State of Maine
Department of Public Safety
Office of Fire Marshal
52 State House Station
Augusta, ME 04333-0052

JANET T. MILLS
GOVERNOR

MICHAEL SAUSCHUCK
COMMISIONER

RICHARD MCCARTHY
STATE FIRE MARSHAL

June 15, 2023

St Joseph's Rehabilitation And Residence
Attn: Joel Rogers, Administrator
1133 Washington Ave
Portland, ME 04103

Provider ID#: 205134
Facility ID#: 0521
Event ID#: IHQD21

Administrator Rogers,

On **June 13, 2023,** the Office of the Fire Marshal conducted a Life Safety Code and Emergency Preparedness survey to determine if your facility complies with Federal participation requirements for nursing facilities in the Medicare and/or Medicaid program (In which you will be receiving a Form CMS-2567 for Life Safety Code and Emergency Preparedness). Your facility was found not to be in substantial compliance with the participation requirements for Life Safety Code and Emergency Preparedness.

The Federal regulatory requirements referenced in this letter are found in Title 42, Code of Federal Regulations (CFR) and in the National Fire Protection Association (NFPA)101 Life Safety Code Standard, 2012 Edition.

PLAN OF CORRECTION

Attached is Form CMS-2567 "Statement of Deficiencies" which enumerates the deficiencies found as a result of the survey. A Plan of Correction (POC) must be submitted by the **tenth (10th) calendar day** from your receipt of this letter. **Please note that a POC is not needed for isolated deficiencies which cause no harm (S/S of A).** Your POC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;

- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- **Include dates when corrective action will be completed**. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility;

- Include documentation to support a waiver request (if appropriate).

You are required to record your plan of correction in the appropriate column on the enclosed Form(s) CMS-2567. **Sign, date, and indicate your title in the blocks provided on page one.** Return the forms(s) with the POC to **State of Maine, Department of Public Safety, Office of State Fire Marshal, 45 Commerce Drive, 52 State House Station, Augusta, ME 04330-0052**.

Remedies will be recommended for imposition by the Centers for Medicare & Medicaid Services (CMS) Regional Office if your facility has failed to achieve substantial compliance by **July 31, 2023,** (Opportunity to Correct). Informal dispute resolution for the cited deficiencies will not delay the imposition of the recommended enforcement actions. A change in the seriousness of the noncompliance may result in a change in the remedy selected. When this occurs, you will be advised of any change in remedy.

RECOMMENDED REMEDIES

Based on the deficiencies cited during the Life Safety Code and Emergency Preparedness Survey of **June 13, 2023**, we are recommending to CMS the imposition of the following remedy(ies):

A Civil Monetary Penalty per day to be determined by CMS.

Directed Plan of Correction (DPOC) effective immediately. The State Agency directs the plan of correction noted on the attached CMS-2567 for deficiencies E004(SS=F), E039(SS=F), K211(SS=E), K321(SS=E), K342(SS=D), K355(SS=B), K371(SS=F), K761(SS=F) & K911(SS=D) (Tags). [42 CFR 488.424]

If you do not achieve substantial compliance by **September 14, 2023,** the CMS Regional Office or State Medicaid Agency must deny payments for new (Medicare/Medicaid) admissions. In addition, we may recommend that **termination of your provider agreement be effective on December 14, 2023,** if substantial compliance is not achieved by that time. [42 CFR 488.456]. **Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination**.

ALLEGATION OF COMPLIANCE

The Plan of Correction will serve as your allegation of compliance until substantiated by a revisit or other means. If upon revisit your facility has not achieved substantial compliance, recommended remedies may be imposed as determined by the CMS Regional Office and continue until substantial compliance is achieved. Additionally, CMS Regional Office may impose revised/additional remedies, if appropriate.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 Code of Federal Regulations §488.331, you have one opportunity to question cited deficiencies through an IDR process. You may also contest scope and severity assessments for deficiencies, which may have resulted in a finding of substandard quality of care (SQC) or immediate jeopardy. To be given such an opportunity, you are required to send your written request, along with the specific deficiencies (or why you are disputing the scope and severity assessments of deficiencies which have been found to constitute SQC or immediate jeopardy) to **Fire Marshal Richard McCarthy** at the address below. This request must be sent during the same 10 calendar days you have for submitting a POC for the cited deficiencies. An incomplete IDR process will not delay the effective date of any enforcement action. IDR in no way is to be construed as a formal evidentiary hearing. It is an informal administrative process to discuss deficiencies. If counsel will accompany you, you must indicate this in your request for IDR so that we may also have counsel present.

Please email back the plan of correction to: FMOHealthcare@maine.gov.

If you have any questions, please contact me at (207) 626-3880.

Yours for Better Fire Prevention,

Richard McCarthy
State Fire Marshal

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205134	A. BUILDING 01 B. WING _____	06/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOSEPH'S REHABILITATION AND RESIDENCE	1133 WASHINGTON AVE PORTLAND, ME 04103

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E 000	Initial Comments Survey Federal Recertification Survey Date: 06/13/2023 Emergency Preparedness Statement St. Joseph's Rehab, a long term care facility, is not in substantial compliance with 42 Code of Federal Regulations Part 483.73 Requirements for Long Term Care Facilities Emergency Preparedness.	E 000		
E 004 SS=F	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.542(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or	E 004		

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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E 004	Continued From page 1 CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. . This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the long term care facility failed to conduct an annual review of the Emergency Preparedness Plan in accordance with 42 CFR 483.73(a) Finding: On 06/13/2023, between 9:00 AM and 1:00 PM, a surveyor, with the Maintenance Director present, observed the following: 1. An annual review of the entire emergency preparedness plan had not been conducted. According to records reveiwed the last time an annual review had been completed was 2018.	E 004		

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E 004	Continued From page 2 The surveyor confirmed this finding with the Maintenance Director at the time of the observation.	E 004		
E 039 SS=F	EP Testing Requirements CFR(s): 483.73(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:	E 039		

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E 039	Continued From page 3 (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is	E 039		

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E 039	Continued From page 4 community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and	E 039		

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E 039	Continued From page 5 maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and	E 039		

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E 039	Continued From page 6 maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop	E 039		

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E 039	Continued From page 7 exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed.	E 039		

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E 039	Continued From page 8 *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is	E 039		

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E 039	Continued From page 9 community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or	E 039		

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E 039	Continued From page 10 workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the long term care facility failed to participate in a full-scale exercise of the Emergency Preparedness Plan in accordance with 42 CFR 483.73	E 039		

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E 039	Continued From page 11 Finding: On 06/13/2023, between 9:00 AM and 1:00 PM, a surveyor, with the Maintenance Director present, observed the following: 1. A full-scale exercise has not been conducted at this facility as required, documentation could not be provided as to when the last full exercise had taken place. The surveyor confirmed this finding with the Maintenance Director at the time of the observation.	E 039		
K 000	INITIAL COMMENTS Federal Recertification Survey Survey Date: 06/13/2023 Life Safety Code Statement: St. Joseph's Rehabilatation and Residence, 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 in substantial compliance.	K 000		
K 211 SS=E	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.	K 211		

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K 211	Continued From page 12 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 exits and exit discharges in the paths of egress free of all obstructions per NFPA 101, Life Safety Code, 2012 edition, sections 7.1.10.1, and 7.1.5.1 Findings: Based on observation and interview on 6/13/2023, between 09:00 AM and 1:00 PM, a surveyor, with the Assistant Director of Maintenance, observed the following: 1. Chain link fencing with two gates were found padlocked secured with master locks. One of the gates has the lock on the non-egress side. The gate serve as exterior exit discharges to the public way used by C and D wing of the facility. Note: The locks were removed prior to the surveyor departure, on 06/13/2023 at 1:00 PM. 2. Exterior lighting strings were found strung across the exterior exit pathways to the public way at heights ranging from 4' 0" to 5', 4". 3. The marked exit door to the side loading dock, by the employee time clock and the compactor room only opened 8 inches because it was obstructed by bread racks and carts. The surveyor confirmed these findings with the Assistant Director of Maintenance at the time of the observation.	K 211		
K 321 SS=E	Hazardous Areas - Enclosure CFR(s): NFPA 101	K 321		

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K 321	Continued From page 13 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the long-term care facility failed to maintain the hazard areas with self-closing and positively latching doors per NFPA 101, Life Safety Code, 2012 edition, sections 8.4, and 19.3.2.1., Finding:	K 321		

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K 321	Continued From page 14 Based on observation and interview on 6/13/2023, between 09:00 AM and 1:00 PM, a surveyor, with the Assistant Director of Maintenance, observed the following: 1. The A Wing Dirty Utility room 90 -minute fire rated door has a striker plate loose and the door did not self-close and latch from the fully open position. The striker plate was cited on the annual fire door inspection report dated 04/26/2022 by Exactitude. The surveyor confirmed this finding with the Assistant Director of Maintenance at the time of the observation.	K 321		
K 342 SS=D	Fire Alarm System - Initiation CFR(s): NFPA 101 Fire Alarm System - Initiation Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system. Manual alarm boxes are provided in the path of egress near each required exit. Manual alarm boxes in patient sleeping areas shall not be required at exits if manual alarm boxes are located at all nurse's stations or other continuously attended staff location, provided alarm boxes are visible, continuously accessible, and 200' travel distance is not exceeded. 18.3.4.2.1, 18.3.4.2.2, 19.3.4.2.1, 19.3.4.2.2, 9.6.2.5 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the long-term care facility failed to maintain the proper of height for the fire alarm pull stations	K 342		

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K 342	Continued From page 15 throughout the facility per NFPA 101, Life Safety Code, 2012 edition, sections 19.3.4.2.1, 9.6.2.5 and NFPA 72, National Fire Alarm and Signaling Code, 2012 edition, Section 17.15. Findings: Based on observation and interview on 6/13/2023, between 09:00 AM and 1:00 PM, a surveyor, with the Assistant Director of Maintenance, observed the following: 1. The fire alarm pull stations throughout the facility were measured and found to be higher than required height of 42-48 inches above the finished floor. The present height of the pull stations are 59 1/2 inches from the floor at the position of the actuating device on the pull station. 1. The manual pull station is obstructed behind A3 cross corridor doors that are held open with a magnetic hold open device. The surveyor confirmed this finding with the Assistant Director of Maintenance at the time of the observation.	K 342		
K 355 SS=B	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the	K 355		

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K 355	Continued From page 16 long-term care facility failed to maintain the proper installation height for the portable fire extinguishers throughout the facility per NFPA 101, Life Safety Code, 2012 edition, sections 19.3.5.12, and 9.7.4.1., which references NFPA 10, Standard for Portable Fire Extinguishers, 2010 edition, Section 6.1.3.8.1. Finding: Based on observation and interview on 6/13/2023, between 09:00 AM and 1:00 PM, a surveyor, with the Assistant Director of Maintenance, observed the following: 1. The portable fire extinguishers that are in the corridors by the exterior exit doors and not in cabinets are mounted at a height higher than 63 inches. Fire extinguishers having a gross weight not exceeding 40 lbs. shall be installed so that the top of the fire extinguisher is not more than 5 ft above the floor. The surveyor confirmed this finding with the Assistant Director of Maintenance at the time of the observation.	K 355		
K 371 SS=F	Subdivision of Building Spaces - Smoke Compar CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Compartments 2012 EXISTING Smoke barriers shall be provided to form at least two smoke compartments on every sleeping floor with a 30 or more patient bed capacity. Size of compartments cannot exceed 22,500 square feet or a 200-foot travel distance from any point in the compartment to a door in the smoke barrier.	K 371		

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K 371	Continued From page 17 19.3.7.1, 19.3.7.2 Detail in REMARKS zone dimensions including length of zones and dead-end corridors. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the long-term care facility failed to maintain the smoke compartment cross corridor doors throughout the facility per NFPA 101, Life Safety Code, 2012 edition, sections 19.3.7.1, and 3.7.2 Findings: Based on observation and interview on 6/13/2023, between 09:00 AM and 1:00 PM, a surveyor, with the Assistant Director of Maintenance, observed the following: 1. A2, 45 minute rated double doors, have panic hardware that is loose and separating from the door. 2. A3, 45 minute rated double doors rub on the floor and doesn't self-close. 3. B2, 90 minute double doors outward leaf rubs on the top center portion of the door frame and doesn't fully close. 4. C1, 45 minute cross corridor wooden doors have panic hardware that is loose and stripped from the door. 5. C2, 45 minute cross corridor wooden doors inward side leaf rubs on the top of the door frame and doesn't fully close. 6. DR2, 20 minute double doors have a floor strike plate that is loose, preventing a leaf from	K 371		

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K 371	Continued From page 18 fully latching. The surveyor confirmed these findings with the Assistant Director of Maintenance at the time of the observation.	K 371		
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 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 observation and interview, the long-term care facility failed to maintain and test the fire rated doors throughout the facility per NFPA 101, Life Safety Code, 2012 edition, sections 19.7.6, 8.3.3.1 and NFPA 80, Standard for Fire Doors and Other Opening Protectives, 2010 edition, Section 5.2.4.2. Findings: Based on observation and interview on 6/13/2023, between 09:00 AM and 1:00 PM, a surveyor, with the Assistant Director of	K 761		

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K 761	Continued From page 19 Maintenance, observed the following: 1. The most recent annual fire door inspection was conducted by exactitude on 04/26/2022. 2. The C Wing Dirty Utility Room 90 minute fire rated door has one screw missing from the center hinge and one screw broken in the bottom hinge. 3. Door K7, in the kitchen is a 90 minute fire rated door that doesn't close all the way because it is rubbing on the floor. 4.Door K4, in the kitchen, is a 20-minute fire rated door that is unable to open fully, because of storage behind the door. The surveyor confirmed this finding with the Assistant Director of Maintenance at the time of the observation.	K 761		
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 observation and interview, the long-term care facility failed to equip the generator with an emergency stop device outside the generator enclosure per NFPA 110, Standard for Emergency and Standby Power Systems,	K 911		

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K 911	Continued From page 20 2010 edition, section 5.6.5.6, and NFPA 99, Health Care Facilities Code, 2012 edition, Section 6.4.1.1. Finding: Based on observation and interview on 6/13/2023, between 09:00 AM and 1:00 PM, a surveyor, with the Assistant Director of Maintenance, observed the following: 1. The only generator remote emergency stop station/device is inside the generator enclosure/housing. There is no labeled remote emergency stop station/device on the exterior of the generator housing. The surveyor confirmed this finding with the Assistant Director of Maintenance at the time of the observation.	K 911		