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

JANET T. MILLS
GOVERNOR

MICHAEL SAUSCHUCK
COMMISIONER

RICHARD MCCARTHY
STATE FIRE MARSHAL

December 7, 2023

Maine Veterans Home - Caribou
Attn: Melissa Graham, Administrator
163 Van Buren Rd Suite 2
Caribou, ME 04736

Provider ID#: 205151
Facility ID#: 0310
Event ID#: BIWM21

Administrator Graham,

On **December 5, 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 only.

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, 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 **January 22, 2024** (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 **December 5, 2023,** the following remedy(ies) are being imposed:

The State Agency directs the plan of correction noted on the attached CMS-2567 for deficiencies K211(SS=D), K271(SS=D), K344(SS=D), K712(SS=D) & K753(SS=D) (Tags). [42 CFR 488.424]

If you do not achieve substantial compliance by **March 7, 2024,** the CMS Regional Office or State Medicaid Agency must deny payments for new (Medicare/Medicaid) admissions. In addition, we may recommend that **termination of your provider agreement be effective on June 7, 2024,** if substantial compliance is not achieved by that time. [42 CFR 488.456]. **Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination**.

ALLEGATION OF COMPLIANCE

The Plan of Correction will serve as your allegation of compliance until substantiated by a revisit or other means. If upon revisit your facility has not achieved substantial compliance, recommended remedies may be imposed as determined by the CMS Regional Office and continue until substantial compliance is acheived. Additionally, CMS Regional Office may impose revised/additional remedies, if appropriate.

INFORMAL DISPUTE RESOLUTION

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

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

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

Yours for Better Fire Prevention,

Gregory J. Day
Assistant State Fire Marshal

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205151	A. BUILDING 01 B. WING _____	12/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAINE VETERANS HOME - CARIBOU	163 VAN BUREN RD SUITE 2 CARIBOU, ME 04736

(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 Recertificatiob Survey Survey Date: 12/5/23 Maine Veterans Home Caribou, a long term care facility, is in substantial compliance with 42 Code of Federal Regulations Part 483.73 Requirement for Long Term Care Facilities Emergency Preparedness.	E 000		
K 000	INITIAL COMMENTS Federal Recertification Survey Survey Date: 12/5/23 Maine Veterans Home Caribou, a long-term care facility, was surveyed pursuant to the National Fire Protection Association, 101 Life Safety Code, 2012 Edition as referenced in Part 483.90(a-d) - Physical Environment is not in substantial compliance.	K 000		
K 211 SS=D	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on Observation during facility tour, the facility failed to ensure that aisles,passageways, corridors,exit discharge,exit locations and accesses are in accordance with National Fire Protection Association (NFPA)101 , Life Safety	K 211		

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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K 211	Continued From page 1 Code,2012 edition, Chapter 7 , and that the means of egress is continuously maintained free of all obstructions to full use in case of emergency unless modified by NFPA 101 safety code, 2012 edition, sections 19.2., 19.2.2 through 19.2.11, and 7.1.10.1 Findings: Observations during a facility tour on 12/05/23 between 9:00 AM and 12:30 PM with the Environmental Service Manager and Assistant Director of Facilities, the following was found: 1. Decorations hanging from the ceiling at multiple locations in the exit corridors, were below 6'-8" and causing an obstruction to egress. 2. Horizontal exit located at the entrance to the hospital (2 hr fire wall) does not have an approved special locking arrangement within the egress path. The required exit path to the public way requires exiting through a second set of corridor doors (located in the hospital) to reach the exterior doors and the public way. The second set of double doors has a controlled access device (badge/swipe card access) that is programmed to lock on egress side at 3pm daily and does not allow for visitors or individuals without badge/swipe cards to exit, unless staff member lets them out. These findings were verified by the Environmental Service Manager, Assistant Director of Facilities facility administrator at the time of observations and exit interview on 12/05/23.	K 211		

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K 271	Continued From page 2	K 271		
K 271 SS=D	Discharge from Exits CFR(s): NFPA 101 Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the long term care facility failed to ensure, exit discharges had unobstructed, level hard-packed all weather surface for evacuation and are in accordance with CMS Survey and Certification Letter 05-38,Isc. 2012 edition 101 Life Safety Code Chapter 19/ 19.2.7, Chapter 7/ 7.7, 7.1.7 This deficient practice could effect safe exiting from the memory care wing as well all residents, staff and visitors in an emergency. Finding: Observation and Interview during facility tour on 12/05/2023 between 9 am to 12:30 pm identified: 1. The facility exit discharges from the memory care wing north corridor. Two exits to pavement that have moved and deteriorated leaving well over a 1/2 inch rise to the concrete pad. These findings were verified by the Environmental Service Manger and the Director of Facility at the time of observations on	K 271		

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K 271	Continued From page 3 12/05/2023	K 271		
K 344 SS=D	Fire Alarm - Control Functions CFR(s): NFPA 101 Fire Alarm - Control Functions The fire alarm automatically activates required control functions and is provided with an alternative power supply in accordance with NFPA 72. 18.3.4.4, 19.3.4.4, 9.6.1, 9.6.5, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on observations and interview, the facility failed to ensure that Fire Alarm System was inspected, tested, and maintained in accordance with National Fire Protection Association (NFPA)101, Life Safety Code 2012, section 19.3.4.4 This deficient practice could affect the entire facility, patients/residents, visitors, and members of facility staff in these location(s). Findings: Observations during a facility tour on 12/05/23 between 9:00 AM and 12:30 PM with the Environmental Service Manager and Assistant Director of Facilities, the following was found: 1. Fire alarm test report from 11/30/23 indicated that the fire alarm pull station located near conference room (LTC) and duct smoke detector near room # 47 (Res. Care) did not function during the test. No documentation could be provided to indicate when the deficient devices would be repaired/replaced.	K 344		

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K 344	Continued From page 4 These findings were verified by the Environmental Service Manager, Assistant Director of Facilities facility administrator at the time of observations and exit interview on 12/05/23.	K 344		
K 712 SS=D	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 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 and interview, the long-term care facility failed to conduct the required number of fire drills per NFPA 101, Life Safety Code, 2012 Edition, Section 19.7.1.4 through 19.7.1.7 Finding: On 12/05/2023, between 9:00 AM and 12:30 PM, a surveyor, with the Environmental Service Manager and Director of Facility's present, observed the following: 1. The facility failed to conduct the proper number of fire drills in the past year; fourth quarter, second shift drill was not completed as	K 712		

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K 712	Continued From page 5 required. There was no fire drill conducted at the facility on the 2nd second shift during 4th Quarter of 2022. This deficient practice could negatively affect the residents, staff and visitors. The surveyor confirmed this finding with the Environmental Service Manager and Director Facility's during document review.	K 712		
K 753 SS=D	Combustible Decorations CFR(s): NFPA 101 Combustible Decorations Combustible decorations shall be prohibited unless one of the following is met: o Flame retardant or treated with approved fire-retardant coating that is listed and labeled for product. o Decorations meet NFPA 701. o Decorations exhibit heat release less than 100 kilowatts in accordance with NFPA 289. o Decorations, such as photographs, paintings and other art are attached to the walls, ceilings and non-fire-rated doors in accordance with 18.7.5.6(4) or 19.7.5.6(4). o The decorations in existing occupancies are in such limited quantities that a hazard of fire development or spread is not present. 19.7.5.6 This REQUIREMENT is not met as evidenced by: Based on observations, interview and records review the facility failed to ensure that combustible decorations were in accordance with	K 753		

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K 753	Continued From page 6 NFPA 101: Life Safety Code, 2012 edition, 19.7.5.6 Findings: Observations during a facility tour on 12/05/23 between 9:00 AM and 12:30 PM with the Environmental Service Manager and Assistant Director of Facilities, the following was found: 1. No documentation could be provided to indicate that combustible decorations throughout the facility were flame retardant from the manufacturer(s) or that they had been treated with an approved flame retardant product. Interview with the Environmental Service Manager revealed that there had been no previous practice of treating and/or documenting for decorations, since he has held the position. These findings were verified by the Environmental Service Manager, Assistant Director of Facilities facility administrator at the time of observations and exit interview on 12/05/23.	K 753		