Cummings, Joanne

From: Cummings, Joanne
Sent: Thursday, July 20, 2023 8:48 AM
To: Bradford C. Peck
Cc: Peaslee, Ronald J; Day, Gregory J
Subject: 205184 SOFD Maine Veterans Home South Paris
Attachments: 205184 Maine Vets Home So. Paris SOFD.pdf

Tracking:

Recipient	Delivery
Bradford C. Peck	
Peaslee, Ronald J	Delivered: 07/20/2023 8:49 AM
Day, Gregory J	Delivered: 07/20/2023 8:50 AM

Good Morning Administrator Peck,

On July 16, 2023, your facility was found not to be in substantial compliance with the participation requirements for Life Safety Code only.

Please do not send your plan of correction to the office via US Mail or fax

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

Joanne Cummings
Office Associate II
Maine Fire Marshal's Office
State House Station 52
45 Commerce Drive
Augusta, ME 04333-0052
O (207) 626-3882
F (207) 287-6251

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
COMMISIONER

RICHARD MCCARTHY
STATE FIRE MARSHAL

July 20, 2023

Maine Veterans Home – So Paris
Attn: Bradford Peck, Administrator
477 High St
South Paris, ME 04281

Provider ID#: 205184
Facility ID#: 1711
Event ID#: L2HO21

Administrator Peck,

On July 18, 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.

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 4, 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 **July 18, 2023,** the following remedy(ies) are being imposed:

The State Agency directs the plan of correction noted on the attached CMS-2567 for deficiencies K161(SS=D), K211(SS=D), K321(SS=D) & K363(SS=D) (Tags). [42 CFR 488.424]

If you do not achieve substantial compliance by **October 19, 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 January 19, 2024,** 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 acheived. 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 DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205184	A. BUILDING 01 B. WING _____	07/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAINE VETERANS HOME - SO PARIS	477 HIGH ST SOUTH PARIS, ME 04281

(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: 07.18.2023 Maine Veteran's Home in South Paris, a long term care facility, is in substantial compliance with 42 Code of Federal Regulations Part 483.73 Requirement for Long Term Care Facilities Emergency Preparedness.	E 000		
K 000	INITIAL COMMENTS Federal Recertification Survey Survey Date: 07.18.2023 Maine Veteran's Home in South Paris 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 is not in substantial compliance.	K 000		
K 161 SS=D	Building Construction Type and Height CFR(s): NFPA 101 Building Construction Type and Height 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5 Construction Type 1 I (442), I (332), II (222) Any number of stories non-sprinklered and sprinklered 2 II (111) One story non-sprinklered	K 161		

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 161	Continued From page 1 Maximum 3 stories sprinklered 3 II (000) Not allowed non-sprinklered 4 III (211) Maximum 2 stories sprinklered 5 IV (2HH) 6 V (111) 7 III (200) Not allowed non-sprinklered 8 V (000) Maximum 1 story sprinklered Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5) Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the long term care facility failed to maintain the 1-hour fire-rated barrier wall per the Life Safety Drawings provided and NFPA 101, Life Safety Code, 2012 Edition, Section 19.1.6.4. Finding: On July 18, 2023, between 10:15 am and 11:45 am, a surveyor, with the Maintenance Director present, observed the following: 1. Cross corridor doors into the C Wing did not	K 161		

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K 161	Continued From page 2 have the floor bolts to latch at the bottom and did not resist the passage of smoke. The Life Safety Drawings indicate that the wall between Administration and C Wing is a 1-hour fire-rated barrier wall. The cross corridor doors are labeled 45-minute fire-rated. The surveyor confirmed this finding with the Maintenance Director at the time of the observation.	K 161		
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 ensure that the corridors were free of obstructions per NFPA 101, Life Safety Code, 2012 Edition, Section 19.2.3.4 (5). Finding: On July 18, 2023, between 10:15 am and 11:45 am, a surveyor, with the Maintenance Director present, observed the following: 1. 2 tables stored in the exit corridor outside the Activities Room found used for guinea pig cages. These are not considered approved items to be	K 211		

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K 211	Continued From page 3 stored in the corridor per Section 19.2.3.4. The surveyor confirmed this finding with the Maintenance Director at the time of the observation and interview. These guinea pig cages were previously housed inside of the Activities room, but were too noisy during quiet activities.	K 211		
K 321 SS=D	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)	K 321		

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K 321	Continued From page 4 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 ensure that the doors to hazardous areas self-closed and positively latched per NFPA 101, Life Safety Code, 2012 Edition, Sections 19.3.2.1.3 and 19.3.2.1.5. Findings: On July 18, 2023, between 10:15 am and 11:45 am, a surveyor, with the Maintenance Director present, observed the following: 1. 45- minute fire-rated door to Kitchen pantry found propped open with condiment box. 2. Clean Utility door in Residential Care wing did not latch when released from 90 degree angle. 3. C Unit Family Room is currently being used for storage. The corridor door to this room shall be equipped with self-closing hardware. The surveyor confirmed these findings with the Maintenance Director at the time of the observation.	K 321		
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for	K 363		

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K 363	Continued From page 5 at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the long term care facility failed to ensure that all corridor doors positively latched per NFPA 101, Life Safety Code, 2012 Edition, Section 19.3.6.3.5. Finding:	K 363		

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K 363	Continued From page 6 On July 18, 2023, between 10:15 am and 11:45 am, a surveyor, with the Maintenance Director present, observed the following: 1. Patient room corridor door B15 did not positively latch when pulled shut. The surveyor confirmed this finding with the Maintenance Director at the time of the observation.	K 363		