STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205114	A. BUILDING 01 B. WING	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGH VIEW REHABILITATION AND LIVING CENTER	517 RIVERVIEW ST MADAWASKA, ME 04756

(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: 04/01/2025 High View Rehabilitation and Living 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 015 SS=F	Subsistence Needs for Staff and Patients CFR(s): 483.73(b)(1) §403.748(b)(1), §418.113(b)(6)(iii), §441.184(b)(1), §460.84(b)(1), §482.15(b)(1), §483.73(b)(1), §483.475(b)(1), §485.542(b)(1), §485.625(b)(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting.	E 015		Revised 4/18/25 Revised 4/17/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Nancy Cote Daigle
TITLE: Administrator
(X6) DATE: 4/14/25

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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E 015	Continued From page 1 (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal. *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the long term care facility failed to maintain documentation for the provision of subsistence needs for staff and patients whether they evacuate or shelter in place for Emergency Preparedness Plan in accordance with 42 CFR 483.73 Finding: On 04/01/2025, between 10:00 AM and 3:30 PM, a surveyor, with the Administrator present,	E 015		

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E 015	Continued From page 2 observed the following: 1. The was no documentation provided in the emergency preparedness plan for food, water, medical and pharmaceutical supplies, or waste disposal with updated Memorandums of Understanding to verify how they would get replenished in the event they had to evacuate or shelter in place. Interview with the Administrator shows that the Emergency Preparedness Plan was updated in October of 2024, but no correspondence with the MOU companies occurred to ensure the contact information and the points of contact were the same since the MOU was drafted back in 2018 or 2019. The surveyor confirmed this finding with the Administrator at the time of the observation and during the exit interview.	E 015		
K 000	INITIAL COMMENTS Federal Recertification Survey Date of Survey 04/01/2025 High View Rehabilitation and 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 Part 483.90(a-d) - Physical Environment is not in substantial compliance.	K 000		
K 321 SS=F	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	K 321		

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K 321	Continued From page 3 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 Separation N/A — Automatic Sprinkler 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 separated from other spaces by doors that self-close and positively latch smoke resisting partitions and doors in accordance with NFPA 101, Life Safety Code, 2012 edition, Sections 8.4., and 19.3.2.1. Findings: Observation and interview during a facility tour with the Maintenance, Housekeeping, and Laundry Supervisor present on 04/01/2025, between 10:00 AM and 3:30 PM identified:	K 321		

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

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K 321	Continued From page 4 1. The food pantry closet that measures 93 square feet did not have a self-closing and latching door. Any storage room greater than 50 square feet shall have a self-closing and latching door. The room was measured with the Maintenance Supervisor present. 2. The 90-minute door to the soiled utility room on the second floor by the elevator and the cross corridor smoke doors didn't self-close and latch as the top latch side of the door is rubbing on the door frame not allowing the door to fully close. Demonstration of the door's inability to self-close was demonstrated at the time of obser vation with the maintenance supervisor. The surveyor confirmed these findings with the Maintenance, Housekeeping, and Laundry Supervisor and the Administrator at the time of the observation and at the exit interview on 04/01/2025 between 10:00 AM and 3:30 PM.	K 321		
K 324 SS=E	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 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	K 324		

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K 324	Continued From page 5 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, and interview, the facility failed to protect the commercial cooking operations by ensuring in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, 2011 edition, Section 12.1.2.2, as referenced by NFPA 101, Life Safety Code, 2012 edition, Section 19.3.2.5.1, and 9.2.3. This deficient practice could affect the kitchen area of the facility by having a commercial cooking assembly that is not properly in place under the kitchen hood extinguishing system. Finding: Observation and interview during a facility tour with the Maintenance, Housekeeping, and Laundry Supervisor present on 04/01/2025, between 10:00 AM and 3:30 PM identified: 1. When commercial cooking appliances are on wheels, an approved method of marking the precise location for the appliance to be installed to ensure it is properly protected by the extinguishing system shall be applied. An approved method shall ensure that the appliance	K 324		

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K 324	Continued From page 6 is returned to its position before cooking takes place. Interview regarding the marking was discussed in the kitchen at the time of the observation. This finding was verified by the Maintenance, Housekeeping, and Laundry Supervisor at the time of the observation, and during the exit interview on 04/01/2025 from 10:00 AM to 3:30 PM.	K 324		
K 362 SS=E	Corridors - Construction of Walls CFR(s): NFPA 101 Corridors - Construction of Walls 2012 EXISTING Corridors are separated from use areas by walls constructed with at least 1/2-hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the transfer of smoke. In nonsprinklered buildings, walls extend to the underside of the floor or roof deck above the ceiling. Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Fixed fire window assemblies in corridor walls are in accordance with Section 8.3, but in sprinklered compartments there are no restrictions in area or fire resistance of glass or frames. If the walls have a fire resistance rating, give the rating _____ if the walls terminate at the underside of the ceiling, give brief description in REMARKS, describing the ceiling throughout the floor area. 19.3.6.2, 19.3.6.2.7 This REQUIREMENT is not met as evidenced by: Based on observations and interview the facility failed to meet the requirements of the National	K 362		

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K 362	Continued From page 7 Fire Protection Association (NFPA) 101, Life Safety Code, 2012 edition for smoke barrier enclosures in two of six smoke compartments in accordance with Section 19.3.2.6.4 Findings include: Observations and Interviews, found the the smoke barrier wall and ceiling had penetrations in them, therefore not maintaining a smoke tight resistive rating during a facility tour on 04/01/2025 between the hours of 10:00 AM and 3:30 PM with the Maintenance-Housekeeping-Laundry Supervisor present. 1. The ceiling in the corridor located by room 301 on the third floor had 2 holes, one hole was circular with a diameter of approximately 9 inches. The second hole was rectangular in shape and approximately 20 inches by 24 inches. 2. Patient room 229 had a 12 inch by 24 inch rectangular hole located in the bathroom due to water damage. The Maintenance-Housekeeping-Laundry Supervisor had been called away at the time this was located and was observed by Surveyor 50034 and Surveyor 51673 This deficient practice could affect the occupants, visitors and staff while trying to exit the building or sheltering in place. These findings were verified by Surveyor 50034 and the Maintenance-Housekeeping-Laundry Supervisor and Administrator at the time of survey and during the exit interview. The Administrator did inquire how we located deficiency 3 during exit interview and was advised DHHS had made us aware. During the exit interview the Administrator and	K 362		

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K 362	Continued From page 8 Maintenance-Housekeeping-Laundry Supervisor advised the holes had been caused by water damage due to damaged "witches hat" devices located on the roof.	K 362		
K 363 SS=F	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 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.	K 363		

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K 363	Continued From page 9 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 Maintenance, Housekeeping, and Laundry Supervisor present on 04/01/2025, between 10:00 AM and 3:30 PM identified: 1. The activities department door to the marked exit corridor opens into the corridor and didn't self-close from the fully open position as the front latch side of the door rubs on the floor in the corridor. Markings on the floor show that this has been occurring. Interview and demonstration with the maintenance supervisor at the Activities room door verified the door's inability to self-close. 2. Resident room 316 in the East wing on the third floor did not latch when fully closed. The striker plate in the door frame did not line up with the door latching mechanism. It appears that the door has lowered enough to cause the misalignment. The maintenance supervisor looked at the latvhing mechanism and how it no longer lines up with the striker plate at the time of the observation. 3. Resident room 210 has a gap on the top latch	K 363		

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K 363	Continued From page 10 side of the door between the door and the door frame that does not resist the passage of smoke. Measurement from the room side of the door, (pull side/inside) was 7/16" and had a clear opening to let light through. The maintenance supervisor verified the gap and the light coming through from the corridor side at the time of the observation. See photo submitted. 4. The kitchen exit door to the exit corridor was a self-closing door that is being held open with a landscaping brick. See photo submitted. The maintenance supervisor explained to the kitchen staff that the door cannot be propped open with the brick or any other object, The surveyor confirmed these findings with the Maintenance, Housekeeping, and Laundry Supervisor at the time of the observation and during the exit interview on 04/01/2025, between 10:00 AM and 3:30 PM.	K 363		
K 511 SS=F	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 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the	K 511		

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K 511	Continued From page 11 long-term care facility was drying mops and rags in the dryer, which is prohibited per NFPA 101, Life Safety Code, 2012 Edition, Sections 19.5.1.1, 9.1.1, and 9.1.2 Finding: On 04/01/2025, between 10:00 AM and 3:30 PM, a surveyor, with the Maintenance, Housekeeping, and Laundry Supervisor present, observed the following: 1. Interview with the laundry personnel and the maintenance supervisor disclosed the facility is drying mop heads and cleaning rags in the dryer after washing them. There was no documentation provided that the dryers are listed for this practice from the manufacturer. At the time of the exit interview documentation was not produced. This deficient practice could affect residents, guests, and staff if this practice leads to the rags or mops catching fire while in the dryer. The surveyor confirmed this finding with the Maintenance, Housekeeping, and Laundry Supervisor at the time of the observation and exit interview on 04/01/2025.	K 511		
K 914 SS=F	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 listed as hospital-grade at these locations are	K 914		

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K 914	Continued From page 12 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 receptacles not listed as hospital-grade are tested at intervals not exceeding 12 months in accordance with NFPA 99, Healthcare Facilities Code, 2012 edition, Sections 6.3.3.2., and 6.3.4.1 Finding: Documentation review and interview during a facility tour with the Maintenance, Housekeeping, and Laundry Supervisor present on 04/01/2025 from 10:00 AM to 3:30 PM identified: 1. The annual testing of the receptacles did not include the retention force of the grounding blade, continuity check of the grounding circuit, the polarity check of the hot and neutral connections, or a physical integrity inspection of each non-hospital grade electrical receptacle in resident rooms. This deficient practice could pose an electrical hazard to all residents, visitors, and members of facility staff in these locations. When	K 914		

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K 914	Continued From page 13 the documentation was requested, the only paperwork produced was the GFCI testing. Interview with the Maintenance supervisor revealed that the reveptacles are not being tested and that the tension tester will have to be purchased. This finding was verified by the Maintenance, Housekeeping, and Laundry Supervisor at the time of interview and document review on 04/01/2025 from 10:00 AM to 3:30 PM.	K 914		
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 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	K 918		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205114	A. BUILDING 01 B. WING	04/01/2025

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K 918	Continued From page 14 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, 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 8.3.7., 8.3.8, and 8.4.1, 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 Maintenance, Housekeeping, and Laundry Supervisor present on 04/01/2025 between 10:00 AM and 3:30 PM identified the following deficiencies: 1) Emergency Power Supply Systems, including all appurtenant components, shall be inspected weekly. The weekly generator inspection reports did not show a voltage conductance test for sealed batteries or an electrolyte specific gravity reading for unsealed automotive batteries. The Inspection and Testing of Emergency Generators	K 918		

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K 918	Continued From page 15 document from CMS was provided to the Maintenance, Housekeeping, and Laundry Supervisor at the time of the observation and he was shown the sections that list what the weekly requirements shall be and that they shall be annotated on the inspection report, and the NFPA code references that apply. 2) The following items are not annotated on the monthly generator inspection as required: Identification of the generator tested, the date the generator was placed in service, KW rating of the generator, 30% of generator load, Fuel type, and the initials of the inspector/tester. The Inspection and Testing of Emergency Generators document from CMS was provided to the Maintenance, Housekeeping, and Laundry Supervisor at the time of the observation and he was shown the sections that list what the monthly requirements shall be and that they shall be annotated on the inspection report, and the applicable NFPA code references. These findings were verified by the Maintenance, Housekeeping, and Laundry Supervisor at the time of observation and at the exit interview. The Inspection and Testing of Emergency Generators document from CMS was provided to the Maintenance, Housekeeping, and Laundry Supervisor at the time of the observation on 04/01/2025 between 10:00 AM and 3:30 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	K 920		

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K 920	Continued From page 16 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 power strips are not used for non-PCREE (Patient-care-related electrical equipment) and that power strips are not used as a substitute for fixed wiring in accordance with NFPA 99, Healthcare Facilities Code, 2012 Edition, Section 10.2.4, NFPA 70, National Electric Code, 2011 edition, chapter 4 {400.8(1)} On 04/01/2025, between 10:00 AM and 3:30 PM, surveyor 50034, with the Maintenance-Housekeeping-Laundry present observed the following: 1. In Patient Rooms 215 and 216 an unsecured	K 920		

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K 920	Continued From page 17 multi-outlet device was plugged into the wall outlet. The facility was unable to produce documentation verifying the multi-outlet device is listed for healthcare use. During the exit interview the Maintenance-Housekeeping-Laundry Supervisor stated he believed the devices in question were brought in and installed by patient family members. The surveyor 50034 confirmed this finding with the Maintenance-Housekeeping-Laundry at the time of the observation.	K 920		

E015

The facility failed to maintain documentation for the provision of subsistence needs for staff and patients whether they evacuate or shelter in place for Emergency Preparedness.

1. No one has been affected by this deficiency.
2. We will update of Memorandum of Understanding (MOU's).
3. The facility will correspond with each of the services to update the MOU's.
4. We will monitor this during our annual policy/procedure review at our QA Meeting.
5. The facility is not requesting a waiver for this tag.
6. Completion date: 04/25/25.

K321

The facility failed to have a self-closing or automatic closing door to the dry food pantry room.

1. No one has been affected by this deficiency.
2. A self-closing door mechanism will be installed to the dry food pantry room.
3. We will monitor this through our annual door inspection.
4. We will monitor this ongoing and through our QA Meetings.
5. The facility is not requesting a waiver for this tag.
6. Completion date: 04/07/25.

The facility failed to secure a self-closing door to close to the Soiled Utility Room on its own.

1. No one has been affected by this deficiency.
2. The door was adjusted to fit properly in the frame, allowing it to properly function.
3. We will monitor this through our annual door inspection.
4. We will monitor this ongoing and through our QA Meetings.
5. The facility is not requesting a waiver for this tag.
6. Completion date: 04/07/25.

K324

The facility failed to protect the commercial cooking operations by ensuring that the oven/stove be properly placed under the kitchen hood extinguishing system.

1. No one has been affected by this deficiency.
2. The facility has ensured in accordance with NFPA the marking on the floor with a yellow tape placed beneath the rear left wheel of the oven/stove. This will allow proper positioning beneath the extinguishing system of the cooking appliance at all times.
3. We will monitor the location of the oven/stove daily.
4. We will monitor this through our quarterly QA Meetings.
5. The facility is not requesting a waiver for this tag.
6. Completion date: 04/10/25.

K362

The facility failed to meet the requirements of the NFPA for smoke barrier enclosures on third floor in the hallway west wing.

1. No one has been affected by this deficiency.
2. The ceiling on the third floor west wing has two holes of which are in the process of being repaired. The repairs include drywall, taping and painting.
3. We will monitor the ceiling smoke barriers on an going basis.
4. We will monitor this through our quarterly QA Meetings.
5. The facility is not requesting a waiver for this tag.
6. Completion date: 04/25/25.

The facility failed to meet the requirements of the NFPA for smoke barrier enclosures on second floor on east wing in rooms 229 and 227.

1. No one has been affected by this deficiency.
2. The ceiling on the second floor east wing, rooms 229 and 227 are both in the process of being repaired. The repairs include drywall, taping and painting.
3. We will monitor the ceiling smoke barriers on an going basis.
4. We will monitor this through our quarterly QA Meetings.
5. The facility is not requesting a waiver for this tag.
6. Completion date: 04/25/25.

K363

The facility failed to maintain the Activity corridor doors two resist the passage of smoke to and from the corridor as referenced by NFPA

1. No one has been affected by this deficiency.
2. The self-closing door to the Activity Room will be repaired and will no longer be rubbing on the floor when widely opened.
3. We will monitor the Activity Room door and all other doors through our annual door inspection.
4. We will monitor this through our quarterly QA Meetings.
5. The facility is not requesting a waiver for this tag.
6. Completion date: 04/25/25.

The facility failed to maintain the room 316 door to latch when fully closed.

1. No one has been affected by this deficiency.
2. The striker plate has been lined up with the door latching mechanism.
3. We will monitor concerns as such ongoing and through our annual door inspection.
4. The facility will monitor this through our quarterly QA Meetings.
5. The facility is not requesting a waiver for this tag.

6. Completion date: 04/25/25.

The facility failed to maintain the room 210 door with a gap on the top latch and does not resist passage of smoke.

1. No one has been affected by this deficiency.
2. The gap to 210 has been repaired to now resist the passage of smoke.
3. We will monitor concerns as such on our annual door inspection.
4. We will monitor this through our quarterly QA Meetings.
5. The facility is not requesting a waiver for this tag.
6. Completion date: 04/25/25.

The facility is holding the self-closing kitchen exit door with a landscaping brick.

1. No one has been affected by this deficiency.
2. The landscaping brick has been removed allowing the door to self-close.
3. We will monitor concerns as such ongoing and through our annual door inspection.
4. We will monitor this through our quarterly QA Meetings.
5. The facility is not requesting a waiver for this tag.
6. Completion date: 04/10/25.

K511

The facility is drying its kitchen mops and rags in the commercial dryer.

1. No one has been affected by this deficiency.
2. The facility is now drying its mops and rags on an air drying rack.
3. We will monitor our rag drying on going.
4. We will monitor this through our quarterly QA Meetings.
5. The facility is not requesting a waiver for this tag.
6. Completion date: 04/07/25.

K914

The facility failed to ensure the proper inspection of the receptacles that are not listed as hospital grade at intervals not exceeding 12 months. The annual testing of the receptacles did not include the retention force of the grounding blade.

1. No one has been affected by this deficiency.
2. The facility has since acquired the proper testing equipment to properly test all receptacles.
3. We will monitor ongoing and on an annual basis.
4. We will report this to our quarterly QA Meetings.
5. The facility is not requesting a waiver for this tag.
6. Completion date: 04/25/25.

K918

The facility's weekly generator inspection reports failed to show a voltage conductance test for sealed batteries or an electrolyte specific gravity reading for unsealed automotive batteries.

1. No one has been affected by this deficiency.
2. The facility has since made note of the voltage conductance test and will be tracking it accordingly.
3. We will monitor the proper tracking annually.
4. We will monitor this through our quarterly QA Meetings.
5. The facility is not requesting a waiver for this tag.
6. Completion date: 04/25/25.

The facility's generator test load inspection reports failed to show the monthly requirements.

1. No one has been affected by this deficiency.
2. The facility has since acquired the proper testing charts to monitor with accuracy the dependability of the generator.
3. We will monitor the proper testing annually.
4. We will monitor this through our quarterly QA Meetings.
5. The facility is not requesting a waiver for this tag.
6. Completion date: 04/25/25.

K920

The facility failed to ensure that power strips are not used for non-patient care related electrical equipment and that power strip are not used as a substitute for fixed wiring in patient rooms 215 and 216.

1. No one has been affected by this deficiency.
2. Unauthorized multi-outlet adaptors have been removed in rooms 215 and 216.
3. We have a licensed electrician that will upgrade these two gang outlets to a four gang outlet for room 215 & 216.
4. A licensed electrician will replace two gang outlets to a four gang outlet as the residents have a need for this expansion.
5. The facility will monitor this through our quarterly QA Meetings.
6. The facility is not requesting a waiver for this tag.
7. Completion date: 04/25/25.