STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205168	A. BUILDING 01 B. WING ______	12/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ORCHARD PARK REHAB & LIVING	107 ORCHARD ST FARMINGTON, ME 04938

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments Federal Recertification Survey Survey Date: 12/11/2024 Orchard Park Rehab & Living, a long-term care facility, is not in substantial compliance with 42 Code of Federal Regulations Part 483.73 Requirement for Long Term Care Facilities for Emergency Preparedness.	E 000	RECEIVED DEC 26 2024 BY:	
E 039 SS=F	EP Testing Requirements CFR(s): 483.73(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires 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	E 039	See attached POC Revised 12/26/2024 J. Pomelau MEA Facility Mgr.	1/17/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Robert Straznitskas | TITLE: Administrator | (X6) DATE: 12-19-24

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 039	Continued From page 1 actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event.	E 039	RECEIVED DEC 26 2024 BY: See attached POC	1/17/2025

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E 039	Continued From page 2 (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a	E 039	RECEIVED DEC 26 2024 BY: See attached POC	1/17/2025

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E 039	Continued From page 3 facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based 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	E 039	RECEIVED BY: See attached PoC	1/17/25

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E 039	Continued From page 4 discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based 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,	E 039	RECEIVED DEC 26 2024 BY: See attached POC	1/17/25

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E 039	Continued From page 5 using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by 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	E 039	RECEIVED [illegible] 2024 BY: See attached POC	1/17/25

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E 039	Continued From page 6 challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (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.	E 039	RECEIVED DEC 26 2024 BY:______ See attached PoC	1/27/25

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E 039	Continued From page 7 *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (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.	E 039	RECEIVED DEC 26 2024 BY: See attached POC	1/17/25

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E 039	Continued From page 8 *[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]: (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:	E 039	RECEIVED DEC 26 2024 BY: See attached POC	1/17/25

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E 039	Continued From page 9 Based on observation, interview and record review, the long-term care facility failed to participate in a full-scale exercise of the Emergency Preparedness Plan in accordance with 42 CFR 483.73 Finding: On 12/11/2024, between the hours of 10:30 AM and 2:00 PM, this surveyor, accompanied with the Administrator observed the following: 1. Provided one actual emergency that they used the EPP with AAR. An additional full-scale exercise or tabletop training has not been conducted at this facility; they could provide no documentation of when the last full exercise or tabletop had taken place. The surveyor confirmed this finding with the Administrator at the time of the observation.	E 039	RECEIVED DEC 2 3 2024 BY: ______ See attached POC	1/17/25
K 000	INITIAL COMMENTS Federal Recertification Survey Date of Survey 12/11/2024 Orchard Park Rehabilitation and Living Center, a long-term care facility, was surveyed pursuant to the National Fire Protection Association 101, Life Safety Code, 2012 Edition, as referenced in Part 483.90(a-d) - Physical Environment is not in substantial compliance.	K 000		
K 211 SS=D	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is	K 211		

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

FORM APPROVED
OMB NO. 0938-0391

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K 211	Continued From page 10 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 maintain the Exit Corridor required width in 2 of 3 egress corridors per NFPA 101, Life Safety Code, 2012 Edition, Sections 18.2.1, 19.2.1, 7.1.10.1 Findings: On 12/11/2024, between 10:30 AM and 2:00 PM, a surveyor, with the Maintenance Director present, observed the following: 1. The corridor in the McIntosh wing had wheeled meal carts stored in the hallway in the path of egress and exit corridor. This deficient practice could affect residents, guest and staff from proper egress in the event of an emergency. 2. The corridor in Northern Spy Wing had 2 chairs across from the nurse's station in the hallway in the path of the egress corridor. These chairs were unsecured and narrowed the egress path to 5ft 6in. This deficient practice could affect residents, guests and staff from proper egress in the event of an emergency. The surveyor confirmed these findings with the Maintenance Director at the time of the observation.	K 211	RECEIVED BY: See attached POC	1/17/25
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure	K 321		

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K 321	Continued From page 11 Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the long-term care facility failed to ensure that the door in one combustible storage room greater than 50 square feet self-close per NFPA 101, Life Safety Code, 2012 Edition, Sections 19.3.2.1.3, and 19.3.2.1.5(7) Finding:	K 321	RECEIVED BY: See attached POC	1/17/25

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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ORCHARD PARK REHAB & LIVING	107 ORCHARD ST FARMINGTON, ME 04938

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K 321	Continued From page 12 On 12/11/2024, between 10:30 AM and 2:00 PM, a surveyor, with the Maintenance Director present, observed the following: 1. The storage room next to the maintenance and housekeeping room on the basement level was not equipped with a self-closer on the door. The interior measurements are 10.5 feet by 6 feet equaling 63 square feet. The surveyor confirmed this finding with the Maintenance Director at the time of the observation.	K 321	RECEIVED DEC 26 2024 BY: ______	
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 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 observations and interview, the facility	K 353	See attached POC	1/17/25

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205168	A. BUILDING 01 B. WING	12/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ORCHARD PARK REHAB & LIVING	107 ORCHARD ST FARMINGTON, ME 04938

(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 353	Continued From page 13 failed to ensure that Sprinkler System was inspected, tested, and maintained in 1 of 3 wings in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. This deficiency does not meet the minimum requirements of maintaining a sprinkler system in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-based Fire Protection Systems, 2011 edition, Chapter 5, section 5.2.1.1.1 Findings: On 12/11/2024, between 10:30 AM and 2:00 PM, a surveyor, with Maintenance present, observed the following: 1. (4) sprinkler heads in the facility's sprinkler escutcheon plates are not secured to the ceiling. The sprinkler heads are located, (2) in patient room 112, (1) in patient room 111 and (1) in patient room 110. The surveyor confirmed these findings with Maintenance at the time of the observation.	K 353	RECEIVED DEC 2 6 2024 BY: See attached POC	1/17/25
K 355 SS=D	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 observations and interview, the facility	K 355		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205168	A. BUILDING 01 B. WING	12/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ORCHARD PARK REHAB & LIVING	107 ORCHARD ST FARMINGTON, ME 04938

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K 355	Continued From page 14 failed to ensure portable fire extinguishers are installed and maintained in accordance with NFPA 101, Life Safety Code, 2012 edition, Sections 9.7.4.1, and 19.3.5.12. in the basement level of the building. Also reference NFPA 10, Standard for Portable Fire Extinguishers, 2010 edition, sections 6.1.3.8.1., and 6.1.3.8.3. for installation height requirements for portable fire extinguishers. Findings: Observations during a facility tour with the Facilities Management Director present on 12/11/2024, between 10:30 AM and 2:00 PM identified: 1. Fire extinguishers shall be installed so that the top of the fire extinguisher is not more than 5 ft above the floor. The red portable ABC fire extinguisher in the maintenance/housekeeping room is mounted so the top of the handle is 5' 11" (71 inches) above the floor. 2. In no case shall the clearance between the bottom of the fire extinguisher and the floor be less than 4 in. The portable fire extinguisher is sitting on the concrete floor in the Elevator Machine room instead of being securely mounted in a conspicuous location at the proper height. 3. In no case shall the clearance between the bottom of the fire extinguisher and the floor be less than 4 in. The portable fire extinguisher is sitting on the concrete floor in the Boiler room instead of being securely mounted in a conspicuous location at the proper height. The surveyor confirmed these findings with the	K 355	RECEIVED BY: See attached POC	1/7/25

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	205168	A. BUILDING 01 B. WING ______	12/11/2024

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K 355	Continued From page 15 Maintenance Director at the time of the observation.	K 355	RECEIVED BY:	
K 363 SS=F	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483,	K 363	See attached POC	1/17/25

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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	205168	A. BUILDING 01 B. WING ______	12/11/2024

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K 363	Continued From page 16 and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the long-term care facility failed to ensure that the corridor doors resist the passage of smoke in all three residential care wings and the administrative wing per NFPA 101, Life Safety Code, 2012 Edition, Sections 19.3.6.3.1. Findings: On 12/11/2024, between 10:30 AM and 2:00 PM, a surveyor, with the Maintenance Director present, observed the following: 1. The corridor door to resident room # 108 in the Cortland wing has a gap more than ½ inch on the top latch side that does not resist the passage of smoke when the door is in a closed and latched position. 2. The corridor door to Resident Room #109 in the McIntosh wing would not close and latch as the privacy curtain was allowed to be in the door frame area. When the door was pulled closed, the door would not close and latch due to the curtain. No curtain hold back device was installed to prevent the obstruction of the closing of the door. 3. The corridor door to Resident room #112 in the McIntosh wing has a gap more than ½ inch that does not resist the passage of smoke when the door is in a closed and latched position. 4. The corridor door to Resident Room 121 in the Northern Spy wing has a gap greater than ? inch along the latch side of the door that doesn't resist	K 363	RECEIVED DEC 26 2024 BY:______ See attached POC	1/17/25

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

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205168	A. BUILDING 01 B. WING	12/11/2024

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K 363	Continued From page 17 the passage of smoke. 5. The corridor door to the copier room is obstructed from self-closing by the bottom of the door rubbing on the carpet. The surveyor confirmed these findings with the Maintenance Director at the time of the observation.	K 363	RECEIVED BY:	
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 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 documentation review, and interview, the long-term care facility failed to use a coded announcement during the third shift fire drills occurring between the hours of 21:00 and 06:00 per NFPA 101, Life Safety Code, 2012 edition, section 19.7.1.7. Findings: On 12/11/2024, between 10:30 AM and 2:00 PM, a surveyor, with the Maintenance present,	K 712	See attached POC	1/17/25

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

FORM APPROVED
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K 712	Continued From page 18 observed the following: 1. The fire drill for the 1st quarter of 2024 on third shift occurred at 23:20 on 03/28/2024. According to the documentation, the drill is silent, and no overhead page is announced. The interview with the maintenance director confirmed that a one-on-one voice "Code Red" is vocalized, and then that message is passed from person to person with no type of intercom being used. 2. The fire drill for the 3rd quarter of 2024 on third shift occurred at 23:00 on 07/31/2024. According to the documentation, the drill is silent, and no overhead page is announced. The interview with the maintenance director confirmed that a one-on-one voice "Code Red" is vocalized, and then that message is passed from person to person with no type of intercom being used. 3. The fire drill for the 4th quarter of 2024 on third shift occurred at 22:25 on 10/31/2024. According to the documentation, the drill is silent, and no overhead page is announced. The interview with the maintenance director confirmed that a one-on-one voice "Code Red" is vocalized, and then that message is passed from person to person with no type of intercom being used The surveyor confirmed these findings with the Maintenance Director at the time of the documentation review.	K 712	RECEIVED BY: See attached POC	1/7/25

Plan of Correction
Life Safety Survey of 12/11/2024
Orchard Park Rehabilitation & Living Center
(REVISED 12/26/2024)

RECEIVED

BY:

E039: Lack of evidence of an additional full-scale exercise or tabletop training.

- The Administrator was educated on the participation in, and documentation of the requirements of Emergency Preparedness full scale and/or tabletop disaster exercise(s). The Facility Operations Manager provided education and a template of an "After Action Report" which can be used for documenting full-scale and/or table top exercises on 12/19/24, via telephone and then via email.
- The facility will conduct an annual exercise which tests the emergency plan, and participate in a full-scale exercise (every two years), if available. The facility will document response(s) to a recent disaster preparation issue to achieve compliance by the use of an After Action Report tool.
- Yearly audits will be conducted by Maintenance Director, or designee to ensure the proper Emergency Preparedness drill(s) are occurring as required. Results of the audits will be discussed at the facility's next Quality Assurance Meeting.
- **Completion Date: January 17, 2025**

K211: Means of Egress

- The meal carts on the McIntosh wing and the chairs in the corridor of Northern Spy wing have been relocated as to allow for sufficient corridor with and removing the barrier to the egress.
- Staff have been educated regarding maintaining the exit corridor required width (specifically, no wheeled meal carts in the path of egress and exit corridor(s)).
- Audits of maintaining the exit corridor required width (no wheeled meal carts in the path of egress and exit corridor(s)) will be conducted by the Maintenance Director, or designee, weekly for four weeks. Results of the audits will be discussed at the facility's next Quality Assurance Meeting.

Completion Date: January 17, 2025

Revised by:
[signature] Pamela W. BARNHART
Facility Operations Mgr.
12/26/2024

K321: Hazardous Areas – Enclosure

- A self-closing device was installed on the door of the storage room located next to the maintenance/housekeeping area.
- Other facility doors have been audited to ensure door(s) have appropriate self-closing devices, if applicable.
- Facility doors will be audited weekly for four weeks by the Maintenance director, or designee, to ensure doors if required to have a self-closing devices are equipped with one, as needed. Results of the audits will be discussed at the facility's next Quality Assurance Meetings.

  Completion Date: January 17, 2025

K353: Sprinkler System: Maintenance and Testing

- The sprinkler head escutcheons: (2) in resident room 112, (1) in resident room 111, and (1) in resident room 110, have been appropriately secured to the ceiling.
- Audits will be conducted weekly by the Maintenance Director, or designee, for four weeks to ensure sprinkler head escutcheon plates are appropriately secured to the ceiling, as required. Results of the audits will be discussed at the facility's next Quality Assurance Meeting.

  Completion Date: January 17, 2025

K355: Portable Fire Extinguishers

- The identified fire extinguisher mounted at 5'11" has been lowered so it is now in compliance. The two portable fire extinguishers identified, located on the concrete floors have been mounted, as required.
- Weekly audits for four weeks will be conducted by the Maintenance Director, or designee, to ensure continued compliance regarding proper installation of fire extinguishers. Results of the audits will be discussed at the facility's next Quality Assurance Meeting.

  Completion Date: January 17, 2025

Revised by:
J.A. Pamelan, BA & MA
Facility Operations Mgr.
12/26/2024

K363: Corridor – Doors

- Trim which is designed to control the penetration of smoke has been applied to the door(s) of resident room(s) #108 (Cortland), #112 (McIntosh) and #121 (Northern Spy). A device was installed which will keep the curtain from the door frame area, thus no longer being an obstruction to proper door closing in resident room #109 (McIntosh). The bottom of copier room door was adjusted so it does not rub on the carpet obstructing it from self-closing.
- The Maintenance Director, or designee, will complete weekly audits for four weeks to ensure doors are not obstructed by curtains and self-close as indicated. Results of the audits will be discussed at the facility's next Quality Assurance Meeting.

  <u>Completion Date</u>: January 17, 2025

K712: Fire Drills

- The Facility's Maintenance Director and Temporary Administrator were educated by the Facility Operations Manager (via phone and email on 12/23/2024) regarding the use of a coded announcement during third shift fire drills (between 2100 and 0600). The Fire Drill Procedure has been revised to include the "Page All" feature through the facility's phone system.
- Audits of the next four fire drills will be conducted by the facility Administrator, or designee with the results of the audits reported at the facility's next Quality Assurance Meeting.
- **<u>Completion Date</u>: January 17, 2025**

Reviewed by:
Ja Panelay, BA RN MHA
Facility Operations Mgr.
12/26/2024