State of Maine
Department of Public Safety
Office of Fire Marshal
45 Commerce Drive, Suite 1
Augusta, ME 04330

JANET T. MILLS
GOVERNOR

MICHAEL SAUSCHUCK
COMMISIONER

RICHARD MCCARTHY
STATE FIRE MARSHAL

November 8, 2023

Rumford Community Home
Attn: Stephanie Burrows, Administrator
11 John F Kennedy Lane
Rumford, ME 04276

Provider ID#: 205099
Facility ID#: 1709
Event ID#: OPO721

Administrator Burrows,

On **November 6, 2023**, the Office of the Fire Marshal conducted a Life Safety Code and Emergency Preparedness survey to determine if your facility complies with Federal participation requirements for nursing facilities in the Medicare and/or Medicaid program (In which you will be receiving a Form CMS-2567 for Life Safety Code and Emergency Preparedness). Your facility was found not to be in substantial compliance with the participation requirements for Life Safety Code only.

The Federal regulatory requirements referenced in this letter are found in Title 42, Code of Federal Regulations (CFR) and in the National Fire Protection Association (NFPA)101 Life Safety Code Standard, 2012 Edition.

PLAN OF CORRECTION

Attached is Form CMS-2567 "Statement of Deficiencies" which enumerates the deficiencies found as a result of the survey. A Plan of Correction (POC) must be submitted by the **tenth (10th) calendar day** from your receipt of this letter. **Please note that a POC is not needed for isolated deficiencies which cause no harm (S/S of A).** Your POC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- **Include dates when corrective action will be completed**. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility;

- Include documentation to support a waiver request (if appropriate).

You are required to record your plan of correction in the appropriate column on the enclosed Form(s) CMS-2567. **Sign, date, and indicate your title in the blocks provided on page one.** Return the forms(s) with the POC to **State of Maine, Department of Public Safety, Office of State Fire Marshal, 45 Commerce Drive, 52 State House Station, Augusta, ME 04330-0052**.

Remedies will be recommended for imposition by the Centers for Medicare & Medicaid Services (CMS) Regional Office if your facility has failed to achieve substantial compliance by **December 24, 2023,** (Opportunity to Correct). Informal dispute resolution for the cited deficiencies will not delay the imposition of the recommended enforcement actions. A change in the seriousness of the noncompliance may result in a change in the remedy selected. When this occurs, you will be advised of any change in remedy.

RECOMMENDED REMEDIES

Based on the deficiencies cited during the Life Safety Code and Emergency Preparedness Survey of **November 6, 2023**, we are recommending to CMS the imposition of the following remedy(ies):

A Civil Monetary Penalty per day to be determined by CMS.

Directed Plan of Correction (DPOC) effective immediately. The State Agency directs the plan of correction noted on the attached CMS-2567 for deficiencies K211(SS=E), K232(SS=D), K355(SS=A), K363(SS=D), K371(SS=D), K712(SS=F), K914(SS=D) & K919(SS=D) (Tags). [42 CFR 488.424]

If you do not achieve substantial compliance by **February 7, 2024,** the CMS Regional Office or State Medicaid Agency must deny payments for new (Medicare/Medicaid) admissions. In addition, we may recommend that **termination of your provider agreement be effective on May 7, 2023,** if substantial compliance is not achieved by that time. [42 CFR 488.456]. **Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination**.

ALLEGATION OF COMPLIANCE

The Plan of Correction will serve as your allegation of compliance until substantiated by a revisit or other means. If upon revisit your facility has not achieved substantial compliance, recommended remedies may be imposed as determined by the CMS Regional Office and continue until substantial compliance is achieved. Additionally, CMS Regional Office may impose revised/additional remedies, if appropriate.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 Code of Federal Regulations §488.331, you have one opportunity to question cited deficiencies through an IDR process. You may also contest scope and severity assessments for deficiencies, which may have resulted in a finding of substandard quality of care (SQC) or immediate jeopardy. To be given such an opportunity, you are required to send your written request, along with the specific deficiencies (or why you are disputing the scope and severity assessments of deficiencies which have been found to constitute SQC or immediate jeopardy) to **Asst. Fire Marshal Gregory J. Day** at the address below. This request must be sent during the same 10 calendar days you have for submitting a POC for the cited deficiencies. An incomplete IDR process will not delay the effective date of any enforcement action. IDR in no way is to be construed as a formal evidentiary hearing. It is an informal administrative process to discuss deficiencies. If counsel will accompany you, you must indicate this in your request for IDR so that we may also have counsel present.

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

If you have any questions, please contact me at (207) 441-0622.

Yours for Better Fire Prevention,

Gregory J. Day
Assistant State Fire Marshal

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	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 | (X6) DATE

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

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K 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		

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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		

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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		

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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		

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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		

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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		

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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		

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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		

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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		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	205099	A. BUILDING: **01** B. WING _____	**11/6/2023**

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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
K 355	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 observation and interview, the long-term care facility failed to ensure that the portable fire extinguishers are inspected manually at least once per calendar month in addition to the annual maintenance per NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition, Section 7.2.1.2., and NFPA 101, Life Safety Code, 2012 edition, Section 18.3.5.12. Finding: On November 6, 2023, between 10:00 AM and 2:00 PM, surveyors, with the Director of Ancillary Services, and the Assistant Director of Ancillary Services, observed the following: 1. The portable ABC fire extinguisher in the basement has no monthly inspections by staff for the months of August and September documented on the attached tag or is a separate log. The surveyor confirmed this finding with the Director of Ancillary Services, and the Assistant Director of Ancillary Services at the time of the observation.

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The above isolated deficiencies pose no actual harm to the residents