



State of Maine
Department of Public Safety
Office of Fire Marshal
52 State House Station
Augusta, ME 04333-005

JANET T. MILLS
GOVERNOR

MICHAEL SAUSCHUCK
COMMISSIONER

RICHARD MCCARTHY
STATE FIRE MARSHAL

August 10, 2023

Cove's Edge
Attn: Cheryl Dobbelsteyn, Administrator
26 Schooner Street
Damariscotta, ME 04543

Provider ID#: 205067
Facility ID#: 1502
Event ID#: J34Z21

Administrator Dobbelsteyn,

On **August 9, 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 only.

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.

PREVENTION * MITIGATION/ SUPPRESSION * LAW ENFORCEMENT

OFFICES LOCATED AT: 45 COMMERCE DRIVE, SUITE 1, AUGUSTA, MAINE 04330
(207) 626-3870 ADMINISTRATION/ INVESTIGATIONS (207) 287-3659 TDD
(207) 626-3880 INSPECTIONS/ PLANS REVIEW (207) 287-6251 FAX

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, 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 **September 2, 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 **August 9, 2023**, the following remedy(ies) are being imposed:

The State Agency directs the plan of correction noted on the attached CMS-2567 for deficiencies K211(SS=D) & K321(SS=A) (Tags). [42 CFR 488.424]

If you do not achieve substantial compliance by **November 7, 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 February 7, 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.

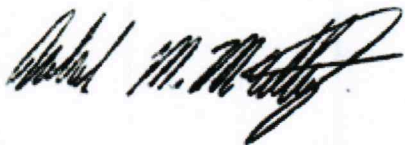
INFORMAL DISPUTE RESOLUTION

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 findings of 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 **State 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 ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs		PROVIDER # 205067	MULTIPLE CONSTRUCTION A. BUILDING: 01 B. WING _____	DATE SURVEY COMPLETE: 8/9/2023
NAME OF PROVIDER OR SUPPLIER COVE'S EDGE		STREET ADDRESS, CITY, STATE, ZIP CODE 26 SCHOONER STREET DAMARISCOTTA, ME		
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES			
K 321	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing 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 observations, the long-term care facility failed to maintain all Hazard areas with the required fire resistive separation per NFPA 101, Life Safety Code, 2012 Edition, Section 19.3.2.1.3. Finding: On August 9, 2023, between 9:45 AM and 12:00 PM, a surveyor, with the Administrator, Maintenance Mechanic II, Senior Facilities Manager, and Director of Operations present, observed the following: 1. The small rehab gym is being used as temporary storage and the door closer has been removed. The door to the 192 square foot storage room shall self-close and positively latch. The surveyor confirmed this finding with the Administrator, Maintenance Mechanic II, Senior Facilities Manager, and Director of Operations at the time of the observation.			

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

The above isolated deficiencies pose no actual harm to the residents

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

PRINTED: 08/10/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205067	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED C 08/09/2023
NAME OF PROVIDER OR SUPPLIER COVE'S EDGE			STREET ADDRESS, CITY, STATE, ZIP CODE 26 SCHOONER STREET DAMARISCOTTA, ME 04543		
(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 Date of Survey: 08/09/23 Cove's Edge, a long-term care facility is in substantial compliance with 42 Code of Federal Regulations Part 483.73, Requirement for Long Term Care Facilities.	E 000			
K 000	INITIAL COMMENTS Federal Recertification Survey Survey Date: 08-09-2023 Cove's Edge, a long-term care facility, was surveyed pursuant to the National Fire Protection Association 101, Life Safety Code, 2012 Edition as referenced in 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 observations, the long-term care facility failed to maintain all exterior exit discharge paths to the public way clear of obstructions and an adequate walking surface per NFPA 101, Life Safety Code, 2012 Edition, Sections 7.1.6, and 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 Finding: On August 9, 2023, between 9:45 AM and 12:00 PM, a surveyor, with the Administrator, Maintenance Mechanic, Senior Facilities Manager and Director of Operations present, observed the following: 1. The courtyard exterior exit discharge paths to the public way has pavement that is excessively cracking, uneven and has ridges greater than 1/4 inch in height. The surveyor confirmed this finding with the Administrator, Maintenance Mechanic II, Senior Facilities Manager, and Director of Operations at the time of the observation.			K 211			