RECEIVED
NOV 21 2023
BY:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205099	A. BUILDING 01 _____ B. WING _____	11/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RUMFORD COMMUNITY HOME	11 JOHN F KENNEDY LANE RUMFORD, ME 04276

(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 Recrtification Survey Survey Date: 11/6/23 Rumford Community Home, a long term care facility, is in substantial compliance with 42 Code of Federal Regulations Part 483.73 Requirement for Long Term Care Facilities Emergency Preparedness.	E 000		
K 000	INITIAL COMMENTS Federal Recrtification Survey Survey Date: 11/6/23 Rumford Community Home, a Long Term Care Facility, was surveyed to the National Fire Protection Association 101 Life Safety Code 2012 Edition as reference on 42 CFR 483.90 (a-d) physical environment and is not in substantial compliance.	K 000		
K 211 SS=E	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 observations, the long-term care facility failed to maintain all exterior exit discharge paths to the public way clear of obstructions and an adequate walking surface per NFPA 101, Life Safety Code, 2012 Edition, Sections 7.1.6, and	K 211		

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

TITLE: Administrator

(X6) DATE: 11/21/23

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205099	A. BUILDING 01 B. WING	11/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RUMFORD COMMUNITY HOME	11 JOHN F KENNEDY LANE RUMFORD, ME 04276

(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 211	Continued From page 1 7.1.10.1 Findings: On November 6, 2023, between 10:00 AM and 2:00 PM, surveyors, with the Director of Ancillary Services, Assistant Director of Ancillary Services and the Administrator present, observed the following: 1. The West Wing deck exterior exit discharge paths to the public way has pavement that is excessively cracking, uneven and has ridges greater than 1/4 inch in height. 2. Laundry Room exterior exit discharge path does not discharge to public way. 3. The North Wing exterior exit discharge path to the public way has pavement that is excessively cracking, uneven and has ridges greater than 1/4 inch in height. The surveyor confirmed these findings with the Director of Ancillary Services, Assistant Director of Ancillary Services and the Administrator at the time of the observation.	K 211		
K 232 SS=D	Aisle, Corridor, or Ramp Width CFR(s): NFPA 101 Aisle, Corridor or Ramp Width 2012 EXISTING The width of aisles or corridors (clear or unobstructed) serving as exit access shall be at least 4 feet and maintained to provide the convenient removal of nonambulatory patients on stretchers, except as modified by 19.2.3.4, exceptions 1-5.	K 232		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205099	A. BUILDING 01 B. WING	11/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RUMFORD COMMUNITY HOME	11 JOHN F KENNEDY LANE RUMFORD, ME 04276

(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 232	Continued From page 2 19.2.3.4, 19.2.3.5 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the long-term care facility failed to maintain the required unobstructed width of corridors serving as an exit per NFPA 101, Life Safety Code, 2012 Edition, Section 19.2.3.4(2), and 19.2.3.4(5)(a). Finding: On November 6, 2023, between 10:00 AM and 2:00 PM, surveyors, with the Director of Ancillary Services, Assistant Director of Ancillary Services and the Administrator present, observed the following: 1. Two electric fans projected 12 inches into the corridor at a height of 5' 9" in the West Wing exit corridor. Projections shall not be more than 6 inches from the corridor wall and a minimum of 6'-8" in height from the floor. The surveyor confirmed this finding with the Director of Ancillary Services, Assistant Director of Ancillary Services and the Administrator at the time of the observation.	K 232		
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist	K 363		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205099	A. BUILDING 01 B. WING	11/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RUMFORD COMMUNITY HOME	11 JOHN F KENNEDY LANE RUMFORD, ME 04276

(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 363	Continued From page 3 the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the long-term care facility failed to maintain smoke tight corridor doors per NFPA 101, Life Safety Code, 2012 Edition, Sections 19.3.6.3.1 & 19.3.6.3.13 (1) & 19.3.6.3.5 Findings:	K 363		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205099	A. BUILDING 01 B. WING	11/06/2023

RECEIVED
NOV 21 2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RUMFORD COMMUNITY HOME	11 JOHN F KENNEDY LANE RUMFORD, ME 04276

(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 363	Continued From page 4 On November 6, 2023, between 10:00 AM and 2:00 PM, surveyors, with the Director of Ancillary Services, Assistant Director of Ancillary Services and the Administrator present, observed the following: 1. Administration wing office Dutch door upper leaf is not equipped with latching device. 2. Resident Room East 4 A did not latch when fully closed. 3. Resident Room West 12 did not latch when pulled closed. The door is warped and the gaps at the top of the door on the latch side make the door not close correctly. The gaps do not resist the passage of smoke and are greater than 1/2 inch. 4. Resident room West 8 door has an excessive gap at the top of the door on the latch side that is greater than 3/8" and does not resist the passage of smoke when the door is closed. The surveyor confirmed these findings with the Director of Ancillary Services, Assistant Director of Ancillary Services and the Administrator at the time of the observation.	K 363		
K 371 SS=D	Subdivision of Building Spaces - Smoke Compar CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Compartments 2012 EXISTING Smoke barriers shall be provided to form at least two smoke compartments on every sleeping floor with a 30 or more patient bed capacity. Size of compartments cannot exceed 22,500 square feet	K 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205099	A. BUILDING 01 B. WING	11/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RUMFORD COMMUNITY HOME	11 JOHN F KENNEDY LANE RUMFORD, ME 04276

(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 371	Continued From page 5 or a 200-foot travel distance from any point in the compartment to a door in the smoke barrier. 19.3.7.1, 19.3.7.2 Detail in REMARKS zone dimensions including length of zones and dead-end corridors. This REQUIREMENT is not met as evidenced by: Based on observation and interview the long-term care facility failed to ensure that smoke barrier walls were free from penetrations in accordance with NFPA 101, Life Safety Code, 2021 edition, section 19.3.7.1. Findings: On November 6, 2023, between 10:00 AM and 2:00 PM, surveyors, with the Director of Ancillary Services, Assistant Director of Ancillary Services, and the Administrator present, observed the following: 1. The 1-hour smoke barrier between the lobby and the East Unit has holes in the drywall and gaps around the penetrating sprinkler pipe viewed from the lobby side, and the residential side above the double doors in the corridor. 2. The 1-hour smoke barrier between the lobby and the West Unit has a 1-inch round hole through the drywall seen from the lobby side above the double doors in the corridor. The surveyor confirmed this finding with the Director of Ancillary Services, Assistant Director of Ancillary Services, and the Administrator at the time of the observation.	K 371		
K 712 SS=F	Fire Drills CFR(s): NFPA 101	K 712		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205099	A. BUILDING 01 B. WING	11/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, ~~STATE, ZIP CODE~~
RUMFORD COMMUNITY HOME	11 JOHN F KENNEDY LANE RUMFORD, ME 04276

(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 712	Continued From page 6 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 hold fire drills quarterly on each shift at expected and unexpected times under varying conditions per NFPA 101, Life Safety Code, 2012 edition, section 19.7.1.6. Finding: On November 6, 2023, between 10:00 AM and 2:00 PM, surveyors, with the Director of Ancillary Services, Assistant Director of Ancillary Services, and the Administrator present, observed the following: 1. No fire drills were conducted in January, February, March, April, or May in 2023. The first 5 months of 2023 were without a fire drill. The surveyor confirmed this finding with the Director of Ancillary Services, Assistant Director of Ancillary Services, and the Administrator at the time of the observation.	K 712		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205099	A. BUILDING 01 RECEIVED NOV 21 2023 B. WING	11/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RUMFORD COMMUNITY HOME	11 JOHN F KENNEDY LANE RUMFORD, ME 04276

(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 914	Continued From page 7	K 914		
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 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 and interview, the long-term care facility failed to maintain testing and maintenance of the electrical system in patient rooms NFPA 99, Healthcare Facilities Code, 2012 Edition, Sections 6.3.3, 6.3.3.1.5, 6.3.3.2, 6.3.4.1, 6.3.4.2 Finding: On November 6, 2023, between 10:00 AM and 2:00 PM, surveyors, with the Director of Ancillary Services, Assistant Director of Ancillary Services	K 914		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205099	A. BUILDING 01 _____ B. WING _____	11/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RUMFORD COMMUNITY HOME	11 JOHN F KENNEDY LANE RUMFORD, ME 04276

(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 914	Continued From page 8 and the Administrator present, observed the following: 1. Patient bedroom duplex outlets are not hospital grade and have not been properly tested at annual intervals. During interview with acting Maintenance Director, no records have been maintained for the testing of the patient room duplex receptacles. The surveyor confirmed this finding with the Director of Ancillary Services, Assistant Director of Ancillary Services and the Administrator at the time of the observation.	K 914		
K 919 SS=D	Electrical Equipment - Other CFR(s): NFPA 101 Electrical Equipment - Other List in the REMARKS section any NFPA 99 Chapter 10, Electrical Equipment, requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 10 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the long-term care facility failed to test and maintain multiple outlet connections in patient rooms NFPA 99, Healthcare Facilities Code, 2012 Edition, Sections 10.2.3.6 Finding: On November 6, 2023, between 10:00 AM and 2:00 PM, surveyors, with the Director of Ancillary Services, Assistant Director of Ancillary Services	K 919		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205099	A. BUILDING 01 B. WING	11/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RUMFORD COMMUNITY HOME	11 JOHN F KENNEDY LANE RUMFORD, ME 04276

(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 919	Continued From page 9 and the Administrator present, observed the following: 1. West Wing patient bedroom number 8, multiple outlet connection devices installed that are not hospital grade and have no record of testing connection. The surveyor confirmed this finding with the Director of Ancillary Services, Assistant Director of Ancillary Services and the Administrator at the time of the observation.	K 919		

Rumford Community Home
The Central Maine Medical Family

RECEIVED
NOV 21 2023
BY:_____

WORK AGREEMENT

November 21, 2023

White's Yard Work agrees to provide a quote and have the work below completed for Rumford Community Home by 4/30/2023.

1. CORRECT: The West Wing deck exterior exit discharge paths to the public way has pavement that is excessively cracking, uneven and has ridges greater than ¼ inch in height.
    a. Discharge path needs new pavement to ensure adequate walking surface

2. CORRECT: The North Wing exterior exit discharge path to the public way has pavement that is excessively cracking, uneven and has ridges greater than ¼ inch in height.
    a. Discharge path needs new pavement to ensure adequate walking surface

3. INSTALL: Laundry Room exterior exit discharge path does not discharge to public way.
    a. Discharge path needs to be constructed and paved to ensure adequate walking surface

White's Yard Work agrees to complete work outlined above and included in quote by 4/30/2024. If work cannot be completed by this time, White's Yard Work understands that Rumford Community Home will need as much advanced notice as possible as they are required to notify the Fire Marshall's Office of any delay past 4/30/2024.

Roger White
White's Yard Work- Representative

11-21-23
Date

Rumford Community Home- Administrator

11/21/23
Date

K 211 Means of Egress- REVISED 11/20/23, REVISED 11/21/2023

All residents have potential to be affected.

Attached work order signed by White's Yard Work to complete corrections to West Wing and North Wing discharge paths and install discharge path from Laundry to public way.

CORRECT: The West Wing deck exterior exit discharge paths to the public way has pavement that is excessively cracking, uneven and has ridges greater than ¼ inch in height. Discharge path needs new pavement to ensure adequate walking surface.

CORRECT: The North Wing exterior exit discharge path to the public way has pavement that is excessively cracking, uneven and has ridges greater than ¼ inch in height. Discharge path needs new pavement to ensure adequate walking surface.

INSTALL: Laundry Room exterior exit discharge path does not discharge to public way. Discharge path needs to be constructed and paved to ensure adequate walking surface

Other exit discharge pathways were reviewed during the survey and found to be in compliance.

The Director of Ancillary Services will include verifying exit discharge pathways are in good repair and discharge to a public way as part of the monthly environmental rounds.

The Administrator will audit discharge pathways to ensure compliance monthly X 6 or until compliant.

Audit results will be reviewed through the facility Quality Assurance/Performance Improvement process until substantial compliance is achieved and maintained for a period of six months.

Compliance Date: November 30, 2023

K 232 Aisle, Corridor, or Ramp Width

Both electric fans in the West Wing exit corridor have been removed. Remaining corridors have been audited and found to be in compliance.

The Director of Ancillary Services or designee will review corridors monthly as part of environmental rounds verifying that projections do not exceed 6 inches from the wall and are at least 6'-8" from the floor.

Administrator, or designee, will randomly audit corridors for projections from the wall during quarterly environmental rounds to ensure continued compliance.

Audit results will be reviewed through the facility Quality Assurance/Performance Improvement process until substantial compliance is achieved and maintained for a period of six months.

Compliance Date: November 6, 2023

K 363 Corridor- Doors- REVISED

All residents have the potential to be affected.

Latching device was ordered and installed by Maintenance Dept. on Administration wing office dutch door on November 13th, 2023.

Mechanical adjustments made by Maintenance Dept on November 9th, 2023, for resident rooms East 4 & West 12 doors so each door fully latches when closed.

Pemko Adhesive Gasketing was applied to resident room doors 8 and 12 on November 20, 2023 to correct door gaps and ensure door fully latches.

The Director of Ancillary Services will complete audit of compliance with door gaps for resident rooms on East and West wings. If audit identifies additional doors that are non-compliant, the doors will be brought into compliance or a purchase order will be submitted for materials and supplies needed to correct.

Preventative Maintenance plan to be reviewed and updated related to Door Inspections as needed.

The Administrator will randomly audit door gaps to ensure compliance. Audit results will be reviewed through the facility Quality Assurance/Performance Improvement process until substantial compliance is achieved and maintained for a period of six months.

Completion Date: November 30, 2023

K 371 Smoke Compartment

Penetrations between lobby and East Wing and between lobby and West Wing have been sealed.

Other fire walls were reviewed as part of the survey process and found to be in compliance.

The Director of Ancillary Services will ensure all penetrations are sealed according to NFPA101 standards when repair work is completed by in house team and/or outside contractor.

Audit results will be reviewed through the facility Quality Assurance/Performance Improvement process until substantial compliance is achieved and maintained for a period of six months.

Compliance Date: November 7, 2023

K 712 Fire Drills- REVISED

All residents have the potential to be affected.

June, July, August, September and October Fire Drills have been completed per NFPA101 standards on alternate shifts under varying conditions.

Fire Drill Calendar developed through June 2024 of tentatively scheduled fire drills to ensure they are completed on alternate shifts and under varying conditions. Director of Ancillary Services to ensure monthly fire drill schedule is followed.

Administrator to ensure fire drill has been completed and compliance is achieved by the 25th of each month allowing for additional days within the month to complete fire drill, if needed. Administrator will review Post Fire Drill Evaluation forms monthly X 6 to ensure continued compliance.

Audit results will be reviewed through the facility Quality Assurance/Performance Improvement process to ensure substantial compliance is maintained for a period of six months.

Compliance Date: November 6, 2023

K 914 Electrical Systems- Maintenance and Testing

All residents have the potential to be affected.

Resident rooms duplex outlet extenders have been removed.

Attached work order signed by Electrical Systems of Maine for installation of new quad outlet extenders throughout resident rooms to take place of prior duplex outlet extenders.

The Director of Ancillary Services or designee will complete audit of duplex extenders in resident rooms on East and West wings. Any outlet extenders found will be removed.

Education provided to Maintenance Department related to "Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months."

Circuit test to be completed by Electrical Systems of Maine upon installation.

Preventative Maintenance plan to be reviewed and updated related to electrical outlets to include testing outlets at intervals not exceeding 12 months. Documentation of testing shall include date testing occurred, room, results and any associated modifications/repairs.

The administrator, or designee, will randomly audit receptacle testing documentation to ensure compliance. Audit results will be reviewed through the facility Quality Assurance/Performance Improvement process until substantial compliance is achieved and maintained for a period of six months.

Completion Date: November 30, 2023

K 919 Electrical Equipment- Other- REVISED

All residents have the potential to be affected.

Resident room West 8, bedroom duplex outlet extenders have been removed.

Attached work order signed by Electrical Systems of Maine for installation of new quad outlet extenders throughout resident rooms to take place of prior duplex outlet extenders.

The Director of Ancillary Services or designee will complete audit of duplex extenders in resident rooms on East and West wings. Additional outlet extenders found will be removed.

Education provided to Maintenance Department related to "Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months."

Circuit test to be completed by Electrical Systems of Maine upon installation.

Preventative Maintenance plan to be reviewed and updated related to electrical outlets to include testing outlets at intervals not exceeding 12 months. Documentation of testing shall include date testing occurred, room, results and any associated modifications/repairs.

The administrator, or designee, will randomly audit receptacle testing documentation to ensure compliance. Audit results will be reviewed through the facility Quality Assurance/Performance Improvement process until substantial compliance is achieved and maintained for a period of six months.

Completion Date: November 30, 2023