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MAY 13 2025
BY:

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

PRINTED: 04/29/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205097	A. BUILDING 01 _____ B. WING _____	04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORWAY CENTER FOR HEALTH & REHABILITATION, LLC	29 MARION AVE NORWAY, ME 04268

(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: 04/24/2025 Norway Center for Health and Rehabilitation, a long-term care facility, is in substantial compliance with 42 Code of Federal Regulations Part 483.73 Emergency Preparedness Requirement for Long Term Care Facilities.	E 000		
K 000	INITIAL COMMENTS Federal Recertification Survey Date of Survey 04/24/2025 Norway Center for Health and Rehabilitation, 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 and is not in substantial compliance.	K 000	Please see accompanying Plan of Correction	
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, the facility failed to ensure that exit discharge is arranged in accordance with NFPA 101, Life Safety Code, 2012 edition, sections 19.2.7, 7.7, and 7.1.6.4.	K 271		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Nathan Rosebrook | TITLE: Administrator | (X6) DATE: 5/9/2025

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 271	Continued From page 1 Findings: On 04/24/2025, between 09:00 AM and 3:00 PM, two surveyors, with the Director of Maintenance, and the Regional Manager of Engineering present, observed the following: 1. The egress path from the basement leads to a gravel path that has been eroded around a square paver block. According to an interview with the Director of Maintenance, the two-inch change in elevation is due to the gravel around the paver being eroded. This exit discharge to the public way not a hard packed, all-weather, level travel surface. 2. The exit discharge from Wing C has a gap and elevation change that is a trip hazard where the concrete pad meets the paved walkway. The elevation difference measured over an inch. Interview with the Director of Maintenance disclosed that it is because of the frost coming out of the ground. The surveyors confirmed these findings with the Director of Maintenance, and the Regional Manager of Engineering at the time of observation and during the exit interview.	K 271	Please see accompanying Plan of Correction	
K 293 SS=D	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies	K 293		

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K 293	Continued From page 2 with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observations and interview with the Director of Maintenance and the Regional Manager of Engineering, the facility failed to install directional, continuously illuminated, exit signage in every exit location in accordance with National Fire Protection Association 101, Life Safety Code, 2012 edition, sections 7.10.5.2.1, 7.10.2.1, and 19.2.10. Finding: On 04/23/2025 between 09:00 AM and 4:00PM two surveyors with the Director of Maintenance and the Regional Manager of Engineering present during a facility tour identified: 1. The exit pathway in the kitchen is marked by non illuminated exit signage. Interview with the Director of Maintenance and the Regional Manager of Engineering revealed that the facility believed that illuminated exit signage was not required in the kitchen as no residents would be in this area. This finding was acknowledged by the Director of Maintenance and the Regional Manager of Engineering at the time of observation and during the exit interview.	K 293	Please see accompanying Plan of Correction	
K 341 SS=E	Fire Alarm System - Installation CFR(s): NFPA 101 Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in	K 341		

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K 341	Continued From page 3 accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the long-term care facility failed to install fire alarm devices in accordance with NFPA 101, Life Safety Code, 2012 edition, sections 19.3.4.2.1, and 9.6.2.5 and NFPA 72, National Fire Alarm and Signaling Code, 2010 edition, Sections 17.14.4, and 18.3.5. Findings: On 04/24/2025, between 09:00 AM and 3:00 PM, the surveyors, with the Director of Maintenance and the Regional Manager of Engineering present identified the following 1. Manually Actuated Alarm-Initiating Devices, (Pull Stations) with the operable part of each device higher than 48 inches above the floor level. Interview with the Director of Maintenance revealed after the basement device was measured that all devices in the facility are at that height. A sample of the measured devices are:	K 341	Please see accompanying Plan of Correction	

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K 341	Continued From page 4 1. A wing 55 inches above the floor 2. B wing 55 inches above the floor 3. C wing 55 inches above the floor 4. D wing 55 inches above the floor 5. Basement level is 55.25 inches above the floor. 2. In the basement level corridor there is a wall type fire alarm notification device installed as a ceiling notification device. These findings were acknowledged by the Director of Maintenance and the Regional Manager of Engineering at the time of observation and the exit interview on 04/15/2025, between 9:00 AM and 1:00 PM.	K 341	Please see accompanying Plan of Correction	
K 911 SS=D	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) This REQUIREMENT is not met as evidenced by: Based on observations and interview, the facility failed to meet the requirements of NFPA 70, National Electrical Code, 2011 edition, Section 314.25, as referenced by NFPA 99, Healthcare Facilities Code, 2012 edition, section 6.3.2.1. Finding:	K 911		

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K 911	Continued From page 5 On 04/22/2025, between 11:00 AM and 4:00 PM, two surveyors with the Director of Maintenance, and the Regional Manager of Engineering present, observed the following: 1. The light switch in the attic above the attic access in the A wing by the smoke door has a broken cover with exposed wiring. The surveyors acknowledged this finding with the Director of Maintenance, and the Regional Manager of Engineering at the time of the observation and during the exit interview.	K 911	Please see accompanying Plan of Correction	
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	K 923		

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K 923	Continued From page 6 handled with precautions as specified in 11.6.2. 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 and interview, the health care facility failed to store oxygen cylinders in an outdoor enclosure that can be secured in accordance with NFPA 99, Healthcare Facilities Code, 2012 edition, Sections 11.3.2, and 11.6.5. Findings: On 04/24/2025, between 09:00 AM and 3:00 PM, the surveyors, with the Director of Maintenance and the Regional Manager of Engineering present identified the following 1. There were racks of oxygen cylinders stored outside of the exterior door to the inside oxygen room. An interview with the Director of Maintenance revealed that oxygen is stored outside to avoid having a capacity of more than 12 cylinders in the inside oxygen storage room. There are 22 E-cylinders with 24 ft^3 each and 1 small cylinder with 9 ft^3 totaling 537 ft^3 stored outside in racks, not in any enclosure. These 23	K 923	Please see accompanying Plan of Correction	

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K 923	Continued From page 7 cylinders were less than 5 feet from the wooden windowsills and roof trim between the resident care wings A, and C. There were six E cylinders in the room at the time of the inspection totaling 144 ft³. 2.. There is no precautionary sign readable from 5 feet 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." because there was no enclosure, door, or gate. 3. The cylinders outside had no signage or markings to segregate empty from full cylinders to avoid confusion and delay. An interview with the Director of Maintenance revealed that only full cylinders are stored outside. The surveyors confirmed these findings with the Director of Maintenance and the Regional Manager of Engineering at the time of the observation and the exit interview.	K 923	Please see accompanying Plan of Correction	

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K271 - Discharge from Exits

1. The egress path from the basement leads to a gravel path that has been eroded around a square paver block. According to an interview with the Director of Maintenance, the two-inch change in elevation is due to the gravel around the paver being eroded. This exit discharge to the public way not a hard packed, all-weather, level travel surface.

2. The exit discharge from Wing C has a gap and elevation change that is a trip hazard where the concrete pad meets the paved walkway. The elevation difference measured over an inch.

K271 POC

The corrective action(s) that will be accomplished for those residents found to have been affected;

1. Corrective action has been taken to address all individuals that may use the egress, Residents do not have access to the basement level. A cement pad has been constructed at the location to create a hard packed, all-weather, level surface.
2. Corrective action has been taken to address all individuals that may use the egress. A section of cement and pavement located at the exit discharge from Wing shall be repaired and replaced as necessary, in-house, to eliminate deficient elevation.

The method to identify other residents having the potential to be affected and what corrective action will be taken;

1. Corrective action has been taken to address all individuals that may use the egress, Residents do not have access to the basement level. A cement pad has been constructed at the location to create a hard packed, all-weather, level surface.
3. Corrective action has been taken to address all individuals that may use the egress. A section of cement and pavement located at the exit discharge from Wing shall be repaired and replaced as necessary, in-house, to eliminate deficient elevation.

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The measures to be put into place, or systemic change(s) made, to ensure non-recurrence:

1. Verifying Compliance of facility to assure each egress provides a level-walking surface with respect to changes in elevation and free of obstructions shall be added to preventative maintenance audits to be conducted annually. Additionally, the exit discharge shall be verified as qualifying as a hard packed all-weather travel surface during each of these audits. Additional action will be taken as necessary in the event that an egress no longer meets the required criteria during the audit.
2. Annual Audit as described above, in this section.

How the facility will monitor its corrective actions to ensure correction and non-recurrence:

1. The Maintenance Director/designee shall verify that work repair has been completed by the specified date and that the repair satisfies meeting regulatory requirements. An annual audit shall be conducted to verify that each egress continues to meet the regulation, with additional action taken as necessary.
2. The Maintenance Director/designee shall verify that work repair has been completed by the specified date and that the repair satisfies meeting regulatory requirements. An annual audit shall be conducted to verify that each egress continues to meet the regulation, with additional action taken as necessary.

The date that the deficiency will be corrected:

1. 5/9/2025
2. 5/30/2025

K293 - Exit Signage

The exit pathway in the kitchen is marked by non-illuminated exit signage.

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K293 POC

The corrective action(s) that will be accomplished for those residents found to have been affected;

While no residents have been affected, corrective action has been taken to eliminate risk. The existing non-illuminated sign will be replaced with an illuminated sign by a licensed electrician to comply with regulatory requirements. An electrical contractor has been retained to complete this work.

The method to identify other residents having the potential to be affected and what corrective action will be taken;

Corrective action has been taken to eliminate risk for all individuals within the Center. The existing non-illuminated sign will be replaced with an illuminated sign by a licensed electrician to comply with regulatory requirements. An electrical contractor has been retained to complete this work."

The measures to be put into place, or systemic change(s) made, to ensure non-recurrence:

In the event that any illuminated exit sign requires replacement, the replacement sign shall be an appropriately illuminated sign.

How the facility will monitor its corrective actions to ensure correction and non-recurrence:

The date that the deficiency will be corrected:

5/30/2025

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K341 – Fire Alarm System – Installation

1. Manually Actuated Alarm-Initiating Devices, (Pull Stations) with the operable part of each device higher than 48 inches above the floor level. Interview with the Director of Maintenance revealed after the basement device was measured that all devices in the facility are at that height. A sample of the measured devices are:
   A wing 55 inches above the floor
   B wing 55 inches above the floor
   C wing 55 inches above the floor
   D wing 55 inches above the floor
   Basement level is 55.25 inches above the floor.
2. In the basement level corridor there is a wall type fire alarm notification device installed as a ceiling notification device.

K341 POC

The corrective action(s) that will be accomplished for those residents found to have been affected;

1. Actions are being taken to address compliance for any individual that may need to trigger the pull stations. All pull stations within the Center shall be lowered to a height at or below 48 inches.
2. The current alarm notification device located in the basement-level corridor shall be replaced with a ceiling notification device.

The method to identify other residents having the potential to be affected and what corrective action will be taken;

1. Actions are being taken to address compliance for any individual that may need to trigger the pull stations. All pull stations within the Center shall be lowered to a height at or below 48 inches.
2. Corrective Action shall address all occupants of the Center. The current alarm notification device located in the basement-level corridor shall be replaced with a ceiling notification device.

The measures to be put into place, or systemic change(s) made, to ensure non-recurrence:

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1. In the event that pull stations require maintenance, repair or replacement, no work shall be permitted that would raise the pull-stations location above 48 inches.
2. In the event that the current alarm notification device located in the basement-level corridor requires replacement, replacement shall only be made with a ceiling notification device.

How the facility will monitor its corrective actions to ensure correction and non-recurrence:

1. All future repair and/or replacement of the pull-stations shall be monitored by the Director of Maintenance to assure they are maintained at a height no greater than 48 inches.
2. In the event that the basement-level ceiling notification device requires replacement, the Maintenance Director will monitor the replacement to assure an appropriate ceiling notification device is installed.

Documentation to support a waiver request (if appropriate);

Please see the attached IDR request for reasoning of waiver.

The date that the deficiency will be corrected:

1. 6/8/2025
2. 6/8/2025

K911 Electrical Systems – Other

The light switch in the attic above the attic access in A-wing, by the smoke door, has a broken cover with exposed wiring.

K911 POC

The corrective action(s) that will be accomplished for those residents found to have been affected;

Corrective action shall be taken to address all occupants of the Center. The cover to the light switch has been replaced.

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The method to identify other residents having the potential to be affected and what corrective action will be taken;

Corrective action shall be taken to address all occupants of the Center. The cover to the light switch has been replaced.

The measures to be put into place, or systemic change(s) made, to ensure non-recurrence:

The Maintenance Director/designee shall audit the light switch covers of the Center as part of the preventative maintenance program. This audit shall be conducted annually to assure compliance, with replacement conducted for any non-compliant switch covers.

How the facility will monitor its corrective actions to ensure correction and non-recurrence:

Results of the audit shall be reported to the Quality Assurance and Performance Improvement (QAPI) team, with further action taken as indicated.

The date that the deficiency will be corrected:

5/9/2025

K 923 Gas Equipment – Cylinder and Container Storage

1. There were racks of oxygen cylinders stored outside of the exterior door to the inside oxygen room. An interview with the Director of Maintenance revealed that oxygen is stored outside to avoid having a capacity of more than 12 cylinders in the inside oxygen storage room. There are 22 E-cylinders with 24 cubic feet each and 1 small cylinder with 9 cubic feet totaling 537 cubic feet stored outside in racks, not in any enclosure. These 23 cylinders were less than 5 feet from the wooden windowsills and roof trim between the resident care wings A, and C. There were six E cylinders in the room at the time of the inspection totaling 144 cubic feet.
2. There is no precautionary sign readable from 5 feet on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum

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"CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Because there was no enclosure, door, or gate.

3. The cylinders outside had no signage or markings to segregate empty from full cylinders to avoid confusion and delay. An interview with the Director of Maintenance revealed that only full cylinders are stored outside.

K 923 POC

The corrective action(s) that will be accomplished for those residents found to have been affected;

1. Corrective action shall be taken to address all occupants of the Center. All oxygen cylinders outside of the oxygen room have been removed and the total number of oxygen has been reduced to 12 E-cylinders or less to assure a total of less than 300 cubic feet of oxygen.
2. No longer applicable as the outdoor area shall no longer be used for oxygen storage.
3. No longer applicable as the outdoor area shall no longer be used for oxygen storage.

The method to identify other residents having the potential to be affected and what corrective action will be taken;

1. Corrective action shall be taken to address all occupants of the Center. All oxygen cylinders outside of the oxygen room have been removed and the total number of oxygen has been reduced to 12 E-cylinders or less to assure a total of less than 300 cubic feet of oxygen.
2. No longer applicable as the outdoor area shall no longer be used for oxygen storage.
3. No longer applicable as the outdoor area shall no longer be used for oxygen storage.

The measures to be put into place, or systemic change(s) made, to ensure non-recurrence:

1. Orders for oxygen shall be limited, to not exceed 12 total tanks of oxygen in the oxygen room at any given time. The area outside of the oxygen room shall no longer be utilized as an oxygen storage area.

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2. The outdoor area shall no longer be used for oxygen storage.
3. The outdoor area shall no longer be used for oxygen storage.

How the facility will monitor its corrective actions to ensure correction and non-recurrence:

1. The Maintenance Director/Designee shall check the oxygen tank quantity daily to assure that the total number of tanks does not exceed 300 cubic feet.
2. The outdoor area shall no longer be used for oxygen storage.
3. The outdoor area shall no longer be used for oxygen storage.

The date that the deficiency will be corrected:

5/16/2025