



State of Maine
Department of Public Safety
Office of Fire Marshal
52 State House Station
Augusta, ME 04333-005

JANET T. MILLS
GOVERNOR

MICHAEL SAUSCHUCK
COMMISSIONER

RICHARD MCCARTHY
STATE FIRE MARSHAL

September 27, 2023

Maine Veterans Home - Bangor
Attn: Gregory Urban, Administrator
44 Hogan Rd
Bangor, ME 04401

Provider ID#: 205185
Facility ID#: 1916
Event ID#: DKGW21

Administrator Urban,

On **September 25, 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.

PREVENTION * MITIGATION/ SUPPRESSION * LAW ENFORCEMENT

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

PLAN OF CORRECTION

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

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- **Include dates when corrective action will be completed.** The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility;
- Include documentation to support a waiver request (if appropriate).

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

Remedies will be recommended for imposition by the Centers for Medicare & Medicaid Services (CMS) Regional Office if your facility has failed to achieve substantial compliance by **November 13, 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 25, 2023,** the following remedy(ies) are being imposed:

The State Agency directs the plan of correction noted on the attached CMS-2567 for deficiencies K133(SS=B), K223(SS=A), K291(SS=D), K321(SS=B) & K363(SS=A) (Tags). [42 CFR 488.424]

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If you do not achieve substantial compliance by **December 28, 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 23, 2024**, if substantial compliance is not achieved by that time. [42 CFR 488.456]. **Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.**

ALLEGATION OF COMPLIANCE

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

INFORMAL DISPUTE RESOLUTION

In accordance with 42 Code of Federal Regulations §488.331, you have one opportunity to question cited deficiencies through an IDR process. You may also contest scope and severity assessments for deficiencies, which may have resulted in a findings of immediate jeopardy. To be given such an opportunity, you are required to send your written request, along with the specific deficiencies (or why you are disputing the scope and severity assessments of deficiencies which have been found to constitute SQC or immediate jeopardy) to **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

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

PRINTED: 09/27/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205185	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 09/25/2023
NAME OF PROVIDER OR SUPPLIER MAINE VETERANS HOME - BANGOR			STREET ADDRESS, CITY, STATE, ZIP CODE 44 HOGAN RD BANGOR, ME 04401		
(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 Date: 9/25/23 Maine Veterans Home Bangor, 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: Date: 09/25/23 Maine Veterans Home Bangor, 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=B	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

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 observations and interview, the Nursing Facility failed to keep the integrity of the two hour fire wall between two separate occupancies fire stopped. Findings: Based on observation of the surveyor 39983 on 9/25/23, in the presence of the Maintenance Director the following was not met: 1. The 2 hr wall located above the entrance to the E unit and the nursing home had penetrations with no fire stopping material present. This finding was verified by the Director of Maintenance at the time of the observation.	K 133			
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: The facility failed to ensure 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 Finding: Based on interview and observation on 09/25/23 between hours of 10:30 am and 2:30 pm.	K 291			

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K 291	Continued From page 2 surveyor 47175 accompanied with Director of Facilities did observe the following: 1. Emergency lights were found not functioning when tested in all 3 locations in the therapy wing, as well as in the exit enclosure leading outside from the therapy wing. This finding was verified by the Director of Maintenance at the time of the observation.	K 291			
K 321 SS=B	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons)	K 321			

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K 321	Continued From page 3 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: The facility failed to protect hazardous area fire barrier walls and ceiling, having 1-hour fire resistance rating in accordance with NFPA 101 Section 19.3.5.9 Finding: Based on interview and observation on 09/25/23 between hours of 10:30 am and 2:30 pm. surveyor 39983 accompanied with Director of Facilities did observe the following: 1. Penetrations in 1-hour rated fire wall in electric room located in the Therapy janitors closet. This finding was verified by the Director of Maintenance at the time of the observation.	K 321			

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs		PROVIDER # 205185	MULTIPLE CONSTRUCTION A. BUILDING: 01 B. WING _____	DATE SURVEY COMPLETE: 9/25/2023
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES			
K 223	Doors with Self-Closing Devices CFR(s): NFPA 101 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: The facility failed to ensure the functionality of self closing doors protecting hazardous area enclosures in accordance with NFPA 101 2012 edition. Finding: Based on interview and observation on 09/25/23 between hours of 10:30 am and 2:30 pm. surveyor 47175 accompanied with Director of Facilities did observe the following: 1. The Fire door in the laundry room leading into the laundry office along the 1 hour rated wall was prevented from closing by stacked boxes. The boxes were removed during survey. This finding was verified by the Director of Maintenance at the time of the observation.			
K 363	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 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			

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The above isolated deficiencies pose no actual harm to the residents

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K 363	Continued From Page 1 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 observations and interview, the Nursing Facility failed to ensure the resident room door latches resulting in a smoke resistant seal. Based on observation of the surveyor 39983 on 9/25/23, in the presence of the Maintenance Director the following was not met: Findings: 1. The door on resident room #3 is obstructed with a precautions equipment storage system located hanging on the door causing the door not to close and latch that could allow smoke to penetrate the resident room. 2. Resident room B36 door did not latch when closed. This finding was verified by the Director of Maintenance at the time of the observation.		