State of Maine
Department of Public Safety
Office of Fire Marshal
45 Commerce Drive
Augusta, ME 04330

JANET T. MILLS
GOVERNOR

MICHAEL SAUSCHUCK
COMMISIONER

RICHARD MCCARTHY
STATE FIRE MARSHAL

October 25, 2023

Bangor Nursing & Rehabilitation Center
Attn: Janet Hope, Administrator
103 Texas Ave
Bangor, ME 04401

Provider ID#: 205020
Facility ID#: 1901
Event ID#: LZVF21

Admjnistrator Hope,

On **October 23, 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 **December 11, 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 **October 23, 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=D), K211(SS=D), K232(SS=D), K353(SS=F), K911(SS=D) & K920(SS=A) (Tags). [42 CFR 488.424]

If you do not achieve substantial compliance by **January 25, 2024,** 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 April 25, 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 achieved. Additionally, CMS Regional Office may impose revised/additional remedies, if appropriate.

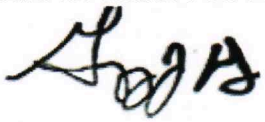
INFORMAL DISPUTE RESOLUTION

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 **Asst. Fire Marshal Gregory J. Day** 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,



Gregory J. Day
Assistant State Fire Marshal

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205020	A. BUILDING **01** B. WING _____	**10/23/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BANGOR NURSING & REHABILITATION CENTER	**103 TEXAS AVE BANGOR, ME 04401**

(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: 10/23/23 Bangor Nursing and Rehab Center, 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 Emergency Preparedness.	E 000		
E 004 SS=D	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 CAH] must comply with all applicable Federal,	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 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 records review and interview, the long-term care facility failed to conduct the annual review of the Emergency Preparedness Plan in accordance with 42 CFR §483.73(a). Finding: On 10/23/2023, between 10:30 AM and 3:00 PM, surveyors 39983 and 47175, with the President present, observed the following: 1. An annual review of the emergency preparedness plan had not been completed since 2021. The surveyor confirmed this finding with the President at the time of the record review.	E 004		

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K 000	Continued From page 2	K 000		
K 000	INITIAL COMMENTS Federal Recertification Survey: Date: 10/23/23 Bangor Nursing and Rehab Center, a Long Term Care Facility, was surveyed to the National Fire Protection Association 101 Life Safety Code 2012 Edition as reference on 42 CFR 483.90 (a-d) physical environment and is not in substantial compliance.	K 000		
K 211 SS=D	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the Nursing Facility failed to ensure the means of egress was free from all obstructions in patient areas per NFPA 101, 2012 edition, 19.2.3.4 (4)(b) The Health care occupancy fire safety plan and training program shall address the relocation of the wheeled equipment during a fire or similar emergency. Upon record review and interview with the maintenance assistant and Regional manager present, the health care occupancies fire safety plan and training program did not document the relocation of the wheeled equipment during a fire	K 211		

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K 211	Continued From page 3 or similar emergency Finding: 1. Wheel chairs and patient lifts were observed stored in the exit corridors throughout the facility . The surveyor confirmed this deficiency with the facilities President at the time of observation.	K 211		
K 232 SS=D	Aisle, Corridor, or Ramp Width CFR(s): NFPA 101 Aisle, Corridor or Ramp Width 2012 EXISTING The width of aisles or corridors (clear or unobstructed) serving as exit access shall be at least 4 feet and maintained to provide the convenient removal of nonambulatory patients on stretchers, except as modified by 19.2.3.4, exceptions 1-5. 19.2.3.4, 19.2.3.5 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the long-term care facility failed to maintain the Exit Corridor required width per NFPA 101, Life Safety Code, 2012 Edition, Sections 18.2.1, 19.2.1, 7.1.10.1 Finding: On 10/23/2023, between 10:30 AM and 3:00 PM, surveyors 39983 and 47175, with the Regional Manager and Maintenance Assistant present, observed the following:	K 232		

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K 232	Continued From page 4 1. The corridor in the Skilled Nursing Unit had wheel medication cart stored in the path of egress and exit corridor. This deficient practice could effect residents, guest and staff from proper egress in the event of an emergency. The surveyor confirmed this finding with the Regional Manager and Maintenance Assistant at the time of the observation.	K 232		
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance 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 and record review, the long-term care facility failed to ensure that Automatic sprinkler and standpipe systems are	K 353		

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K 353	Continued From page 5 inspected, tested, and maintained in accordance with NFPA 25 2011 edition, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems sections 7.3.1 and 14.2.1.1 Findings: On 10/23/2023, between 10:30 AM and 3:00 PM, this surveyor, the Maintenance Assistant, Regional Manager, and President, observed the following: 1. The facility failed to complete the assessment of the internal condition of sprinkler piping during the required 5 year time interval since the completion of the most recent test. 2. The facility failed to complete the hydrostatic testing of underground and exposed piping of the fire department connection during the required 5 year time interval since the completion of the most recent test. These finding were confirmed with the Maintenance Assistant, Regional manager, and President at the time of the observation and record review.	K 353		
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	K 911		

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K 911	Continued From page 6 citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observations and interview, the Nursing Facility failed to ensure electrical cabinets were free from obstructions per NFPA 70®, National Electrical Code®, 2011 edition, Spaces About Electrical Equipment, Access and working space shall be provided and maintained about all electrical equipment to permit ready and safe operation and maintenance of such equipment..(2) Width of Working Space. The width of the working space in front of the electrical equipment shall be the width of the equipment or 762 mm (30 in.), whichever is greater. In all cases, the work space shall permit at least a 90 degree opening of equipment doors or hinged panels. Findings: Based on observation of the surveyor 39983 and 47175 on 10/23/23, in the presence of the Maintenance Assistant and Regional Manager observed the following: 1. A rolling utility cart stored in front of 2 electrical panels in the main kitchen. 2. Medical equipment (wheelchair and hoyer lift) stored in front of electrical power panel located in the skilled nursing unit. During the time of the observation, both findings were verified with the Maintenance Assistant and Regional Manager .	K 911		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
K 920	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the long-term care facility failed to ensure that power strips are not used for non-PCREE (Patient-care-related electrical equipment) and that power strips are not used as a substitute for fixed wiring in accordance with NFPA 99, 2012 edition, Chapter 10, and NFPA 70, 2011 edition, chapter 4 {400.8(1)} On 10/23/2023, between 10:30 AM and 3:00 PM, surveyor 47175, with the Maintenance Assistant, and Regional Manager present observed the following: 1. In the schedulers office, a mini fridge was found plugged into a power strip as a permanent power source. 2. In the activities wing, a microwave was found plugged into a power strip as a permanent power source. This was removed during survey. The surveyor 47175 confirmed this finding with the Maintenance Assistant, and Regional Manager 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