

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205127	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 08/29/2023
NAME OF PROVIDER OR SUPPLIER MAINE VETERANS HOME - SCARBOROUGH			STREET ADDRESS, CITY, STATE, ZIP CODE 290 US RT 1 SCARBOROUGH, ME 04874		
(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	E 000			
E 036 SS=F	Federal Recertification Survey Survey Dates: 08-29-23 Maine Veterans Home - Scarborough, a long term care facility, is not in substantial compliance with 42 Code of Federal Regulations Part 483.73 Requirement for Long Term Care Facilities for Emergency Preparedness. EP Training and Testing CFR(s): 483.73(d) §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.542(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d). *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, REHs at §485.542, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(d):] (d) Training	E 036			

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

TITLE

(X6) DATE

Mark A. Jacobs

Administrator

9/8/23

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 036	Continued From page 1 and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. ¶[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years. This REQUIREMENT is not met as evidenced by:	E 036				

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E 036	Continued From page 2 Based on observation, interview, and record review, the long term care facility failed to include the training and testing program in the Emergency Preparedness Plan. Finding: On 08/29/2023, between 08:00 am and 10:30 am, a surveyor, with the Facilities Director present, observed the following: 1. Documentation was not included in the Emergency Preparedness Plan to indicate that there was program to train and test staff on the use of this Plan. The surveyor confirmed this finding with the Facilities Director at the time of record review.	E 036	E036 Documentation was added to the Emergency Preparedness Plan (EPP) to indicate that there is a program to train and test staff on the use of this plan. Maintenance Supervisor will check monthly to ensure that the training program has not been removed from the EPP and will report the same to the QAPI Committee x3 months. QAPI Committee will assess whether to continue monitoring at that time. Completed August 31, 2023.		
E 037 SS=F	EP Training Program CFR(s): 483.73(d)(1) §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.542(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, REHs at §485.542, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under	E 037			

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

FORM APPROVED
OMB NO. 0938-0391

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E 037	Continued From page 3 arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training	E 037				

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E 037	Continued From page 4 program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. (v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the	E 037				

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E 037	Continued From page 5 following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):] (1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following:	E 037			

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NAME OF PROVIDER OR SUPPLIER

MAINE VETERANS HOME - SCARBOROUGH

STREET ADDRESS, CITY, STATE, ZIP CODE

290 US RT 1

SCARBOROUGH, ME 04074

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E 037	Continued From page 6 (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training 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 include the training and testing program in the Emergency Preparedness Plan. Finding:	E 037		

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E 037

Continued From page 7

On 08/29/2023, between 08:00 am and 10:30 am, a surveyor, with the Facilities Director present, observed the following:

1. Documentation was not included in the Emergency Preparedness Plan to include the curriculum of the training program or demonstration of staff knowledge of the Emergency Preparedness procedures.

The surveyor confirmed this finding with the Facilities Director at the time of record review.

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

E 037

E037

Documentation was added to the Emergency Preparedness plan to indicate that there was a curriculum for the program to train and test staff on the use of this Plan. The program includes demonstration of staff knowledge which is recorded in our education system.

Maintenance Supervisor will check monthly to ensure that the curriculum has not been removed from the EPP and that the demonstration of staff knowledge is recorded. Supervisor will report the same to the QAPI Committee x3 months. QAPI Committee will assess whether to continue monitoring at that time.

Completed August 31, 2023.

E 039

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E 039	Continued From page 8 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: (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	E 039				

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E 039	Continued From page 9 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 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	E 039				

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E 039	Continued From page 10 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 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	E 039			

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E 039	Continued From page 11 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 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	E 039				

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(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 039	Continued From page 12 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 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	E 039			

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NAME OF PROVIDER OR SUPPLIER

MAINE VETERANS HOME - SCARBOROUGH

STREET ADDRESS, CITY, STATE, ZIP CODE

290 US RT 1

SCARBOROUGH, ME 04074

(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 039	Continued From page 13 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. *[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.	E 039		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205127	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____ BY: _____		(X3) DATE SURVEY COMPLETED 08/29/2023
NAME OF PROVIDER OR SUPPLIER MAINE VETERANS HOME - SCARBOROUGH			STREET ADDRESS, CITY, STATE, ZIP CODE 290 US RT 1 SCARBOROUGH, ME 04074		
(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 039	Continued From page 14 (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 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.	E 039			

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NAME OF PROVIDER OR SUPPLIER MAINE VETERANS HOME - SCARBOROUGH			STREET ADDRESS, CITY, STATE, ZIP CODE 290 US RT 1 SCARBOROUGH, ME 04074			
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E 039	Continued From page 15 (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 §486.380] (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 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. *[RNHCIs 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	E 039				

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NAME OF PROVIDER OR SUPPLIER MAINE VETERANS HOME - SCARBOROUGH			STREET ADDRESS, CITY, STATE, ZIP CODE 200 US RT 1 SCARBOROUGH, ME 04074			
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E 039	Continued From page 16 maintain documentation of all tabletop exercises, and emergency events, and revise the RNHC'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 include documentation to indicate full-scale exercise and table top exercises were conducted in the Emergency Preparedness Plan. Finding: On 08/29/2023, between 08:00 am and 10:30 am, a surveyor, with the Facilities Director present, observed the following: 1. Documentation was not included in the Emergency Preparedness Plan to indicate that a full-scale exercise or table top exercises were conducted in the last 12 months. The surveyor confirmed this finding with the Facilities Director at the time of record review.	E 039	E039 Documentation of a full-scale exercise or a table top exercise within the last 12 months will be added to the Emergency Preparedness Plan. Actual events in the prior 12 months were recorded and maintained in separate binders for Fire Alarm Panel situation, Extreme Weather Event, and Lost Person Drill. Maintenance Supervisor will check monthly to ensure that the documentation of the full-scale exercise or table top exercises have not been removed from the EPP and will report the same to the QAPI Committee x3 months. QAPI Committee will assess whether to continue monitoring at that time. Completed by September 12, 2023.			
K 000	INITIAL COMMENTS Federal Recertification Survey Survey Dates: 08/29/2023 Life Safety Code Statement 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 at the time of the inspection, the facility is not in substantial compliance.	K 000				
K 211	Means of Egress - General	K 211				

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K 211 SS=E	Continued From page 17 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 the long term care facility failed to ensure that the exit corridors remained free of obstructions per NFPA 101, Life Safety Code, 2012 Edition, Section 19.2.3.4. Findings: On 08/29/2023, between 08:00 am and 10:30 am, a surveyor, with the Facilities Technician present, observed the following: 1. On C Wing, a straight back chair was found stored in the corridor outside Room 37/38. There was a sign on the adjacent wall calling it out as a Charting Area. Two straight back chairs were found stored in the corridor outside Room 6 and a hand sanitizer stand was found in the exit corridor outside the Dining area. 2. On B Wing, a hand sanitizer stand and a straight back chair was found stored in the exit corridor outside the Dining area. The surveyor confirmed these findings with the Facilities Technician at the time of the observation.	K 211	K 211 On B and C Wings, the straight back chairs and hand sanitizer were removed from the corridors. Floor staff was educated that chairs and hand sanitizer chairs must be kept in resident rooms, dining rooms, and other common areas and excluded from corridors at all times. Maintenance Supervisor or designee will perform monthly audits and document such to ensure items are not stored in the exit corridors in the nursing care units. This will be reported to the QAPI Committee x3 months. QAPI Committee will assess whether to continue monitoring at that time. Completed by September 12, 2023.			

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K 353 K 353 SS=D	Continued From page 18 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 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 observation the long term care facility failed to maintain the required ceiling assembly for a sprinkler protected facility per NFPA 13, Standard for the Installation of Sprinkler Systems, 2010 Edition, Section 8.6.4.1.1 and NFPA 101, Life Safety Code, 2012 Edition, Section 19.3.5.1. Finding: On 08/29/2023, between 08:00 am and 10:30 am, a surveyor, with the Facilities Technician present, observed the following: 1. A ceiling tile was out of place in the Kitchen Water Heater Room. This ceiling assembly is in	K 353 K 353			

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K 353	Continued From page 19 in place so that the appropriate temperature of the stairwell will activate the required sprinkler heads when reached.	K 353	K 353 The ceiling tile in the kitchen water heater room was put in place. All ceiling tiles in the kitchen were inspected to ensure that they were properly seated the assembly.			
K 372 SS=D	The surveyor confirmed this finding with the Facilities Technician at the time of the observation. 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) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observations and interview with the Maintenance Technician the facility failed to meet the requirements of the National Fire Protection Association (NFPA) 101, Life Safety Code, 2012 edition for smoke barrier enclosures in accordance with 19.3.7.3. Findings include: Observations found that 2 smoke barrier walls had penetrations in them, therefore not maintaining a smoke tight resistive rating during a	K 372	K 372 Maintenance Supervisor or designee will perform monthly audits and document such to ensure ceiling tiles in the kitchen are properly positioned. This will be reported to the QAPI Committee x3 months. QAPI Committee will assess whether to continue monitoring at that time. Completed by September 12, 2023.			

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K 372	Continued From page 20 facility tour on 08/29/2023 between 08:00am and 10:30am with the Maintenance Technician. 1. A section of he Smoke barrier wall above the double doors by Wing A, had a conduit penetration through the wall and a bundle of cables that were penetrating the wall in the smoke barrier above the ceiling. All smoke barrier wall penetrations are required to be sealed in accordance with the wall listing. 2. A section of he Smoke barrier wall above the double doors by Wing C had a bundle of cables penetrating the smoke barrier above the ceiling. All smoke barrier wall penetrations are required to be sealed in accordance with the wall listing. This deficient practice could affect the occupants, visitors and staff while trying to exit the building or sheltering in place. These findings were verified by the Maintenance Technician at the time of observation.	K 372	K372 The conduit penetration through a section of the smoke barrier wall above the double doors by A Unit and the cable bundle penetration through a section of the smoke barrier wall above the double doors by C Unit have been sealed in accordance with the wall listing. The smoke barrier wall above the double doors by B Unit were inspected to ensure that there were no other penetrations needing to be sealed. Maintenance Supervisor or designee will perform monthly audits when any work – by maintenance or outside contractor – is performed in the smoke barrier areas. They will document these inspections which will be reported to the QAPI Committee x3 months. QAPI Committee will assess whether to continue monitoring at that time.			
K 919 SS=D	Electrical Equipment - Other CFR(s): NFPA 101 Electrical Equipment - Other List in the REMARKS section any NFPA 99 Chapter 10, Electrical Equipment, 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 10 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the long term care facility failed to comply with NFPA 99.	K 919	Completed by September 12, 2023.			

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K 919	Continued From page 21 Healthcare Facilities Code, 2012 sections 10.5.2.7, 10.5.3.1, & NFPA 101, Life Safety Code, 2012 Edition. Finding: On 08/29/2023, between 08:00 am and 10:30 am, a surveyor, with the Facilities Technician present, observed the following: 1. On C Wing, multiple wheelchair batteries were found charging in the common area. Policies are required to be established for appliances not supplied by the facility Batteries shall not be charged in any resident area, in any area open to residents or exit corridors. Batteries shall be charged within the guidelines set forth by the manufactures recommendations. Batteries are required to be charged in a rated room not open to residents, or the general public. The surveyor confirmed this finding with the Facilities Technician at the time of the observation.	K 919	K 919 Maine Veterans' Home Scarborough has policies for the inspection of electrical equipment prior to use on the floor. Wheelchair battery chargers were removed from the common areas and will be charged within the manufacturer's guidelines. Floor staff will be trained on proper wheelchair battery charging protocols. Maintenance Supervisor or designee will perform monthly audits to ensure that wheelchair battery chargers are not being used in common areas. They will document these inspections which will be reported to the QAPI Committee x3 months. QAPI Committee will assess whether to continue monitoring at that time. Completed by September 12, 2023.		