

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

PRINTED: 03/26/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205170	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 03/18/2025
NAME OF PROVIDER OR SUPPLIER ODD FELLOWS HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 85 CARON LANE AUBURN, ME 04210		
(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 Survey Date: 3/18/25 Odd Fellows Health Care 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 007 SS=F	EP Program Patient Population CFR(s): 483.73(a)(3) §403.748(a)(3), §416.54(a)(3), §418.113(a)(3), §441.184(a)(3), §460.84(a)(3), §482.15(a)(3), §483.73(a)(3), §483.475(a)(3), §484.102(a)(3), §485.68(a)(3), §485.542(a)(3), §485.625(a)(3), §485.727(a)(3), §485.920(a)(3), §491.12(a)(3), §494.62(a)(3). [(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 the following:] (3) Address [patient/client] population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.** *[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. The plan must do all of the following: (3) Address resident population, including, but not	E 007			

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 007	Continued From page 1 limited to, persons at-risk; the type of services the LTC facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans. *NOTE: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC/FQHC, or ESRD facilities.] This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the long term care facility failed to maintain an emergency plan addressing resident population, including, but not limited to, persons at-risk; the type of services the LTC facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans. For LTC facilities at §483.73(a). On 3/18/25, between 9:30 AM and 5:00 PM, a surveyor, with the Director of plant operations and Administrator observed the following: 1. There was no evidence in the emergency preparedness plan of a policy addressing resident population, including, but not limited to, persons at-risk; the type of services the LTC facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans. Upon interview, the Administrator stated that the plan was located elsewhere in another binder, not in the packet provided. When offered the opportunity to go get the policy, the Administrator declined stating that he probably did not have what we were looking for.	E 007			

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E 007	Continued From page 2 These findings were verified by the Director of Plant Operations and Administrator at the times of observation, interview, and document review on 3/18/25 between 9:30 AM and 5:00 PM.	E 007			
E 015 SS=F	Subsistence Needs for Staff and Patients CFR(s): 483.73(b)(1) §403.748(b)(1), §418.113(b)(6)(iii), §441.184(b) (1), §460.84(b)(1), §482.15(b)(1), §483.73(b)(1), §483.475(b)(1), §485.542(b)(1), §485.625(b)(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal. *[For Inpatient Hospice at §418.113(b)(6)(iii):]	E 015			

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E 015	Continued From page 3 Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the long term care facility failed to maintain provision of subsistence needs for staff and patients whether they evacuate or shelter in place for Emergency Preparedness Plan in accordance with 42 CFR 483.73. On 3/18/25, between 9:30 AM and 5:00 PM, a surveyor, with the Director of plant operations and Administrator observed the following: 1. There was no evidence in the emergency preparedness plan of a policy addressing the provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical	E 015			

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E 015	Continued From page 4 supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal. Upon interview, the Administrator stated that the plan was located elsewhere in another binder, not in the packet provided. When offered the opportunity to go get the policy, the Administrator declined stating that he probably did not have what we were looking for. These findings were verified by the Director of Plant Operations and Administrator at the times of observation, interview, and document review on 3/18/25 between 9:30 AM and 5:00 PM.	E 015			
E 023 SS=F	Policies/Procedures for Medical Documentation CFR(s): 483.73(b)(5) §403.748(b)(5), §416.54(b)(4), §418.113(b)(3), §441.184(b)(5), §460.84(b)(6), §482.15(b)(5), §483.73(b)(5), §483.475(b)(5), §484.102(b)(4), §485.68(b)(3), §485.542(b)(5), §485.625(b)(5), §485.727(b)(3), §485.920(b)(4), §486.360(b)(2), §491.12(b)(3), §494.62(b)(4). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency	E 023			

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E 023	Continued From page 5 plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] [(5) or (3),(4),(6)] A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records. *[For RNHCIs at §403.748(b) and REHs at §485.542(b):] Policies and procedures. (5) A system of care documentation that does the following: (i) Preserves patient information. (ii) Protects confidentiality of patient information. (iii) Secures and maintains the availability of records. *[For OPOs at §486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the long term care facility failed to maintain a system of medical documentation that preserves client information, protects confidentiality of client information, and secures and maintains the availability of records for Emergency Preparedness Plan in accordance with 42 CFR 483.73.	E 023			

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E 023	Continued From page 6 Finding: On 3/18/25, between 9:30 AM and 5:00 PM, a surveyor, with the Director of plant operations and Administrator observed the following: 1. The was no evidence in the emergency preparedness plan of a policy to maintain a system of medical documentation that preserves client information, protects confidentiality of client information, and secures and maintains the availability of records for Emergency Preparedness Plan. Upon interview, the Administrator stated that the plan was located elsewhere in another binder, not in the packet provided. When offered the opportunity to go get the policy, the Administrator declined stating that he probably did not have what we were looking for. These findings were verified by the Director of Plant Operations and Administrator at the times of observation, interview, and document review on 3/18/25 between 9:30 AM and 5:00 PM.	E 023			
E 025 SS=F	Arrangement with Other Facilities CFR(s): 483.73(b)(7) §403.748(b)(7), §418.113(b)(5), §441.184(b)(7), §460.84(b)(8), §482.15(b)(7), §483.73(b)(7), §483.475(b)(7), §485.625(b)(7), §485.920(b)(6), §494.62(b)(6). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section,	E 025			

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E 025	Continued From page 7 and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] *[For Hospices at §418.113(b), PRFTs at §441.184,(b) Hospitals at §482.15(b), and LTC Facilities at §483.73(b):] Policies and procedures. (7) [or (5)] The development of arrangements with other [facilities] [and] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. *[For PACE at §460.84(b), ICF/IIDs at §483.475(b), CAHs at §486.625(b), CMHCs at §485.920(b) and ESRD Facilities at §494.62(b):] Policies and procedures. (7) [or (6), (8)] The development of arrangements with other [facilities] [or] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. *[For RNHCIs at §403.748(b):] Policies and procedures. (7) The development of arrangements with other RNHCIs and other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of non-medical services to RNHCI patients. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the long term care facility failed to develop and implement emergency preparedness policies for LTC Facilities at §483.73(b):] Policies and	E 025			

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E 025	Continued From page 8 procedures. (7) [or (5)] The development of arrangements with other [facilities] [and] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. On 3/18/25, between 9:30 AM and 5:00 PM, a surveyor, with the Director of plant operations and Administrator observed the following: 1. There was no evidence in the emergency preparedness plan of a policy addressing arrangements with other [facilities] [and] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. Upon interview, the Administrator stated that the plan was located elsewhere in another binder, not in the packet provided. When offered the opportunity to go get the policy, the Administrator declined stating that he probably did not have what we were looking for. These findings were verified by the Director of Plant Operations and Administrator at the times of observation, interview, and document review on 3/18/25 between 9:30 AM and 5:00 PM.	E 025			
E 029 SS=F	Development of Communication Plan CFR(s): 483.73(c) §403.748(c), §416.54(c), §418.113(c), §441.184(c), §460.84(c), §482.15(c), §483.73(c), §483.475(c), §484.102(c), §485.68(c), §485.542(c), §485.625(c), §485.727(c), §485.920(c), §486.360(c), §491.12(c), §494.62(c).	E 029			

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E 029	Continued From page 9 (c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the long term care facility failed to maintain a communication plan for Emergency Preparedness Plan in accordance with 42 CFR 483.73(C). Finding: On 3/18/25, between 9:30 AM and 5:00 PM, a surveyor, with the Director of plant operations and Administrator observed the following: 1. There was no evidence in the emergency preparedness plan of a communications plan. The facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every year. These findings were verified by the Director of Plant Operations and Administrator at the times of observation, interview, and document review on 3/18/25 between 9:30 AM and 5:00 PM.	E 029			
E 030 SS=F	Names and Contact Information CFR(s): 483.73(c)(1) §403.748(c)(1), §416.54(c)(1), §418.113(c)(1), §441.184(c)(1), §460.84(c)(1), §482.15(c)(1), §483.73(c)(1), §483.475(c)(1), §484.102(c)(1), §485.68(c)(1), §485.542(c)(1), §485.625(c)(1),	E 030			

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E 030	Continued From page 10 §485.727(c)(1), §485.920(c)(1), §486.360(c)(1), §491.12(c)(1), §494.62(c)(1). [(c) The [facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following:] (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [facilities]. (v) Volunteers. *[For Hospitals at §482.15(c) and CAHs at §485.625(c)] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [hospitals and CAHs]. (v) Volunteers. *[For RNHCIs at §403.748(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Next of kin, guardian, or custodian.	E 030			

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E 030	Continued From page 11 (iv) Other RNHCIs. (v) Volunteers. *[For ASCs at §416.45(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For Hospices at §418.113(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Hospice employees. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Other hospices. *[For HHAs at §484.102(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For OPOs at §486.360(c):] The communication plan must include all of the following: (2) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Volunteers.	E 030			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205170	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 03/18/2025
NAME OF PROVIDER OR SUPPLIER ODD FELLOWS HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 85 CARON LANE AUBURN, ME 04210		
(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 030	Continued From page 12 (iv) Other OPOs. (v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA). This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the long term care facility failed to develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities] 483.73(c)(1). On 3/18/25, between 9:30 AM and 5:00 PM, a surveyor, with the Director of plant operations and Administrator observed the following: 1. There was no evidence in the emergency preparedness plan of a policy developed for emergency preparedness communication including the Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [facilities]. (v) Volunteers. These findings were verified by the Director of Plant Operations and Administrator at the times of observation, interview, and document review on 3/18/25 between 9:30 AM and 5:00 PM.	E 030			
E 031 SS=F	Emergency Officials Contact Information CFR(s): 483.73(c)(2) §403.748(c)(2), §416.54(c)(2), §418.113(c)(2), §441.184(c)(2), §460.84(c)(2), §482.15(c)(2), §483.73(c)(2), §483.475(c)(2), §484.102(c)(2),	E 031			

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E 031	Continued From page 13 §485.68(c)(2), §485.542(c)(2), §485.625(c)(2), §485.727(c)(2), §485.920(c)(2), §486.360(c)(2), §491.12(c)(2), §494.62(c)(2). [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following: (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. *[For LTC Facilities at §483.73(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) The State Licensing and Certification Agency. (iii) The Office of the State Long-Term Care Ombudsman. (iv) Other sources of assistance. *[For ICF/IIDs at §483.475(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. (iii) The State Licensing and Certification Agency. (iv) The State Protection and Advocacy Agency. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the long term care facility failed to develop and maintain an emergency preparedness communication plan that complies with Federal,	E 031			

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E 031	Continued From page 14 State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities] 483.73(c)(1). On 3/18/25, between 9:30 AM and 5:00 PM, a surveyor, with the Director of plant operations and Administrator observed the following: 1. There was no evidence in the emergency preparedness plan of a policy developed for emergency preparedness communication including For LTC Facilities at §483.73(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) The State Licensing and Certification Agency. (iii) The Office of the State Long-Term Care Ombudsman. (iv) Other sources of assistance. These findings were verified by the Director of Plant Operations and Administrator at the times of observation, interview, and document review on 3/18/25 between 9:30 AM and 5:00 PM.	E 031			
E 032 SS=F	Primary/Alternate Means for Communication CFR(s): 483.73(c)(3) §403.748(c)(3), §416.54(c)(3), §418.113(c)(3), §441.184(c)(3), §460.84(c)(3), §482.15(c)(3), §483.73(c)(3), §483.475(c)(3), §484.102(c)(3), §485.68(c)(3), §485.542(c)(3), §485.625(c)(3), §485.727(c)(3), §485.920(c)(3), §486.360(c)(3), §491.12(c)(3), §494.62(c)(3). [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every	E 032			

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E 032	Continued From page 15 2 years [annually for LTC facilities]. The communication plan must include all of the following: (3) Primary and alternate means for communicating with the following: (i) [Facility] staff. (ii) Federal, State, tribal, regional, and local emergency management agencies. *[For ICF/IIDs at §483.475(c):] (3) Primary and alternate means for communicating with the ICF/IID's staff, Federal, State, tribal, regional, and local emergency management agencies. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the long term care facility failed to develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities] 483.73(c)(1). On 3/18/25, between 9:30 AM and 5:00 PM, a surveyor, with the Director of plant operations and Administrator observed the following: 1. There was no evidence in the emergency preparedness plan of a policy developed for emergency preparedness communication including Primary and alternate means for communicating with the following: (i) [Facility] staff. (ii) Federal, State, tribal, regional, and local emergency management agencies. These findings were verified by the Director of Plant Operations and Administrator at the times	E 032			

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E 032	Continued From page 16 of observation, interview, and document review on 3/18/25 between 9:30 AM and 5:00 PM.	E 032			
E 033 SS=F	Methods for Sharing Information CFR(s): 483.73(c)(4)-(6) §403.748(c)(4)-(6), §416.54(c)(4)-(6), §418.113(c)(4)-(6), §441.184(c)(4)-(6), §460.84(c)(4)-(6), §441.184(c)(4)-(6), §460.84(c)(4)-(6), §482.15(c)(4)-(6), §483.73(c)(4)-(6), §483.475(c)(4)-(6), §484.102(c)(4)-(5), §485.68(c)(4), §485.542(c)(4)-(6), §485.625(c)(4)-(6), §485.727(c)(4), §485.920(c)(4)-(6), §491.12(c)(4), §494.62(c)(4)-(6). [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following: (4) A method for sharing information and medical documentation for patients under the [facility's] care, as necessary, with other health providers to maintain the continuity of care. (5) A means, in the event of an evacuation, to release patient information as permitted under 45 CFR 164.510(b)(1)(ii). [This provision is not required for HHAs under §484.102(c), CORFs under §485.68(c)] (6) [(4) or (5)]A means of providing information about the general condition and location of patients under the [facility's] care as permitted under 45 CFR 164.510(b)(4).	E 033			

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E 033	Continued From page 17 *[For RNHCIs at §403.748(c):] (4) A method for sharing information and care documentation for patients under the RNHCI's care, as necessary, with care providers to maintain the continuity of care, based on the written election statement made by the patient or his or her legal representative. *[For RHCs/FQHCs at §491.12(c):] (4) A means of providing information about the general condition and location of patients under the facility's care as permitted under 45 CFR 164.510(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the long term care facility failed to develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities] 483.73(c)(1). On 3/18/25, between 9:30 AM and 5:00 PM, a surveyor, with the Director of plant operations and Administrator observed the following: 1. There was no evidence in the emergency preparedness plan of a policy developed for emergency preparedness communication including the following: (1) A method for sharing information and medical documentation for patients under the [facility's] care, as necessary, with other health providers to maintain the continuity of care. (2) A means, in the event of an evacuation, to release patient information as permitted under 45	E 033			

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E 033	Continued From page 18 CFR 164.510(b)(1)(ii). [This provision is not required for HHAs under §484.102(c), CORFs under §485.68(c)] (3) A means of providing information about the general condition and location of patients under the [facility's] care as permitted under 45 CFR 164.510(b)(4). These findings were verified by the Director of Plant Operations and Administrator at the times of observation, interview, and document review on 3/18/25 between 9:30 AM and 5:00 PM.	E 033			
E 034 SS=F	Information on Occupancy/Needs CFR(s): 483.73(c)(7) §403.748(c)(7), §416.54(c)(7), §418.113(c)(7) §441.184(c)(7), §482.15(c)(7), §460.84(c)(7), §483.73(c)(7), §483.475(c)(7), §484.102(c)(6), §485.68(c)(5), §485.68(c)(5), §485.727(c)(5), §485.542(c)(7), §485.625(c)(7), §485.920(c)(7), §491.12(c)(5), §494.62(c)(7). [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following: (7) [(5) or (6)] A means of providing information about the [facility's] occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee.	E 034			

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E 034	Continued From page 19 *[For ASCs at 416.54(c)]: (7) A means of providing information about the ASC's needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. *[For Inpatient Hospice at §418.113(c)]: (7) A means of providing information about the hospice's inpatient occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the long term care facility failed to develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities] 483.73(c)(1). On 3/18/25, between 9:30 AM and 5:00 PM, a surveyor, with the Director of plant operations and Administrator observed the following: 1. There was no evidence in the emergency preparedness plan of a policy developed for emergency preparedness communication including the following: (1) A means of providing information about the [facility's] occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. These findings were verified by the Director of	E 034			

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E 034	Continued From page 20 Plant Operations and Administrator at the times of observation, interview, and document review on 3/18/25 between 9:30 AM and 5:00 PM.	E 034			
E 036 SS=F	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 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	E 036			

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E 036	Continued From page 21 (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: Based on observation, interview and record review, the long term care facility failed to 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	E 036			

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E 036	Continued From page 22 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 in accordance with 42 CFR 483.73. On 3/18/25, between 9:30 AM and 5:00 PM, a surveyor, with the Director of plant operations and Administrator observed the following: 1. There was no evidence in the emergency preparedness plan of a policy developed for a training and testing program that is based on the emergency plan, risk assessment, procedures at paragraph, and the communication plan. The training and testing program must be reviewed and updated at least annually. These findings were verified by the Director of Plant Operations and Administrator at the times of observation, interview, and document review on 3/18/25 between 9:30 AM and 5:00 PM.	E 036			
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]:	E 039			

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E 039	Continued From page 23 (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: (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	E 039			

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E 039	Continued From page 24 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 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	E 039			

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E 039	Continued From page 25 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 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	E 039			

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E 039	Continued From page 26 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 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	E 039			

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E 039	Continued From page 27 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 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			E 039			

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E 039	Continued From page 28 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. *[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	E 039			

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E 039	Continued From page 29 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 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:	E 039			

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E 039	Continued From page 30 (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 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]:	E 039			

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E 039	Continued From page 31 (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 conduct exercises to test the emergency plan annually. The facility must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures in accordance with 42 CFR 483.73. On 3/18/25, between 9:30 AM and 5:00 PM, a surveyor, with the Director of plant operations and Administrator observed the following: 1. Documentation provided for one tabletop drill that did not contain evidence that the drill presented a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. 2. No documentation provided showed evidence that the facility conducted exercises to test the emergency plan at least twice per year including unannounced staff drills using emergency	E 039			

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E 039	Continued From page 32 procedures doing any of 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.	E 039			
E 041 SS=F	These findings were verified by the Director of Plant Operations and Administrator at the times of observation, interview, and document review on 3/18/25 between 9:30 AM and 5:00 PM. Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e), §485.542(e) (e) Emergency and standby power systems. The [LTC facility CAH and REH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.542(e)(1), §485.625(e)(1) Emergency generator location. The generator	E 041			

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E 041	Continued From page 33 must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2), §485.542(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3), §485.542(e)(2) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), REHs at §485.542(g), and and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource			E 041			

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E 041	Continued From page 34 Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record	E 041			

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E 041	Continued From page 35 review, the long term care facility failed to implement emergency and standby power systems based on the emergency plan in accordance with §483.73(e) On 3/18/25, between 9:30 AM and 5:00 PM, a surveyor, with the Director of plant operations and Administrator observed the following: 1. There was no evidence in the emergency preparedness plan of a policy to maintain the following: (A) Maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. (B) Emergency generator inspection and testing. The LTC facility must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. (C) Emergency and standby power systems. The [LTC facility] must implement emergency and standby power systems based on the emergency plan. These findings were verified by the Director of Plant Operations and Administrator at the times of observation, interview, and document review on 3/18/25 between 9:30 AM and 5:00 PM.	E 041			
K 000	INITIAL COMMENTS Federal Recertification Survey: Date: 3/18/25	K 000			

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K 000	Continued From page 36	K 000			
K 131 SS=F	Odd Fellows Health Care 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. Multiple Occupancies CFR(s): NFPA 101 Multiple Occupancies - Sections of Health Care Facilities Sections of health care facilities classified as other occupancies meet all of the following: - o They are not intended to serve four or more inpatients for purposes of housing, treatment, or customary access. - o They are separated from areas of health care occupancies by construction having a minimum two hour fire resistance rating in accordance with Chapter 8. - o The entire building is protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. Hospital outpatient surgical departments are required to be classified as an Ambulatory Health Care Occupancy regardless of the number of patients served. 19.1.3.3, 42 CFR 482.41, 42 CFR 485.623 This REQUIREMENT is not met as evidenced by: Based on observation, the long-term care facility failed to ensure that Sections of health care facilities classified as other occupancies meet all	K 131			

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K 131	Continued From page 37 of the following: They are separated from areas of health care occupancies by construction having a minimum two hour fire resistance rating in accordance with Chapter 8 of NFPA 101 2018 edition 19.1.3.3. Findings: On 3/18/25, between 9:30 AM and 5:00 PM, a surveyor, with the Director of plant operations observed the following: 1. No documentation could be provided to show that the wall separating the nursing and residential care sides of the building was a listed 2-hour rated fire barrier assembly. No documentation on previously provided plans of corrections show a licensed design professional in charge of the repair of the wall, or what and tested assembly repairs used to maintain the 2-hour wall rating. These findings were verified by the Director of Plant Operations at the times of observation, interview, and document review on 3/18/25 between 9:30 AM and 5:00 PM.	K 131			
K 133 SS=D	Multiple Occupancies - Construction Type CFR(s): NFPA 101 Multiple Occupancies - Construction Type Where separated occupancies are in accordance with 18/19.1.3.2 or 18/19.1.3.4, the most stringent construction type is provided throughout the building, unless a 2-hour separation is provided in accordance with 8.2.1.3, in which case the construction type is determined as follows: * The construction type and supporting construction of the health care occupancy is	K 133			

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K 133	Continued From page 38 based on the story in which it is located in the building in accordance with 18/19.1.6 and Tables 18/19.1.6.1 * The construction type of the areas of the building enclosing the other occupancies shall be based on the applicable occupancy chapters. 18.1.3.5, 19.1.3.5, 8.2.1.3 This REQUIREMENT is not met as evidenced by: Based on observation, the long-term care facility failed to ensure that 2 hour separation fire barrier, separating occupancies of long term care and board and care, are in accordance with 18/19.1.3.2 and 18/19.1.3.4, the most stringent construction type is provided throughout the building, unless a 2-hour separation is provided in accordance with 8.2.1.3, in which case the construction type is determined as follows: The construction type and supporting construction of the health care occupancy is based on the story in which it is located in the building in accordance with 18/19.1.6 and Tables 18/19.1.6.1. Findings: On 3/18/25, between 9:30 AM and 5:00 PM, a surveyor, with the Director of plant operations observed the following: 1. No documentation/Life Safety Drawings could be provided to show that the wall separating the nursing and residential care sides of the building was a listed 2-hour rated fire barrier assembly. The surveyor could not confirm without life safety drawings that the wall identified as a two-hour barrier extend to the basement, and is continuous separating the building from floor to the roof deck. The facility did not have a copy of construction plans stamped and signed by a licensed design	K 133			

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K 133	Continued From page 39 professional showing the construction type of the building, or an accurate location of the 2-hour barrier. These findings were verified by the Director of Plant Operations at the times of observation, interview, and document review on 3/18/25 between 9:30 AM and 5:00 PM.	K 133			
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 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. NFPA 101, Life Safety Code, 2012 edition, section 7.1.10.1 and 19.2.1. Findings: On March 18, 2025, between 9:30 AM and 5:00 PM, a surveyor, with the Director of Plant Operations present, observed the following: 1. In the corridor by the maintenance shop,	K 211			

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K 211	Continued From page 40 storage of folding chairs, winter ice melt, and some patient belongings were observed being stored. This deficient practice could affect all occupants including residents, employees, and visitors to the facility.	K 211			
K 222 SS=D	The surveyor confirmed these findings with the Director of Plant Operations at the time of the observation and record review. Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a	K 222			

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K 222	Continued From page 41 complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure that doors in a required means of egress met the latching/locking requirements of NFPA 101 Life Safety Code (2012 edition) 19.2.2.2.6 (2) and 7.2.1.6.2. This deficient practice could affect the patients/residents,	K 222			

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K 222	Continued From page 42 visitors, and members of facility staff in this location(s). Findings: Observation(s) and Interview(s), during a facility tour on 3/18/25 between 9:30 AM and 5:00 PM a surveyor with the Director of Plant Operations present, observed the following: 1. The facility failed to provide exit access (fencing in place exiting the cooler/pantry in the basement) was readily accessible at all times by having special locking arrangements (a padlock used with a fork latch) with staff being the only people with access to keys regardless of resident independent cognitive ability which is not in accordance with LSC Section 19.2.2.2.4, 19.2.2.2.5, 19.2.2.2.5.2 and 7.2.1.6. This deficient practice could affect exiting from the pantry area, as well as an indeterminable number of residents, staff and visitors. Observation and Interview with the Director of Plant Operations at the time of observation confirmed the door could only be unlocked by a food service employee and an occupant without a key would be trapped inside. 2. 1. The facility failed to provide exit access (stairs to the basement from the nursing area, doors exiting the sunroom into a gated courtyard, the gate exiting the courtyard, and the double doors exiting from nursing into the main lobby) was readily accessible at all times by having special locking arrangements (coded lock release pads) with staff being the only people with access to exits regardless of resident independent cognitive ability which is not in accordance with LSC Section 19.2.2.2.4, 19.2.2.2.5, 19.2.2.2.5.2	K 222			

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K 222	Continued From page 43 and 7.2.1.6. This deficient practice could affect exiting from all facility designated exits, as well as an indeterminable number of residents, staff and visitors. Observation and Interview with the Maintenance Director at the time of observation confirmed the exit doors had access codes that required assistance from staff with knowledge of the codes. These findings were verified by the Director of Plant Operations at the times of observation, interview, and document review on 3/18/25 between 9:30 AM and 5:00 PM.	K 222			
K 291 SS=D	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on the observation and interview, the long-term care facility failed to conduct the required testing of emergency lighting systems in accordance with NFPA 101, The Life Safety Code, 2012 edition, Section 7.9.3.1.1 (3)(5). Findings: On March 18, 2025, between 9:30 AM and 5:00 PM, a surveyor, with the Director of Plant Operations present, observed the following: 1. During the review of emergency light testing, there was no documentation of the required 90-minute test. The Director of Plant Operations	K 291			

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K 291	Continued From page 44 stated he did not know that the 90-minute tests had to be completed.	K 291			
K 321 SS=D	The surveyor confirmed these findings with the Director of Plant Operations at the time of the observation and record review. 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)	K 321			

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K 321	Continued From page 45 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the long-term care facility failed to ensure hazardous areas are protected by fire barrier having a 1-hour fire resistive rating. NFPA 101, The Life Safety Code, 2012 edition, section 8.3.5.1 and 19.3.1.8. Findings: On March 18, 2025, between 9:30 AM and 5:00 PM, a surveyor, with the Director of Plant Operations present, observed the following: In the new wing boiler, penetrations were observed not protected or sealed with a rated firestop system. The penetrations were from the electrical conduit that goes from the transfer switch up through the ceiling and from the furnace vent that goes up through the ceiling. The firestop system is required for the room to maintain its 1-hour fire resistive rating. This deficient practice could affect any occupants, residents, employees, and visitors to the facility. The surveyor confirmed these findings with the Director of Plant Operations at the time of the observation and record review.	K 321			
K 353 SS=D	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	K 353			

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K 353	Continued From page 46 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 interview, the long-term facility care failed to inspect and maintain the sprinkler system in accordance to NFPA 25. NFPA 101, The Life Safety Code, 2012 edition, section 9.7.5, NFPA 25, The Standard for Inspection, Testing, and Maintenance of Water-based Fire Protection Systems, 2011 edition, section 5.2.1.1.1. Findings: On March 18, 2025, between 9:30 AM and 5:00 PM, a surveyor, with the Director of Plant Operations present, observed the following: All 3 sprinkler heads in the laundry's folding room were observed loaded with dust and debris, potentially preventing the sprinkler operate as designed. This deficient practice could affect all occupants including residents, employees, and visitors to the facility. The surveyor confirmed these findings with the Director of Plant Operations at the time of the	K 353			

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K 353	Continued From page 47 observation and record review.	K 353			
K 355 SS=F	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 the observation and interview, the long-term care facility failed to ensure that the portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10 per NFPA 101, The Life Safety Code, 2012 edition, Sections 9.7.4.1 and 19.3.5.12, and NFPA 10, Standard for Portable Fire Extinguishers, 2010 edition, section 7.3.1.1.1 Findings: On March 18, 2025, between 9:30 AM and 5:00 PM, a surveyor, with the Director of Plant Operations present, observed the following: 1. During the inspection the portable fire extinguishers were found to be 2 months overdue for the yearly maintenance inspection. The Director of Plant Operations advised that all the extinguishers in the facility have not had annual service completed. The surveyor confirmed these findings with the Director of Plant Operations at the time of the observation and record review.	K 355			
K 541	Rubbish Chutes, Incinerators, and Laundry Chu	K 541			

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NAME OF PROVIDER OR SUPPLIER ODD FELLOWS HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 85 CARON LANE AUBURN, ME 04210		
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K 541 SS=F	Continued From page 48 CFR(s): NFPA 101 Rubbish Chutes, Incinerators, and Laundry Chutes 2012 EXISTING (1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor shall be sealed by fire resistive construction to prevent further use or shall be provided with a fire door assembly having a fire protection rating of 1-hour. All new chutes shall comply with 9.5. (2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, shall be provided with automatic extinguishing protection in accordance with 9.7. (3) Any trash chute shall discharge into a trash collection room used for no other purpose and protected in accordance with 8.4. (Existing laundry chutes permitted to discharge into same room are protected by automatic sprinklers in accordance with 19.3.5.9 or 19.3.5.7.) (4) Existing fuel-fed incinerators shall be sealed by fire resistive construction to prevent further use. 19.5.4, 9.5, 8.4, NFPA 82 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure that per NFPA 101 2018 edition, section 19.5.4 any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor shall be sealed by fire resistive construction to prevent further use or shall be provided with a fire door assembly having a fire protection rating of 1-hour. All new chutes shall comply with 9.5, and that any rubbish chute or linen chute, including pneumatic rubbish and linen systems, shall be provided with	K 541			

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K 541	Continued From page 49 automatic extinguishing protection in accordance with 9.7. Findings include: Observation(s) and Interview(s), during a facility tour on 3/18/25 between 9:30 AM and 5:00 PM a surveyor with the Director of Plant Operations present, observed the following: 1. The laundry chute connecting all floors of the building was equipped with non-rated/listed wood doors in locations on the first and second floors, 2. The laundry chute has holes were drilled into the top of the chute compromising the metal and could allow for the passage of smoke/fire outside of the enclosure. This deficient practice could affect the occupants, visitors and staff while occupying the building and utilizing the corridors in this smoke compartment. 2. There was not adequate sprinkler coverage provided inside of the laundry chute. A sprinkler head was present above and outside of the laundry chute, coverage provided by this sprinkler head was obstructed by the top of the chute. There was no additional sprinkler located inside of the upper portion of the laundry chute. This deficient practice could effect all building occupants including residents, staff, and visitors of the facility as the laundry chute is a vertical opening penetrating all floors. These findings were verified by the Director of Plant Operations at the times of observation, interview, and document review on 3/18/25 between 9:30 AM and 5:00 PM.	K 541			
K 700 SS=D	Operating Features - Other CFR(s): NFPA 101	K 700			

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K 700	Continued From page 50 Operating Features - Other List in the REMARKS section any LSC Section 18.7 and 19.7 Operating Features 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 in Form CMS-2567. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the long-term care facility failed to maintain that dumpsters and containers more shall not be stored within 10 ft of combustible walls, openings, or combustible roof eave lines per NFPA 1, Fire Code, 2012 edition, section 19.2.1.4. On March 18, 2025, between 9:30 AM and 5:00 PM, a surveyor, with the Director of Plant Operations present, observed the following: 1. Several plastic storage sheds were observed up against the exterior of the building by the delivery door. According to the Director of Plant Operations, these sheds are used to store trash. The surveyor confirmed these findings with the Director of Plant Operations at the time of the observation and record review.	K 700			
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar	K 712			

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K 712	Continued From page 51 with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the long-term care facility failed to ensure that fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift per NFPA 101, Life Safety Code, 2012 Edition, Section 19.7.1.4 through 19.7.1.7 Findings: On March 18, 2025, between 9:30 AM and 5:00 PM, a surveyor, with the Director of Plant Operations present, observed the following: During the review of the fire drill records and interview with the Director of Plant Operations, it was determined that the facility failed to conduct fire drills as outlined in the facilities fire emergency plan. During interview with director of plant operations it was identified that a scenerio would be established and once staff identified the issue they would meet at a planned location and dicuss what they would do and determine rolls for the incident. The staff did not activly/physically participate in actual simulations of the facilities fire emergency plan. The surveyor confirmed these findings with the Director of Plant Operations at the time of the observation and record review.	K 712			
K 751 SS=D	Draperies, Curtains, and Loosely Hanging Fabr	K 751			

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K 751	Continued From page 52 CFR(s): NFPA 101 Draperies, Curtains, and Loosely Hanging Fabrics Draperies, curtains including cubicle curtains and loosely hanging fabric or films shall be in accordance with 10.3.1. Excluding curtains and draperies: at showers and baths; on windows in patient sleeping room located in sprinklered compartments; and in non-patient sleeping rooms in sprinklered compartments where individual drapery or curtain panels do not exceed 48 square feet or total area does not exceed 20 percent of the wall. 18.7.5.1, 18.3.5.11, 19.7.5.1, 19.3.5.11, 10.3.1 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the long-term care facility failed to ensure that draperies, curtains including cubicle curtains and loosely hanging fabric or films be in accordance with NFPA 101, The Life Safety Code, 2012 edition, section 10.3.1 and 19.5.5.1. Findings: On March 18, 2025, between 9:30 AM and 5:00 PM, a surveyor, with the Director of Plant Operations present, observed the following: 1. In the doorway between the laundry room and folding room, there was plastic strip curtain observed. The curtain had no labeling or documentation stating that the curtain listing that it is compliant with NFPA 10.3.1. No documentaion could be provided that the flame retardant spray was not beyond its shelf or when the product was sprayed on the curtain. This deficient practice could affect all occupants including residents, employees, and visitors to the	K 751			

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K 751	Continued From page 53 facility.	K 751			
K 754 SS=D	The surveyor confirmed these findings with the Director of Plant Operations at the time of the observation and record review. Soiled Linen and Trash Containers CFR(s): NFPA 101 Soiled Linen and Trash Containers Soiled linen or trash collection receptacles shall not exceed 32 gallons in capacity. The average density of container capacity in a room or space shall not exceed 0.5 gallons/square feet. A total container capacity of 32 gallons shall not be exceeded within any 64 square feet area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gallons shall be located in a room protected as a hazardous area when not attended. Containers used solely for recycling are permitted to be excluded from the above requirements where each container is less than or equal to 96 gallons unless attended, and containers for combustibles are labeled and listed as meeting FM Approval Standard 6921 or equivalent. 18.7.5.7, 19.7.5.7 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the long-term care facility failed to ensure that soiled linen receptacles were stored in a room, and not in the corridor per NFPA 101, The Life Safety Code, 2012 edition, section 19.7.5.7.1. This deficient practice could affect the patients/residents, visitors, and members of facility staff in this location. Findings:	K 754			

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K 754	Continued From page 54	K 754			
	During the inspection mobile laundry receptacles were found in the corridor outside of room 4 and room 12.				
	The surveyor confirmed these findings with the Director of Plant Operations at the time of the observation and record review.				
K 761 SS=D	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101	K 761			
	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 ensure that the fire doors were in compliance with NFPA 80, Standard for Fire Doors and Other Opening Protectives, 2010 edition, section 5.2.4.2 and 6.3.1.7. NFPA 101, The Life Safety Code, 2012 edition, section 8.3.3.1.				
	Findings:				

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K 761	Continued From page 55 On March 18, 2025, between 9:30 AM and 5:00 PM, a surveyor, with the Director of Plant Operations present, observed the following: 1. The double leaf 90-minute fire doors, separating nursing care from residential care, had a gap greater than ½" at the top of horizontal plan of the left side door. 2. The door had unsecured screws/fasteners and missing screws/fasteners from the door hardware. This deficient practice could prevent the doors from operating as designed affecting all occupants including residents, employees, and visitors to the facility. The surveyor confirmed these findings with the Director of Plant Operations at the time of the observation and record review.	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 ensure that electrical wiring was secure and cover plates in place per NFPA 101, The Life Safety Code, 2012 edition, section 9.1.2, NFPA 1, Fire Code, 2012	K 911			

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K 911	Continued From page 56 edition, section 11.1.10 On March 18, 2025, between 9:30 AM and 5:00 PM, a surveyor, with the Director of Plant Operations present, observed the following: 1. On the nursing side of the double doors between the nursing and residential care, it was observed that there was open unsecured and improperly terminated wiring above the suspended ceiling. This deficient practice could affect all occupants including residents, employees, and visitors to the facility. The surveyor confirmed these findings with the Director of Plant Operations at the time of the observation and record review.	K 911			
K 914 SS=D	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are	K 914			

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K 914	Continued From page 57 maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation, interview and documentation review, the long-term care facility failed to provide documentation that the receptacles in patient bed locations were tested at intervals not exceeding 12 months per NFPA 99, Health Care Facilities Code, 2012 Edition, Sections 6.3.4.1.3 Findings: On March 18, 2025, between 9:30 AM and 5:00 PM, a surveyor, with the Director of Plant Operations present, observed the following: 1. During the review of testing records the Director of Plant Operations stated that they did not keep records of the testing of receptacles in patient rooms and no documentation could be provided at time of survey. The surveyor confirmed these findings with the Director of Plant Operations at the time of the observation and record review.	K 914			
K 918 SS=D	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a	K 918			

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K 918	Continued From page 58 process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on observation, interview and documentation review, the long-term care facility failed to maintain the Essential Electric System Generator per NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, sections 8.4.1 and 8.4.2, as referenced by NFPA 99, Healthcare Facilities Code, 2012 edition, section 6.4.4.1.1.3. This deficient practice could affect the patients/residents, visitors, and	K 918			

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K 918	Continued From page 59 members of facility staff in this location. Findings: On March 18, 2025, between 9:30 AM and 5:00 PM, a surveyor, with the Director of Plant Operations present, observed the following: Upon inspection of the generator maintenance records, there was no documentation that the generator was receiving a monthly test under operating temperature conditions at not less than 30% of the EPS nameplate kW rating. The surveyor confirmed these findings with the Director of Plant Operations at the time of the observation and record review.	K 918			
K 920 SS=D	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) assemblies 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.	K 920			

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K 920	Continued From page 60 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 the observation and interview, the long-term care facility failed to ensure power strips, extension cords, and multi-use adapters are not used as a substitute for fixed wiring and that extension cords used temporarily are removed immediately upon completion of the purpose in which it was installed per NFPA 70, National Electric Code, 2011 edition, Section 400.8, NFPA 1, Fire Code, 2012 edition, section 11.1.7.6 On March 18, 2025, between 9:30 AM and 5:00 PM, a surveyor, with the Director of Plant Operations present, observed the following: 1. In the Activities Director's office, a power strip was found plugged into a multi-use outlet adapter. 2. In the maintenance shop, a multi-use adapter was found plugged into the ceiling drop cord. Removed during inspection by the Director of Plant Operations. The surveyor confirmed these findings with the Director of Plant Operations at the time of the observation and record review.	K 920			
K 923 SS=D	Gas Equipment - Cylinder and Container Storage CFR(s): NFPA 101	K 923			

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

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205170	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 03/18/2025
NAME OF PROVIDER OR SUPPLIER ODD FELLOWS HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 85 CARON LANE AUBURN, ME 04210		
(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	
K 923	Continued From page 61 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the	K 923			

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NAME OF PROVIDER OR SUPPLIER ODD FELLOWS HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 85 CARON LANE AUBURN, ME 04210			
(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
K 923	Continued From page 62 long-term care facility failed to ensure storage of oxygen tanks greater than 300 cubic feet, but less than 3000 cubic feet were separated from combustibles by 5 feet per NFPA 99, Health Care Facilities Code, 2012 edition, section 11.3.2.3, and NFPA 101, The Life Safety Code, 2012 edition, section 19.3.2.4 Findings: On March 18, 2025, between 9:30 AM and 5:00 PM, a surveyor, with the Director of Plant Operations present, observed the following: 1. The oxygen storage closet was found to have an excess of 13 E sized tanks. The tanks were stored in proximity with combustibles including shelving and non-oxygen delivery supplies. This deficient practice could affect all occupants including residents, employees, and visitors to the facility. The surveyor confirmed these findings with the Director of Plant Operations at the time of the observation and record review.			K 923			