NC Southridge Rehabilitation & Living Center
10 May Street, Biddeford, ME 04005
Tel. (207) 282-4138 Fax (207) 282-8242

Ms. Cummings,

Please find the attached plan(s) of corrective action for the Life Safety Code and Emergency Preparedness survey conducted on June 25, 2024.

Please contact me if you have any questions or if you need any additional information regarding the POC.

Thank-you,

Sincerely,

Cassandra Byorak, RN, BSN

Cassandra Byorak, RN, BSN

Administrator

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205136	A. BUILDING 01 B. WING	06/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHRIDGE REHAB & LIVING CTR	10 MAY ST BIDDEFORD, ME 04005

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E 000	Initial Comments Federal Recertification Survey: Survey Date: 06.25.2024 Southridge Rehab & Living 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 and is in substantial compliance.	E 000		
K 000	INITIAL COMMENTS Federal Recertification Survey: Survey Date: 06.25.2024 Southridge Rehab & Living 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 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	K 222	please see attached	

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

Cassandra Byrak | administrator | 7-5-24

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 222	Continued From page 1 all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on	K 222		

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K 222	Continued From page 2 door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on Observation and Interview, the facility failed to provide exit access serving the Somerset Wing and Webster courtyard that were readily accessible at all times by having special locking arrangements (coded key exit egress) with staff being the only people with access to exits regardless of resident independent cognitive ability which is not in accordance with LSC Section 19.2.2.2.4, 19.2.2.2.5, 19.2.2.2.5.2 and 7.2.1.6. This deficient practice could affect exiting from all facility designated exits, as well as an indeterminable number of residents, staff and visitors. Findings Include: Observation on 06.25.2024 at approximately 9:00 AM to 12:45 PM during the facility tour identified the facility designated exits at a A2/B2 exits had a coded exit by key code controlled by staff without any means to provide visitors or oriented residents access to the means of exit. Interview on 06.25.2024 at approximately 9:00 AM to 12:45 PM during the facility tour with the Administrator and the Maintenance Director stated the doors were all key code controlled, and residents did not have the codes. Observation and Interview with the Administrator and the Maintenance Director at the time of observation confirmed the exit doors had key code that could only be accessed by staff. The facility failed to provide exit access that was readily accessible at all	K 222		

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K 222	Continued From page 3 times by having special locking arrangements in accordance with LSC Section 19.2.2.2.4, 19.2.2.2.5, 19.2.2.2.5.2 and 7.2.1.6. This surveyor confirmed this finding with the Administrator and the Maintenance Director the time of the observation and review.	K 222		
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 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	K 321		

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K 321	Continued From page 4 Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation, interview, during the facility tour, the long-term care facility failed to maintain the hazard area doors ability to self-close and latch per NFPA 101, Life Safety Code, 2012 Edition, Section 19.3.2.1.3. Findings: On June 25th, 2024, between 9:00 AM and 12:45 PM, a surveyor, with the Maintenance Director and Administrator present, observed the following: 1. The A-1 Laundry room door did not self-close and latch due to the fan inside the room. When the fan was turned off, the door was able to operate properly. 2. The metal door in the kitchen storage room hits on the frame, not allowing it to fully close. The surveyor confirmed these findings with the Maintenance Director and Administrator at the time of the observation.	K 321		
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	K 324		

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K 324	Continued From page 5 * cooking facilities open to the corridor in smoke 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 06.25.2024, between 9:00 AM and 12:15 PM, a surveyor, with the Maintenance Director and Administrator present, observed the following: 1. The wheeled, gas-fired 9 burner stove/griddle on the cooking line in the kitchen was not provided with an approved method that would ensure that the appliances were returned to an	K 324		

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K 324	Continued From page 6 approved design location after they had been moved for maintenance and cleaning. This surveyor confirmed this finding with the Administrator and the Maintenance Director at the time of the observation.	K 324		
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 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 interview, and monthly fire drill documentation review during the facility tour, the long-term care facility failed to conduct quarterly fire drills on each shift and use a coded announcement only between 9:00 PM and 6:00 AM per NFPA 101, Life Safety Code, 2012 Edition, Sections 19.7.1.6, and 19.7.1.7. Findings: On June 25th, 2024, between 9:00 AM and 12:45 PM, a surveyor, with the Maintenance Director and Administrator present, observed the following:	K 712		

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K 712	Continued From page 7 1. There was no 2nd shift fire drill in the 2nd quarter of 2023. 2. There was no 1st shift fire drill in the 3rd quarter of 2023. 3. There was no 3rd shift fire drill in the 4th quarter of 2024. 4. A coded announcement was used on 02/29/2024 at 06:20. 5. A coded announcement was used on 05/29/2024 at 06:30. 6. A coded announcement was used on 10/16/2023 at 19:30. The surveyor confirmed these findings with the Maintenance Director and Administrator at the time of the observation.	K 712		
K 761 SS=D	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 by: Based on interview and record review, the long-term care facility failed to conduct an annual	K 761		

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K 761	Continued From page 8 fire door inspections program that ensure they are inspected, tested, and maintained in accordance with NFPA 80, Standard for Fire Door and Other Opening Protectives, 2010 edition Section 5.2 in accordance with NFPA 101 Life Safety Code , 2012 edition, sections 19.2.2.2.1, 19.7.6, 4.6.12, and 8.3.3.1. Finding: On 06.25.2024, between 09:00 AM and 12:45 PM, this surveyor observed the following findings with the Administrator and Maintenance Director present. 1. The facility failed to provide documentation to verify completion of the annual assessment of all fire doors in the facility. Fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection. The facility had no documentation that the doors had been inspected by a trained employee or an outside qualified vendor within the last year. This surveyor confirmed this finding with the Administrator and the Maintenance Director the time of the observation and review.	K 761		
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a	K 918		

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K 918	Continued From page 9 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 installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on observation, interview, and weekly inspection documentation review during the facility tour, the long-term care facility failed to maintain the Essential Electric System Generator batteries per NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, section 8.3.7., and NFPA 99, Healthcare Facilities Code, 2012 edition, sections 6.4.4.1.1.3.	K 918		

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K 918	Continued From page 10 Finding: On June 25th, 2024, between 9:00 AM and 12:45 PM, a surveyor, with the Maintenance Director and Administrator present, observed the following: 1. The generator inspection reports do not show a voltage conductance test for sealed batteries or an electrolyte specific gravity reading for unsealed automotive batteries. The surveyor confirmed this finding with the Maintenance Director and Administrator at the time of the observation.	K 918		

K 222- Egress Doors

All residents, visitors and staff have the potential to be affected by the identified deficient practice.

No residents, visitors or staff were identified as being affected by the noted deficient practice.

A2 egress door and B2 egress door have exit codes posted as of 7-3-24.

Random audits will be done weekly x 4, then monthly x 4 to ensure the codes are posted by the doors.

The findings of the audits will be presented at the QAPI meetings.

The Director of Maintenance or designee will be responsible for the audits.

K 321- Hazardous Areas- Enclosure

All residents, visitors and staff have the potential to be affected by the identified deficient practice.

No residents, visitors or staff were identified as being affected by the noted deficient practice.

The A1 laundry door's closer was adjusted so the door will self-close and latch on 7-1-24.

The metal door in the kitchen was removed after conversation with Chad Charland on 7-2-24.

Random audits will be done weekly x4, then monthly x 4 to ensure proper self-closing and latching of the laundry door on A1.

The findings of the audits will be presented at the QAPI meetings.

The Director of Maintenance or designee will be responsible for the audits.

K 324- Cooking Facilities

All residents, visitors and staff have the potential to be affected by the identified deficient practice.

No residents, visitors or staff were identified as being affected by the noted deficient practice.

Grip tape to be applied to the tiles to indicate proper placement of the front wheels of the stove by 7-3-24.

Education to be provided to the kitchen staff on the proper placement on the stove by 7-8-24.

Random audits to be done weekly x 4, then monthly x 4 to ensure proper placement of the stove.

The findings of the audits will be presented at the QAPI meetings.

The Director of Maintenance or designee will be responsible for the audits.

K 712- Fire Drills

All residents, visitors and staff have the potential to be affected by the identified deficient practice.

No residents, visitors or staff were identified as being affected by the noted deficient practice.

A year calendar will be kept for fire drills, including what shift will be done during the quarter, and the acceptable times of a silent drill on the night shift.

The year calendar will be kept in the Director of Maintenance's office.

Fire drills will be discussed at the monthly Safety meetings.

Director of Maintenance will be responsible for reporting the monthly fire drills.

K 761- Maintenance, Inspection and Testing- Doors

All residents, visitors and staff have the potential to be affected by the identified deficient practice.

No residents, visitors or staff were identified as being affected by the noted deficient practice.

Fire door training to be completed by the Director of Maintenance by 7-10-24.

Annual fire door inspections to be added to the annual checklist.

All fire doors to be inspected and tested in the facility by 7-12-24.

K 918- Electrical Systems- Essential Electrical System Maintenance and Testing

All residents, visitors and staff have the potential to be affected by the identified deficient practice.

No residents, visitors or staff were identified as being affected by the noted deficient practice.

Generator battery was checked on 7-2-24 and was found to be a maintenance free battery and was confirmed by ESM via phone.

Voltage check performed on 7-2-24.

Battery voltage check added to the weekly generator checklist

Random audits will be done weekly x 4, then monthly x 4 to ensure generator battery voltage is being checked.

Findings of the audit will be presented at the QAPI meetings.

The Director of Maintenance or designee will be responsible for the audits.

Year:

Southridge Fire Drill Log

	Jan	Feb	March	April	May	June	July	August	Sept	Oct	Nov	Dec
Day												
Shift												
Time Pulled												
Time Secured												
Unit												
Device to Set Alarm												
Observer(s)												
Called Monitoring Company Before												
Called Monitoring Company After												
Called F.D. Before												
Called F.D. After												
Initials												

Maine Fire Protection Monitor # 1-844-545-5858
Acct# 824-3028
Pass Code# 4138

Fire Department (Dispatch) # 284-4551
Lock box key # 11 fire panel
9/64 allen wrench to reset pull station

***** EVERY QUARTER MUST HAVE A 1ST SHIFT, 2ND SHIFT, 3RD SHIFT - NO EXCEPTIONS *****

***** SILENT DRILLS ARE ALLOWED FROM THE HOURS OF 9:00 PM TILL 6:00 AM - NO EXCEPTIONS *****

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NC NORTH COUNTRY ASSOCIATES
The Health Care Professionals

Physical Plant Regulatory Compliance Calendar

Facility: **Year:**

Book 1 Regulatory Compliance	Jan	Feb	Mar	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec
1.1 Sprinkler Internal Pipe Examination (Every 5 Years)												
1.2 Kitchen Hood Clean (Yearly)												
1.3 Back Flow Prevent Inspection (Yearly)												
1.4 Kitchen Dry System (Semi-annual)												
1.5 Sprinkler Test (Quarterly)												
2.1 Fire Alarm Test (Yearly)												
2. Fire Alarm Sensitive Test (Bi-annual)												
3 Fire Drills (Monthly)												
4 Fire Extinguisher (Monthly)												
5 FIRE DOORS (ANNUAL)												
6 Generator Load Test (Monthly)												
7.1 Elevator Inspection (Yearly)												
7.2 Elevator Pm (Monthly)												
8 Medical Waste Records												
9 Boiler Water Temperature Records												
10 Building Water Temperature Records												
11 Nursing Call Syst. Inspection (Yearly)												
12 Exit Door & Secure Care Inspection												
13 Pest Management Records												
14.1 Building Safety Inspection												
14.2 Resident Room Safety Inspection												

Created by Marcia D. Blaney

YEAR

SOUTHRIDGE EMERGENCY GENERATOR TEST LOG

Dead River Co fuel supply 929 5550
Power Products annual service 797 5188

Date	Oil Check	Coolant	Time ran	Hrs Start	Under Load	Emergency	Temp	Pressure	Amps	Fuel	Batt. Volts	Auto	Initials

RECEIVED
JUL 05 2024
BY:

Call each Nov for top up unless needed sooner.

Fuel Delivery is on Maintenance Dir. call to Dead River

Last 4 hour test was on: 04-04-2024 thru 04-05-2024 Gen. ran for 19 hours (Emergency)