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APR 17 2025

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

REVISED

PRINTED: 04/10/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205053	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 03/26/2025
NAME OF PROVIDER OR SUPPLIER ST MARY'S D'YOUVILLE PAVILION			STREET ADDRESS, CITY, STATE, ZIP CODE 102 CAMPUS AVE LEWISTON, ME 04240		
(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: 03.26.2025 St. Mary's D'Youville, a long-term care facility, is in substantial compliance with 42 Code of Federal Regulations Part 483.73 Requirement for Long Term Care Facilities for Emergency Preparedness.	E 000			
K 000	INITIAL COMMENTS Federal Recertification Survey: Date: 03.26.2025 St. Mary's D'Youville, 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 211 SS=D	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the long-term care facility failed to maintain the Exit Corridor required width in 5 of 6 egress corridors per NFPA 101, Life Safety Code, 2012 Edition, Sections 18.2.1, 19.2.1, 7.1.10.1	K 211	Please see attached		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Maurissa Varney

Administrator

4-17-25

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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K 211	Continued From page 1 Findings: On 03.26.2025, between 9:00 AM and 4:30 PM, a surveyor, with QAPI Manager present, observed the following: 1. The patio exit enclosure had floor cleaning machines and mopheads stored in the hallway in the path of egress and exit enclosure. This deficient practice could effect residents, guest and staff from proper egress in the event of an emergency. 2. Outside room 231 across from the nurse's station had a blood pressure machine stored in the path of egress corridor. This deficient practice could effect residents, guest and staff from proper egress in the event of an emergency. 3. Outside patient room 234 had (2) blood pressure machine stored in the path of egress corridor. This deficient practice could effect residents, guest and staff from proper egress in the event of an emergency. 4. Outside patient room 246 had (2) blood pressure machine stored in the path of egress corridor. This deficient practice could effect residents, guest and staff from proper egress in the event of an emergency. 5. Outside patient room 337 had a blood pressure machine stored in the path of egress corridor. This deficient practice could effect residents, guest and staff from proper egress in the event of an emergency. 6. Outside patient room 449 had a blood pressure machine stored in the path of egress corridor. This deficient practice could effect residents, guest and staff from proper egress in the event of an emergency. 7. Across from 4W nurse's station had a blood pressure machine stored in the path of egress	K 211			

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K 211	Continued From page 2 corridor. This deficient practice could effect residents, guest and staff from proper egress in the event of an emergency. 8. The patio exit path to the public way was snow covered and would be an impediment to full instant use of means of egress. The surveyor confirmed these findings with QAPI Manager at the time of the observation.	K 211			
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 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	K 222	Please see attached		

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K 222	Continued From page 3 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 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 ensure that doors in a required means of egress met the latching/locking requirements of NFPA 101 Life Safety Code (2012 edition) 19.2.2.2.6 (2) and 7.2.1.6.2. This deficient practice could affect the patients/residents,			K 222			

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K 222	Continued From page 4 visitors, and members of facility staff in this location(s). Finding: Observation(s) and Interview(s), during a facility tour on 03.26.2025 between 9:00 AM and 4:30 PM with the QAPI Manager present, observed the following: 1. The facility failed to provide exit access to Stairwell A floor 2 & 4 and Stairwell B floor 2 & 4 was readily accessible at all times by having special locking arrangements (keycoded) 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. Observation and Interview with the Manager QAPI at the time of observation confirmed the exit doors had coded keypad that could only be accessed by staff with access code. The facility failed to provide exit access that was readily accessible at all 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 findings was verified by the QAPI Manager at the time of observation and exit interview on 03.26.2025.	K 222			
K 291 SS=F	Emergency Lighting CFR(s): NFPA 101	K 291	Phase see attached		

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K 291	Continued From page 5 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: Based on documentation review, the facility failed to maintain and test the emergency lighting in 7 of 7 smoke compartments in accordance with National Fire Protection Association (NFPA) 101, Life Safety Code, 2012 edition, sections 7.9.3, and 19.2.9.1. Findings include: Documentation reviews of emergency lighting testing reports during a facility tour with the Quality Assurance, Performance, and Improvement Manager (QAPI Manager) present on 03.26.2025 from 09:00 AM to 4:30 PM identified: 1. The emergency lights testing reports were not filled out from April to December of 2024. The months were filled in ahead of time, but no monthly inspections were annotated. Written records of visual inspections and tests shall be kept for inspection. See the attached 2024 reports. 2. There is no documentation regarding the 90-minute annual test for the emergency lighting. According to the monthly sheets, it was supposed to happen in August of 2024, but the pages are blank after March of 2024 to Present. These findings were verified by the QAPI Manager at the time of observation and exit interview on 03.26.2025 from 09:00 AM to 4:30 PM.	K 291			

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K 293 SS=E	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 with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observations, interviews and document review with the Facilities Director and the Maintenance Director, the facility failed to maintain the illuminated exit signage in 3 of 7 smoke compartments in accordance with National Fire Protection Association (NFPA) 101, Life Safety Code, 2012 edition sections 7.10.5.2.1, and 19.2.10. Findings include: Interviews, Observations, and Documentation reviews of exits signage during a facility tour with the Quality Assurance Performance, and Improvement Manager (QAPI Manager) present on 03.26.2025 from 09:00 AM to 4:30 PM identified: 1. The exit sign by Stairs A on floor 3 was not continuously illuminated. 2. The exit signs by the Nurse's station on the third floor, east side were not continuously illuminated. 3. The exit sign in the resident dining room on the second floor is not continuously illuminated. 4. According to the monthly exit sign inspection	K 293	Please see attached		

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K 293	Continued From page 7 report, there are 22 illuminated exit signs that were inoperative in all reports in 2024, and in 2025. See the attached report. These findings were verified by the QAPI Manager at the time of observation and exit interview on 03.26.2025 from 09:00 AM to 4:30 PM.	K 293			
K 345 SS=D	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the long-term care facility failed to inspect and maintain the fire alarm system in accordance with the requirements of NFPA 72, National Fire Alarm and Signaling Code, 2010 edition, section 14, per NFPA 101, The Life Safety Code, 2012 edition, sections 9.6.1.5.3 and 19.3.4.1 Finding: On March 26, 2025, between 9:00 AM and 4:30 PM, a surveyor, with the Manager QAPI present, observed the following: 1. During documentation review, it was observed that the fire alarm inspection was last conducted	K 345	Please see attached		

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K 345	Continued From page 8 in February of 2024. Administration staff reached out to maintenance who reported that the annual inspection of the fire alarm system had not been completed yet.	K 345			
K 351 SS=D	The finding was verified by the Manger QAPI at the time of observations on 3/26/2025. Sprinkler System - Installation CFR(s): NFPA 101 Sprinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the long-term care facility failed to install the water-based fire protection system in 2 of 7 smoke compartments in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, 2010 edition, Sections 8.3.2.5., and 8.5.7.1 as referenced by NFPA 101, Life Safety	K 351	Please see attached		

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205053

(X2) MULTIPLE CONSTRUCTION
A. BUILDING 01

B. WING _____

(X3) DATE SURVEY
COMPLETED

03/26/2025

NAME OF PROVIDER OR SUPPLIER

ST MARY'S D'YOUVILLE PAVILION

STREET ADDRESS, CITY, STATE, ZIP CODE

102 CAMPUS AVE
LEWISTON, ME 04240(X4) ID
PREFIX
TAGSUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL
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(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY)(X5)
COMPLETION
DATE

K 351

Continued From page 9
Code, 2012 edition, Section 19.3.5. This deficient practice could affect the response of the facility, and the sprinkler in case of activation of the sprinkler system.

Findings:

On 03.26.2025, between 09:00 AM and 4:30 PM, a surveyor with the Manager of QAPI present, observed the following:

1. There are two missing ceiling tiles in residents room 103.
2. There are two missing ceiling tiles in resident room 108.
3. There is a ceiling tile missing in resident room 114.
4. There is a ceiling tile out of place in the laundry room above the dryers.

These findings were verified by the Manager of QAPI at the time of observations and during the exit interview..

K 353 SS=F Sprinkler System - Maintenance and Testing
CFR(s): NFPA 101

Sprinkler System - Maintenance and Testing
Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.

a) Date sprinkler system last checked _____

K 351

K 353

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102 CAMPUS AVE

LEWISTON, ME 04240

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K 353	Continued From page 10 b) Who provided system test c) Water system supply source Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observations, interview and document review, the facility failed to ensure that Sprinkler System was inspected and maintained in 5 of 7 smoke compartments in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. This deficiency does not meet the minimum requirements of maintaining a sprinkler system in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-based Fire Protection Systems, 2011 edition, sections 4.3.1 and 5.2.1.1.1 Findings: Observation and Interview and documentation review during a facility tour on 3/26/2025 between the hours of 9:00 AM to 4:30 PM with the Manager QAPI present, observed the following: 1. During the walk-through inspection several sprinkler heads were observed covered with dust and debris. These sprinkler head locations include, but are not limited to: the kitchen supervisor's office, the office to the right of the kitchen's supervisor's office, 2 west nurse's station, second floor corridor by the clinical resources office, the corridor double doors by the 3rd floor memory unit dining room, 4west nurses station, inside room 449 and room 448. This	K 353		

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K 353	Continued From page 11 deficient practice could impair the operation of the sprinkler from its designed use and could affect all occupants including residents, employees, and visitors to the facility. 2. During the review of records, the facility failed to provide documentation of the required sprinkler system inspections and testing. The most recent document available was from February 2024. This deficient practice could affect all occupants including residents, employees, and visitors to the facility. These findings were verified by the Manager QAPI at the time of observations on 3/26/2025.	K 353			
K 372 SS=D	Subdivision of Building Spaces - Smoke Barrier CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure that the 1-Hour smoke barrier walls remain free of un firestopped penetrations in two of 12 smoke compartments in accordance	K 372	Please see attached		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205053	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 03/26/2025
NAME OF PROVIDER OR SUPPLIER ST MARY'S D'YOUVILLE PAVILION			STREET ADDRESS, CITY, STATE, ZIP CODE 102 CAMPUS AVE LEWISTON, ME 04240		
(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	
K 372	Continued From page 12 with NFPA 101, Life Safety Code, 2012 edition, Sections 19.3.7.3, and 8.6.7.1. Findings: Documentation review and interview during a facility tour with the Quality Assurance, Performance, and Improvement Manager (QAPI Manager) present on 03.26.2025 from 09:00 AM to 4:30 PM identified: 1. The wall above the cross-corridor doors by the Business office, room 1111 has two holes that go through both sides of the wall. They are at least 3 inches in diameter. One hole has an insulated pipe penetrating through, and one hole has nothing penetrating through. See photograph submitted. 2. There is a flexible conduit penetration that is not firestopped above the double doors in the East wing of floor 2. These findings were verified by the QAPI manager and at the time of observation on 03.26.2025 from 09:00 AM to 4:30 PM.	K 372			
K 761 SS=F	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	K 761	Please see attached		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205053	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 03/26/2025
NAME OF PROVIDER OR SUPPLIER ST MARY'S D'YOUVILLE PAVILION			STREET ADDRESS, CITY, STATE, ZIP CODE 102 CAMPUS AVE LEWISTON, ME 04240		
(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	
K 761	Continued From page 13 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 documentation review, the long-term care facility failed to conduct an annual fire door inspection that ensures that all fire rated doors and hardware are inspected, tested, and maintained by individuals performing the door inspections that possess knowledge, training or experience that demonstrates ability in accordance with NFPA 80, Standard for Fire Door and Other Opening Protectives, 2010 edition Section 5.2 as referenced by NFPA 101, Life Safety Code, 2012 Edition, Sections 19.7.6, and 8.3.3.1 Finding: Documentation review and interview during a facility tour with the Quality Assurance, Performance, and Improvement Manager (QAPI Manager) present on 03.26.2025 from 09:00 AM to 4:30 PM identified: 1. The facility failed to complete the annual assessment of all fire doors in the facility. The facility had no documentation that the doors had been inspected by a trained employee or a qualified outside vendor since Certified Fire Door Co. did the inspection on 02/22/2024. This surveyor confirmed this finding with the QAPI Manager at the time of observation and exit interview on 03.26.2025 from 09:00 AM to 4:30 PM	K 761			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205053	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 03/26/2025
NAME OF PROVIDER OR SUPPLIER ST MARY'S D'YOUVILLE PAVILION			STREET ADDRESS, CITY, STATE, ZIP CODE 102 CAMPUS AVE LEWISTON, ME 04240		
(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	
K 914 SS=D	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 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 retention force of receptacles not listed as hospital-grade are tested at intervals not exceeding 12 months in accordance with NFPA 99, Healthcare Facilities Code, 2012 edition, Section 6.3.3.2.4. Finding: Documentation review and interview during a facility tour with the manager QAPI present on 03.26.2025 from 09:00 AM to 4:30 PM identified:	K 914	Please see attached		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205053	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 03/26/2025
NAME OF PROVIDER OR SUPPLIER ST MARY'S D'YOUVILLE PAVILION			STREET ADDRESS, CITY, STATE, ZIP CODE 102 CAMPUS AVE LEWISTON, ME 04240		
(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	
K 914	Continued From page 15	K 914			
K 918 SS=F	1. The annual testing of the receptacles did not include the retention force of the grounding blade of each electrical receptacle to ensure it is not less than 4 oz. This deficient practice could pose an electrical hazard to all residents, visitors, and members of facility staff in this locations. This finding was verified by the manager QAPI at the time of interview and document review on 03.26.2025 from 09:00 AM to 4:30 PM. Electrical Systems - Essential Electric System 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	Please see attached		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205053	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 03/26/2025
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NAME OF PROVIDER OR SUPPLIER

ST MARY'S D'YOUVILLE PAVILION

STREET ADDRESS, CITY, STATE, ZIP CODE

102 CAMPUS AVE
LEWISTON, ME 04240

(X4) ID
PREFIX
TAGSUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL
REGULATORY OR LSC IDENTIFYING INFORMATION)ID
PREFIX
TAGPROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY)(X5)
COMPLETION
DATE

K 918

Continued From page 16
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 documentation review 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 8.3.8, as referenced by 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.

Finding:

Review of documentation and interview with the
Quality Assurance, Performance, and
Improvement Manager (QAPI Manager) present
on 03.26.2025 from 09:00 AM to 4:30 PM
identified:

- 1) No documentation showing an annual fuel
quality test was provided on the generator testing
and maintenance documentation.
A fuel quality test shall be performed at least
annually using appropriate ASTM standards or
the manufacturer's recommendations.

K 918

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205053	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 03/26/2025
NAME OF PROVIDER OR SUPPLIER ST MARY'S D'YOUVILLE PAVILION			STREET ADDRESS, CITY, STATE, ZIP CODE 102 CAMPUS AVE LEWISTON, ME 04240		
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K 918	Continued From page 17 This finding was verified by the QAPI Manager at the time of observation and exit interview on 03.26.2025 from 09:00 AM to 4:30 PM.	K 918			

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ST. MARY'S d'YOUVILLE PAVILION

Provider ID# 205053

Facility ID# 0104

Event ID# HXDW21

PLAN OF CORRECTION

K 211 Means of egress = General

Findings:

The facility failed to maintain the Exit Corridor required width in 5 of 6 corridors.

1. Patio exit enclosure had floor cleaning machines and mopheads stored in the hallway in the path of egress and exit enclosure.
2. Blood pressure machines in hallways (#2 - #7)
3. The patio exit path to the public way was snow covered and would be an impediment to full instant use of means of egress.

All of these findings could affect residents, guests, and staff from proper egress in the event of an emergency.

Plan of Correction:

1. All machines and mopheads have been removed from the hallway leading to the patio exit enclosure.
2. All blood pressure machines have been relocated to other storage areas. The compliant storage areas vary by floor.
3. The patio exit path to the public way will be monitored by facilities staff during inclement weather. All walkways will be maintained to assure access/egress.
4. Performance will be monitored through the Quality Assurance and Performance Improvement Program. Performance will be reported through the Quality and Performance Improvement Committee no less than quarterly.

Compliance Date: 03/26/2025

STATUS: Complete

K 222 Egress Doors

Findings:

The facility failed to provide exit access to Stairwell A Floor 2 and 4 and Stairwell B floor 2 and 4.

This practice could affect residents, guests, and staff from proper egress in the event of an emergency.

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Plan of Correction:

The code to open the door has been placed above each keypad and is readily available to anyone needing to exit through this door.

An annual inspection of all exits serving emergency exits shall be conducted by the Facilities Department.

Performance will be monitored through the Quality Assurance and Performance Improvement Program. Performance will be reported through the Quality and Performance Improvement Committee no less than quarterly.

Compliance Date: 4/3/2025

STATUS: Complete

K 291 Emergency Lighting

Findings:

The Emergency lights testing reports were not filled out from April to December of 2024. No monthly inspections were not annotated.

There was no documentation regarding the 90-minute annual test for emergency lighting.

This practice could affect residents, guests, and staff from proper egress in the event of an emergency.

Plan of Correction:

Monthly testing of the emergency lighting in all smoke compartments will be conducted in compliance with NFPA 101, Life Safety Code, 2012 edition sections 7.9.3, and 19.2.9.1.

A 90 minute annual test for emergency lighting will be conducted.

Documentation for all visual inspections and tests of Emergency Lighting will be maintained by the Facilities department. Documentation will be available for review.

Performance will be monitored through the Quality Assurance and Performance Improvement Program. Performance will be reported through the Quality and Performance Improvement Committee no less than quarterly.

Compliance Date: May 1, 2025

Status: Being scheduled. Project to be completed prior to May 1, 2025.

K 293 Exit Signage

Findings:

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4/14/25

04/10/2025
04/17/2025 Revised

Exit signs by Stairs A on floor 3; Nurse's station on 3 East; and the RDR on the 2nd floor were not continuously illuminated. Monthly EXIT Sign Inspection reports from 2024 reflected 22 signs that were inoperative.

This situation could affect residents, guests, and staff from proper egress in the event of an emergency.

Plan of Correction:

Monthly testing of EXIT signs will be conducted in compliance with NFPA 101, Life Safety Code, 2012 edition sections 7.10.5.2.1, and 19.2.10.

Documentation for all visual inspections and tests of EXIT and Directional Signs will be maintained by the Facilities department. Documentation will be available for review.

Performance will be monitored through the Quality Assurance and Performance Improvement Program. Performance will be reported through the Quality and Performance Improvement Committee no less than quarterly.

Compliance Date: May 1, 2025

Status: Being scheduled. Project to be completed prior to May 1, 2025.

K 345 Fire Alarm System – Testing and Maintenance

Findings:

Fire Alarm Inspection was last conducted in February of 2024. Annual Inspection of the Fire Alarm system has not been completed.

This situation could affect residents, guests, and staff in the event of a fire in the facility.

Plan of Correction:

Inspection of the Fire Alarm will be conducted in compliance with NFPA 72, National Fire Alarm and Signaling Code, 2010 edition, Section 14, per NFPA 101, the Life Safety Code, 2012 edition, sections 9.6.1.5.3 and 19.3.4.1. Inspection will be conducted by a third-party vendor.

Documentation for all visual inspections and tests of the Fire Alarm will be maintained by the Facilities department. Documentation will be available for review.

Performance will be monitored through the Quality Assurance and Performance Improvement Program. Performance will be reported through the Quality and Performance Improvement Committee no less than quarterly.

Compliance Date: May 1, 2025.

Status: Completed April 8, 2025. See attached.

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04/10/2025

04/17/2025 Revised

K 351 Sprinkler System – Installation

Findings:

1. Two missing ceiling tiles in room 103.
2. Two ceiling tiles missing in room 108.
3. Missing ceiling tile in room 114.
4. Ceiling tile out of place in the laundry room above the dryers.

This situation could affect residents, guests, and staff in the event of a fire in the facility.

Plan of Correction:

Replace all missing ceiling tiles.

Performance will be monitored through the Quality Assurance and Performance Improvement Program. Performance will be reported through the Quality and Performance Improvement Committee no less than quarterly.

Facilities Work orders have been submitted for missing ceiling tiles.

Compliance Date: May 1, 2025

STATUS: Completed

K 353 Sprinkler system – Maintenance and Testing

Findings:

1. Several sprinkler heads were observed covered with dust and debris. These sprinkler heads were located but not limited to: kitchen supervisor's office; the office to the right of that office; 2 West Nurses station; corridor by the clinical resource office; the corridor by the 3 East RDR; 4 West Nurses Station; Rooms 449 and 448.
2. No documentation of Sprinkler System Inspection and testing.

This situation could affect residents, guests, and staff in the event of a fire in the facility.

Plan of Correction:

All sprinkler heads will be inspected and cleaned.

All sprinkler heads will be inspected no less than monthly and cleaned as needed.

Performance will be monitored through the Quality Assurance and Performance Improvement Program. Performance will be reported through the Quality and Performance Improvement Committee no less than quarterly.

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An annual inspection of Sprinkler Heads will be performed by an outside vendor.

Compliance Date: May 1, 2025

STATUS: Contracted items are currently being quoted and scheduled. Project to be completed prior to May 1, 2025.

K 372 Subdivision of Building Spaces – Smoke Barrier Construction

Findings:

The wall above the cross-corridor doors by the Business Office, Room 111 has 2 holes that go through both sides of the wall.

There is flexible conduit penetration that is not fire stopped above the double doors in 2 East.

This situation could affect residents, guests, and staff in the event of a fire in the facility.

Plan of Correction:

Holes in doors and conduit penetrations will be repaired in accordance with NFPA 101, Life Safety Code, 2012 edition, Sections 19.3.7.3 and 8.6.7.1.

Performance will be monitored through the Quality Assurance and Performance Improvement Program. Performance will be reported through the Quality and Performance Improvement Committee no less than quarterly.

Iron Oak Construction will be contracted to repair holes in doors and conduit penetrations.

Completion Date: May 1, 2025

STATUS: Contracted items are currently being quoted and scheduled. Project to be completed prior to May 1, 2025.

K 761 Maintenance, Inspection & Testing

Findings:

The facility failed to complete the annual assessment of all fire doors in the facility.

This situation could affect residents, guests, and staff in the event of a fire in the facility.

Plan of Correction:

An annual assessment of all fire doors in the facility will be conducted by an outside vendor.

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Performance will be monitored through the Quality Assurance and Performance Improvement Program. Performance will be reported through the Quality and Performance Improvement Committee no less than quarterly.

Completion Date: May 1, 2025

STATUS: Contracted items are currently being quoted and scheduled. Project to be completed prior to May 1, 2025.

K 914 Electrical Systems – Maintenance and Testing

Findings:

The annual testing of the receptacles did not include the retention force of the grounding blade of each electrical receptacle to ensure it is not less than 4 ounces.

This could pose an electrical hazard to residents, visitors, and staff.

Plan of Correction:

All electrical receptacles not listed as hospital-grade will be tested annually to ensure it is not less than 4 ounces.

Performance will be monitored through the Quality Assurance and Performance Improvement Program. Performance will be reported through the Quality and Performance Improvement Committee no less than quarterly.

Completion Date: May 1, 2025

STATUS: Scheduling of project is currently being conducted. Project to be completed prior to May 1, 2025.

K 918 Electrical Systems – Essential electric System Maintenance and Testing

Findings:

There was no documentation showing an annual fuel quality test was provided on the generator testing and maintenance documentation.

This practice could affect the residents, visitors, and staff at DYP.

Plan of Correction:

An annual fuel quality test will be conducted using appropriate ASTM standards or manufacturer's recommendations. Documentation of this testing shall be maintained by the Facilities Department and made available as needed.

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Performance will be monitored through the Quality Assurance and Performance Improvement Program. Performance will be reported through the Quality and Performance Improvement Committee no less than quarterly.

Completion Date: May 1, 2025

STATUS: Scheduling of project is currently being conducted. Project to be completed prior to May 1, 2025.

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D'Youville Pavillion

102 Campus Ave

Lewiston, Me 04240

207-777-8347

Building Contact: Therese Boies
Title: Executive Secretary

Company: R.B. Allen Company, Inc.
Contact: Justin Talbot
Title: Inspector

Inspection Date: Apr 8, 2025

Tested to NFPA 72 Standards

This Inspection was performed in accordance with applicable NFPA Standards. The subsequent pages of this report provide performance measurements, listed ranges of acceptable results, and complete documentation of the inspection. Whenever discrepancies exist between acceptable performance standards and actual test results, notes and/or recommended solutions have been proposed or provided for immediate review and approval.

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BY: _____

EXECUTIVE SUMMARY

Generated by: BuildingReports.com

Building Information

D'Youville Pavillion
102 Campus Ave
Lewiston, Me 04240
United States of America

Contact: Therese Boies
Phone: 207-777-8347
Fax: 207-777-8351
Mobile:
Email: tboies@stmarysmaine.com

Inspection Performed By

R.B. Allen Company, Inc.
131 Lafayette Road
North Hampton, NH 03862
United States of America

Inspector: Justin Talbot
Phone: 603-519-0249
Fax:
Mobile:
Email: jtalbot@rballen.com

System Control Unit

Manufacturer: gamewell
Model Number: 650
Software Version:
Location: 1st Main entrance
Current Protection:

Inspection Date: 04/08/2025
Install Date: 04/08/2025
Version Date: 04/08/2025
Disconnect Location:

IDC Style:
SLC Style:
NAC Style:
Disconnect Type:

Inspection Summary

Category	Total Items		Serviced		Passed		Failed/Other	
	Qty	%	Qty	%	Qty	%	Qty	%
Auxiliary	46	9.98%	46	100.00%	46	100.00%	0	0.00%
Control	5	1.08%	5	100.00%	5	100.00%	0	0.00%
Indicating	100	21.69%	100	100.00%	100	100.00%	0	0.00%
Initiating	310	67.25%	310	100.00%	310	100.00%	0	0.00%
Totals	461	100%	461	100.00%	461	100.00%	0	0.00%

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Quarterly Inspection Report

Completed on: 2025-01-07

for

St. Mary's - D'Youville Pavilion
102 Campus Ave
Lewiston, ME 04240-6019

Conducted By:

Howard McNally

Licensed Fire Sprinkler Inspector #IFS381

High Tech Fire Protection Co.

PO Box 156

Minot, ME 04258

This Joint Commission inspection was performed in accordance with the following codes and regulations:

- NFPA 25 2011 - Standard for the Inspection, Testing, and Maintenance of Water Based Fire Protection Systems

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St. Mary's - D'Youville Pavilion
102 Campus Ave
Lewiston, ME, 04240-6019
Ref # 2587SQ



Summary

EC 02.03.05 EP 09

For automatic sprinkler systems: Every 12 months, the hospital tests main drains at system low point or at all system risers. The results and completion dates are documented.

Note: For additional guidance on performing tests, see NFPA 25-2011: 13.2.5; 13.3.3.4; Table 13.1.1.2; Table 13.8.1.

Devices Types	Tested this Inspection	Pass	Fail	Tested YTD	Not Tested YTD	Total
Wet	1	1	0	1	0	1

EC 02.03.05 EP 10

For automatic sprinkler systems: Every quarter, the hospital inspects all fire department water supply connections. The results and completion dates are documented.

Note: For additional guidance on performing tests, see NFPA 25-2011: 13.7; Table 13.1.1.2.

See FIRE DEPARTMENT CONNECTION section for full test results.

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St. Mary's ~~BD~~ Youville Pavilion
102 Campus Ave
Lewiston, ME, 04240-6019
Ref # 2587SQ



EC 02.03.05 EP 09 Summary

EC 02.03.05 EP 09

For automatic sprinkler systems: Every 12 months, the hospital tests main drains at system low point or at all system risers. The results and completion dates are documented.

Note: For additional guidance on performing tests, see NFPA 25-2011: 13.2.5; 13.3.3.4; Table 13.1.1.2; Table 13.8.1.

Devices Types	Tested this Inspection	Pass	Fail	Tested YTD	Not Tested YTD	Total
Wet	1	1	0	1	0	1

EC 02.03.05 EP 09 Detail - Wet1

	Device Type	Last Tested	Status
1	Wet1	2025-01-07	Pass

MAIN DRAIN FLOW TESTS NFPA 25, 2011 edition(Section 13.2.5) EC.02.03.05 EP9

System	Initial Static	Residual	Static	Seconds to Return to Initial Static	Flow Observed ?	Did waterflow alarm operate?	Are results comparable to previous test?	Status
Wet1	101	75	82	5	Yes	Yes	Yes	Pass

Conducted by: Howard McNally

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Report of Inspection / Test

Quarterly NFPA 25



2025-01-07
Property
 St. Mary's - D'Youville Pavilion
 2587SQ
 102 Campus Ave
 Lewiston ME 04240-6019
 Print Date: 2025-01-07

Conducted by: Howard McNally
 Licensed Fire Sprinkler Inspector #IFS381

High Tech Fire Protection Co.
 PO Box 156
 Minot ME 04258
 (207) 998-2551
 LSmith@htfp.me

Report of Inspection / Test General Questions

OWNER SECTION

Are all fire sprinkler systems in service?	☒ Yes ☐ No ☐ NA	Are the control valves accessible, in correct position, locked, and or, tampered, and or sealed?	☒ Yes ☐ No ☐ NA
Date of inspection	1/7/2025		

VALVE AREA

Are all check valves externally inspected, operating properly, and are in good condition?	☒ Yes ☐ No ☐ NA	Are the gauges on system operable and in good working condition?	☒ Yes ☐ No ☐ NA
Have the mechanical waterflow alarm devices passed tests by opening inspector's test connection/bypass connection with alarms actuating and flow observed?	☒ Yes ☐ No ☐ NA	All control valves operated through full range and returned to normal position?	Not exercised during this inspection
Was a drain test conducted after opening any closed valve?	☒ Yes ☐ No ☐ NA	Valve area appears properly heated?	☒ Yes ☐ No ☐ NA
Is the hydraulic name plate (calculated systems) attached securely to the riser and legible?	☒ Yes ☐ No ☐ NA	All valves identified with signage?	☒ Yes ☐ No ☐ NA
Pump in Service and Operational?	N/A	Type of Pump	N/A

BACKFLOW PREVENTERS

Is relief port on RPZ device not discharging?	☐ Yes ☐ No ☒ NA	
---	---	--

ALARMS

Are alarms and supervisory devices not damaged?	☒ Yes ☐ No ☐ NA	Alarm panel clear after inspection completed?	☒ Yes ☐ No ☐ NA
Did Alarm Supervisory Co. receive signal properly	☒ Yes ☐ No ☐ NA		

FIRE DEPARTMENT CONNECTION

Is the FDC plainly visible and easily accessible?	☒ Yes ☐ No ☐ NA	Are the FDC swivels and couplings not damaged?	☒ Yes ☐ No ☐ NA
---	---	--	---

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Report of Inspection / Test

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HIGH TECH

FIRE PROTECTION

2025-01-07

Property

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102 Campus Ave

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(207) 998-2551

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Are the FDC caps and plugs in place and undamaged?	☒ Yes ☐ No ☐ NA	Are the FDC gaskets in place?	☒ Yes ☐ No ☐ NA
Is the FDC check valve free of leaks?	☒ Yes ☐ No ☐ NA	Is the FDC identification sign(s) in place?	☒ Yes ☐ No ☐ NA
Location of FDC	N/A		
SPRINKLER HEADS			
Are there the proper number and type of spare sprinklers and wrenches in place?	☒ Yes ☐ No ☐ NA		
5 YEAR			
When was the last internal pipe inspection performed (remove a flushing connection and a sprinkler near the end of a branch line)?	2024	Is the 5year Internal pipe inspection up to date	☒ Yes ☐ No ☐ NA
Gauge replacement due? If yes, what type and how many?	N/A		
ALARM VALVE			
Is the valve assembly free from physical damage?	☒ Yes ☐ No ☐ NA	Is the trim in correct (open or closed) position?	☒ Yes ☐ No ☐ NA
Is there no leakage in the retarding chamber or drains?	☒ Yes ☐ No ☐ NA		

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Report of Inspection / Test
Quarterly NFPA 25



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MAIN DRAIN FLOW TESTS NFPA 25, 2011 edition(Section 13.2.5) EC.02.03.05
EP9

System	Initial Static	Residual	Static	Seconds to Return to Initial Static	Flow Observed?	Did waterflow alarm operate?	Are results comparable to previous test?
Wet1	101	75	82	5	Yes	Yes	Yes

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Report of Inspection / Test
Quarterly NFPA 25



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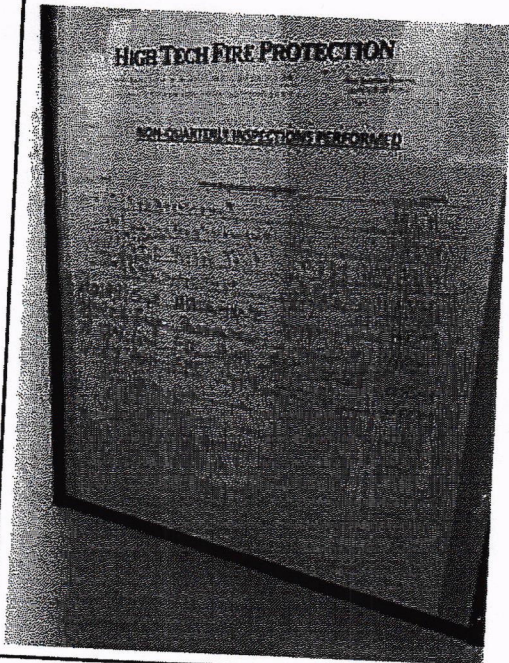
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Questions with Photos and Notes

Visit Photos



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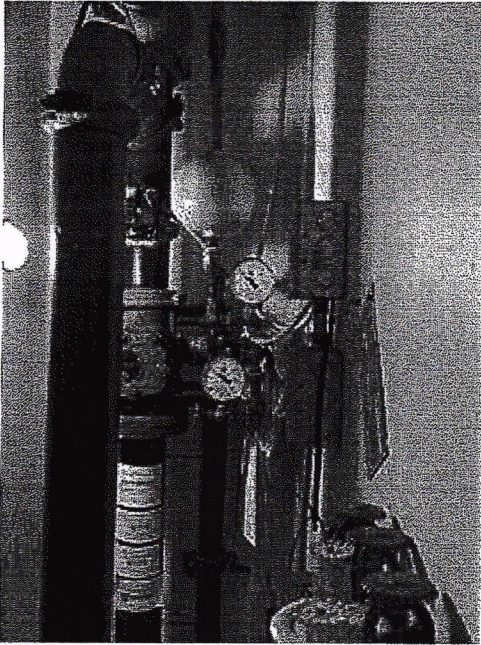
Report of Inspection / Test
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Deficiencies - General Questions

None

Deficiencies - General Wet System Questions

None

Deficiencies - Wet1

None

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BY: _____

Quarterly Inspection Report

Completed on: 2025-02-07

for

St. Mary's - D'Youville Pavilion
102 Campus Ave
Lewiston, ME 04240-6019

Conducted By:

Howard McNally
Licensed Fire Sprinkler Inspector #IFS381
High Tech Fire Protection Co.
PO Box 156
Minot, ME 04258

This Joint Commission inspection was performed in accordance with the following codes and regulations:

- NFPA 25 2011 - Standard for the Inspection, Testing, and Maintenance of Water Based Fire Protection Systems

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St. Mary's - D'Youville Pavilion
102 Campus Ave
Lewiston, ME, 04240-6019



Summary

EC 02.03.05 EP 09

For automatic sprinkler systems: Every 12 months, the hospital tests main drains at system low point or at all system risers. The results and completion dates are documented.

Note: For additional guidance on performing tests, see NFPA 25-2011: 13.2.5; 13.3.3.4; Table 13.1.1.2; Table 13.8.1.

Devices Types	Tested this Inspection	Pass	Fail	Tested YTD	Not Tested YTD	Total
Wet	1	1	0	1	0	1

EC 02.03.05 EP 10

For automatic sprinkler systems: Every quarter, the hospital inspects all fire department water supply connections. The results and completion dates are documented.

Note: For additional guidance on performing tests, see NFPA 25-2011: 13.7; Table 13.1.1.2.

See FIRE DEPARTMENT CONNECTION section for full test results.

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St. Mary's - D'Youville Pavilion
102 Campus Ave
Lewiston, ME, 04240-6019



EC 02.03.05 EP 09 Summary

EC 02.03.05 EP 09						
For automatic sprinkler systems: Every 12 months, the hospital tests main drains at system low point or at all system risers. The results and completion dates are documented. Note: For additional guidance on performing tests, see NFPA 25-2011: 13.2.5; 13.3.3.4; Table 13.1.1.2; Table 13.8.1.						
Devices Types	Tested this Inspection	Pass	Fail	Tested YTD	Not Tested YTD	Total
Wet	1	1	0	1	0	1

EC 02.03.05 EP 09 Detail - Wet1

	Device Type	Last Tested	Status
1	Wet1	2025-02-07	Pass

MAIN DRAIN FLOW TESTS NFPA 25, 2011 edition(Section 13.2.5) EC.02.03.05 EP9

System	Initial Static	Residual	Static	Seconds to Return to Initial Static	Flow Observed ?	Did waterflow alarm operate?	Are results comparable to previous test?	Status
Wet1	101	75	85	5	Yes	Yes	Yes	Pass

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Report of Inspection / Test

Quarterly NFPA 25



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 LSmith@htfp.me

Report of Inspection / Test General Questions

OWNER SECTION

Are all fire sprinkler systems in service?	☒ Yes ☐ No ☐ NA	Are the control valves accessible, in correct position, locked, and or, tampered, and or sealed?	☒ Yes ☐ No ☐ NA
--	---	--	---

Date of Inspection 2/4/2025

VALVE AREA

Are all check valves externally inspected, operating properly, and are in good condition?	☒ Yes ☐ No ☐ NA	Are the gauges on system operable and in good working condition?	☒ Yes ☐ No ☐ NA
Have the mechanical waterflow alarm devices passed tests by opening inspector's test connection/bypass connection with alarms actuating and flow observed?	☒ Yes ☐ No ☐ NA	All control valves operated through full range and returned to normal position?	Not exercised during this inspection
Was a drain test conducted after opening any closed valve?	☒ Yes ☐ No ☐ NA	Valve area appears properly heated?	☒ Yes ☐ No ☐ NA
Is the hydraulic name plate (calculated systems) attached securely to the riser and legible?	☒ Yes ☐ No ☐ NA	All valves identified with signage?	☒ Yes ☐ No ☐ NA
Pump in Service and Operational?	N/A	Type of Pump	N/A

BACKFLOW PREVENTERS

Is relief port on RPZ device not discharging?

☐ Yes
☐ No
☒ NA

ALARMS

Are alarms and supervisory devices not damaged?	☒ Yes ☐ No ☐ NA	Alarm panel clear after inspection completed?	☒ Yes ☐ No ☐ NA
Did Alarm Supervisory Co. receive signal properly	☒ Yes ☐ No ☐ NA		

FIRE DEPARTMENT CONNECTION

Is the FDC plainly visible and easily accessible?	☒ Yes ☐ No ☐ NA	Are the FDC swivels and couplings not damaged?	☒ Yes ☐ No ☐ NA
---	---	--	---

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Report of Inspection / Test
Quarterly NFPA 25**HIGH TECH**
FIRE PROTECTION

2025-02-07

PropertySt. Mary's - D'Youville Pavilion
2587SQ102 Campus Ave
Lewiston ME 04240-6019

Print Date: 2025-02-07

Conducted by: Howard McNally
Licensed Fire Sprinkler Inspector #IFS381High Tech Fire Protection Co.
PO Box 156
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Are the FDC caps and plugs in place and undamaged?	☒ Yes ☐ No ☐ NA	Are the FDC gaskets in place?	☒ Yes ☐ No ☐ NA
Is the FDC check valve free of leaks?	☒ Yes ☐ No ☐ NA	Is the FDC identification sign(s) in place?	☒ Yes ☐ No ☐ NA
Location of FDC	N/A		

SPRINKLER HEADS

Are there the proper number and type of spare sprinklers and wrenches in place?	☒ Yes ☐ No ☐ NA
---	---

5 YEAR

When was the last internal pipe inspection performed (remove a flushing connection and a sprinkler near the end of a branch line)?	2024	Is the 5year Internal pipe inspection up to date	☒ Yes ☐ No ☐ NA
Gauge replacement due? If yes, what type and how many?	N/A		

ALARM VALVE

Is the valve assembly free from physical damage?	☒ Yes ☐ No ☐ NA	Is the trim in correct (open or closed) position?	☒ Yes ☐ No ☐ NA
Is there no leakage in the retarding chamber or drains?	☒ Yes ☐ No ☐ NA		

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System	Initial Static	Residual	Static	Seconds to Return to Initial Static	Flow Observed?	Did waterflow alarm operate?	Are results comparable to previous test?
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FIRE PROTECTION

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Deficiencies - General Questions

None

Deficiencies - General Wet System Questions

None

Deficiencies - Wet1

None

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Elizabeth H Church

APR 17 2025

From:

Sent:

To:

Subject:

BY:

TMS@accruent.com

Tuesday, April 8, 2025 9:04 AM

Elizabeth H Church

Work Order Completed WO#67001

WARNING - EXTERNAL SENDER

This message originated from outside Covenant Health's email system.
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Covenant Health, Inc

DO NOT REPLY, This is an Automated Response.

The Status for the Work Order has been changed

WO Number #67001	
Status	COMPLETED (CMPLT)
Sub Status	(CHANGES ARE ALLOWED) (CHANG)
Additional Values	
WO #	67001
Description	Missing/stained ceiling tiles
Status Description	COMPLETED
Date Created	4/6/2025 3:37:30 PM
Requester Name	elizabeth church
Requester Remarks	Rooms 103; 108; Resident Room 114; laundry room above dryers
Completed Date	4/8/2025 9:01:07 AM
Completion Comments	



**COVENANT
HEALTH**

Our Name is Our Promise

K761

PO Number: 630125-520414

PO Date: 04/15/2025

Vendor: CERTIFIED FIRE DOOR CO 107 MILTON AVE SANFORD, ME 04073 CHARLES NOBLE 207-206-6977	Ship To: ST MARYS REG MED CTR - RECEIVING 318 SABATTUS ST LEWISTON, ME 04240 GLN: Phone: 207-777-8659 Fax: 207-777-8864	Bill To: ACCOUNTS PAYABLE SML 172 KINSLEY STREET PO BOX 2013 NASHUA, NH 03060 Phone: 603-882-3000 Fax: 603-579-5698
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If shipping charges contractually apply, ship via FedEx account #477693644, FOB Destination. Insert our PO# in recipient 2nd address field. If combined shipping weight exceeds 150lbs, call 888-457-5851 for carrier instructions prior to shipping.

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LORI M CLOUTIER

lcloutier1@covh.org

1. Include in ALL shipments a packing slip showing contents and PO #.
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3. Purchase order is subject to all terms and conditions as provided to the vendor.
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**COVENANT
HEALTH**

Our Name is Our Promise

PO Number: 630125-520414

PO Date: 04/15/2025

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Vendor: CERTIFIED FIRE DOOR CO 107 MILTON AVE SANFORD, ME 04073 CHARLES NOBLE 207-206-6977			Ship To: ST MARYS REG MED CTR - RECEIVING 318 SABATTUS ST LEWISTON, ME 04240 GLN: Phone: 207-777-8659 Fax: 207-777-8864			Bill To: ACCOUNTS PAYABLE SML 172 KINSLEY STREET PO BOX 2013 NASHUA, NH 03060 Phone: 603-882-3000 Fax: 603-579-5698		
Vendor Code: CFDC PO Type: GEN PO Status: Draft Customer No:			Comment:			Composed By: LORI M CLOUTIER Terms: INV NET 1 FOB: Delivery Date: Tax ID Number: 01-0211551		
Line Modified	Vendor Catalog GTIN	Order Quantity	Mfr Catalog Contract	Charge Dept. Sub-Ledger	Project Sub-Project	Price Discount List Price	Ext. Price Tax Ext Price w/ Tax	
Item: [non-catalog] ANNUAL FIRE DOOR INSPECTIONS FOR D'YOUVILLE PAVILION								
1		1 EA		6301-79463-635900		\$3,000.00	\$3,000.00 \$0 \$3,000.00	
PO Sub Total:		\$3,000.00	Tax Total:		\$0	Purchase Order Total: \$3,000.00		
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