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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S D'YOUVILLE PAVILION	**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		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 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 mopheadsstored 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. Outisde 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. Outisde 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. Outisde 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. Outisde 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. Outisde 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		

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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		

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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		

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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		

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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. The finding was verified by the Manger QAPI at the time of observations on 3/26/2025.	K 345		
K 351 SS=D	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		

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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. The clean laundry room had mix K factor heads on the same branch. The branch had a blue standard response bulb on the same branch as red standard response bulbs. 2. The laundry room with dryers had mix K factor heads on the same branch. The branch in front of the dryers had (2) green standard response heads on the same branch as a red standard response head. 3. There are two missing ceiling tiles in redsident room 103. 4. There are two missing ceiling tiles in resident room 108. 5. There is a ceiling tile missing in resident room 114. 6. 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 351		
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	K 353		

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K 353	Continued From page 10 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 _____ 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	K 353		

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K 353	Continued From page 11 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 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 Barrie 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)	K 372		

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K 372	Continued From page 12 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 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	K 761		

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ST MARY'S D'YOUVILLE PAVILION	**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 annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on interview and 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	K 761		

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

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K 761	Continued From page 14 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		
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	K 914		

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	205053	A. BUILDING **01** B. WING _____	**03/26/2025**

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K 914	Continued From page 15 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: 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.	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	K 918		

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	205053	A. BUILDING **01** B. WING _____	**03/26/2025**

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K 918	Continued From page 16 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on 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	K 918		

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K 918	Continued From page 17 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. 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		