Areas Open to Corridor	K 361		

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K 361 SS=D	Continued From page 5 CFR(s): NFPA 101 Corridors - Areas Open to Corridor Spaces (other than patient sleeping rooms, treatment rooms and hazardous areas), waiting areas, nurse's stations, gift shops, and cooking facilities, open to the corridor are in accordance with the criteria under 18.3.6.1 and 19.3.6.1. 18.3.6.1, 19.3.6.1 This REQUIREMENT is not met as evidenced by: Based on observation, the long-term care facility failed to keep hazardous operations out of the open spaces in the corridor per NFPA 101, Life Safety Code, 2012 Edition, Sections 19.3.6.1(1)(a). Findings: On September 19, 2023, between 09:15 AM and 1:45 PM, this surveyor , with the Maintenance Director present, observed the following: 1. Hamilton wing exit corridor has automated blood pressure machine stored in the corridor. 2. Eliot wing exit corridor has automated blood pressure machine stored in the corridor. The surveyor confirmed these findings with the Maintenance Director at the time of the observation.	K 361		
K 363 SS=E	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	K 363		

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K 363	Continued From page 6 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, etc. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the long-term care facility failed to ensure there were no impediments to the closing of all corridor doors in 4 out of 8 patient care areas per NFPA	K 363		

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K 363	Continued From page 7 101, Life Safety Code, 2012 Edition, Section 19.3.6.3.5. Findings: On 09/19/2023, between 09:15 AM and 1:45 PM, a surveyor, with the Maintenance Director, present, observed the following: 1. Adams Wing resident room door A5 is rubbing at the top of the frame on the latch side preventing it from fully closing and latching. 2. Buchanan Wing resident room B1 has a chair that is preventing the closure of the corridor door. The surveyor confirmed these findings with the Maintenance Director at the time of the observation.	K 363		
K 372 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by:	K 372		

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K 372	Continued From page 8 Based on observation and interview, this long-term care facility failed to ensure that the 1-hour rated smoke barriers were free of unfirestopped penetrations in 6 of 8 resident care areas per NFPA 101, Life Safety Code, 2012 Edition, Section 19.3.7.3. Findings: On 09/19/2023, between 09:15 AM and 1:45 PM, a surveyor, with the Maintenance Director, present, observed the following: 1. Hamilton Wing, there is a flexible conduit/wire penetration that is not firestopped above the cross-corridor double doors visible from the lobby side of the doors. 2. Gilbert Wing, there is a clear plastic tubing penetration, two groups of wire penetrations, and a copper pipe penetration that is not firestopped above the cross-corridor doors visible from the lobby side of the doors. 3. Franklin Wing, there are holes on the right side of the hook that is holding the blue wires above the cross-corridor doors, visible from the lobby side. 4. Eliot Wing, there is a group of wires that are not firestopped above the cross-corridor doors visible from the lobby side. 5. Easy Street, there is a wire penetration in the wall on the wing side above the cross-corridor doors. 6. Carter House 1, there is a 1-inch hole with 2 wires in it that is not firestopped above the ceiling and cross-corridor doors, visible from the residence side of the doors. The surveyor confirmed these findings with the Maintenance Director at the time of the	K 372		

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K 372	Continued From page 9 observation.	K 372		
K 754 SS=F	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 by: Based on observation and interview, the long-term care facility failed to maintain mobile soiled linen collection receptacles in a room protected as a hazard area per NFPA 101, Life Safety Code, 2012 Edition, Sections 18.7.5.7. Findings: On September 19, 2023, between 9:15 AM and 1:45 PM, a surveyor, with the Maintenance Director present, observed the following: 1. Gilbert wing (2) 32-gallon soiled linen carts were found stored in exit corridor.	K 754		

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K 754	Continued From page 10 2. Hamilton wing (2) 32-gallon soiled linen carts were found stored in exit corridor. 3. Franklin wing (2) 32-gallon soiled linen carts were found stored in the exit corridor. 4. Eliot wing (1) 32-gallon soiled linen cart was found stored in the exit corridor. 5. Adams wing (1) 32-gallon soiled linen cart was found stored in the exit corridor. 6. Buchanan wing (2) 32-gallon soiled linen carts were found stored in the exit corridor. 7. Carter wing (2) 32-gallon soiled linen carts were found stored in the exit corridor. Maintenance Director states the LTC facility is using a new linen company and the soiled linen in the corridors is new. The surveyor confirmed these findings with the Maintenance Director at the time of the observation.	K 754		
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced	K 761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205072	A. BUILDING 01 B. WING _____	09/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARSHWOOD CENTER	33 ROGER STREET LEWISTON, ME 04240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 761	Continued From page 11 by: Based on observation and interview, the facility failed to inspect and test fire door assemblies in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives, 2010 edition, Section 5.2.2, 5.2.3.1, 5.2.3.5.2(1), and NFPA 101, Life Safety Code, 2021 edition, sections 19.7.6, 4.6.12, 8.3.3.1, and 8.3.3.2.3 Findings: On 09/19/2023, between 09:15 AM and 1:45 PM, a surveyor, with the Maintenance Director, present, observed the following: 1. A record of all inspections and testing shall be signed by the inspector and kept for inspection and review. There were no records of an annual fire door inspection conducted at the facility. 2. Testing of fire door and window assemblies shall be performed by a qualified person with knowledge and understanding of the operating components of the type of assembly being subject to testing. No staff member at the facility has the required NFPA 80 certification, and no verification of inspection by an outside agency could be produced. 3. The fire rated patient room doors have labels that are not clearly visible and legible as they have been painted over in the 6 of the 8 resident care wings in the following locations: a. Carter House: 90-minute Exit stair door, 30- minute resident sleeping room doors C2, C3, C4. b. Gilbert Wing: 30-minute resident sleeping room doors G2, G3, G5, G6, G7, G8. c. Hamilton Wing: 30-minute resident	K 761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205072	A. BUILDING 01 B. WING _____	09/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 761	Continued From page 12 sleeping room H1. d. Franklin Wing: 30-minute resident sleeping room F6. e. Eliot Wing: 30-minute resident sleeping room E6. f. Buchanan Wing: 30-minute resident sleeping room B4. g. Carter House: 30-minute resident sleeping room C2, C3, C4. The surveyor confirmed these findings with the Maintenance Director at the time of the observation.	K 761		
K 923 SS=D	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 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.	K 923		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205072	A. BUILDING 01 B. WING _____	09/19/2023

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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
K 923	Continued From page 13 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, the long-term care facility failed to maintain Gas Equipment - cylinder and Container Storage finish per NFPA 99 Healthcare Facilities, Code 2015 Edition, Section 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 On September 19, 2023, between 9:15 AM and 1:45 PM, a surveyor, with the Maintenance Director present, observed the following: Findings: 1. Oxygen storage closet in Eliot wing is greater than 300 cubic feet. Observation at time of inspection was 46 E cylinders, each containing 24 cubic feet (1104 cubic feet of oxygen total) stored in closet. The closet does not achieve 1-hour fire rated enclosure due to the combustible material used for scab patch on wall. 2. Oxygen shall be separated from combustible materials like the wood mopboards and wood scab patch on wall for a minimum of 5 feet if the storage room contains more than 300 cubic feet.	K 923		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205072	A. BUILDING 01 B. WING _____	09/19/2023

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K 923	Continued From page 14 The surveyor confirmed these findings with the Maintenance Director at the time of the observation.	K 923		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 205072	MULTIPLE CONSTRUCTION A. BUILDING: 01 B. WING _____	DATE SURVEY COMPLETE: 9/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARSHWOOD CENTER	**33 ROGER STREET LEWISTON, ME**

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
K 353	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 sprinkler piping free of external loads resting on the pipe in 3 of the 8 resident care wings per NFPA 25, Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.2.2 and NFPA 101, Life Safety Code, 2012 Edition, Sections 19.3.5.1. and 9.7.6. Findings: On 09/19/2023, between 09:15 AM and 1:45 PM, a surveyor, with the Maintenance Director, present, observed the following: 1. On the Eliot Wing, there are wires that are resting on the sprinkler piping above the cross-corridor doors visible from the lobby side. 2. On the Adams Wing, there are wires that are resting on the sprinkler piping above the cross-corridor doors, above the ceiling visible from the lobby side. 3. On Easy Street Wing, there are wires resting on the sprinkler piping above the cross-corridor doors, above the ceiling, visible from the wing side. The surveyor confirmed these findings with the Maintenance Director at the time of the observation.
K 911	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. Chapter 6 (NFPA 99)

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

The above isolated deficiencies pose no actual harm to the residents

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 205072	MULTIPLE CONSTRUCTION A. BUILDING: 01 B. WING _____	DATE SURVEY COMPLETE: 9/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARSHWOOD CENTER	**33 ROGER STREET LEWISTON, ME**

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
K 911	Continued From Page 1 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the long-term care facility failed to ensure the components of the facilities electrical systems are maintained per NFPA 70, National Electrical Code, 2011 Edition, Section 314.25 Findings: On 09/19/2023, between 09:15 AM and 1:45 PM, a surveyor, with the Maintenance Director, present, observed the following: 1. An electrical junction box above the Easy Street ceiling, above by the cross-corridor double doors is missing a faceplate. (cover) 2. Outlet in Room A5 was not secure to the wall. Maintenance Director states it was knocked off by staff lowering and lifting the hospital bed. This is on his work list to have repaired. The surveyor confirmed these findings with the Maintenance Director at the time of the observation.