## Cummings, Joanne

**From:** Cummings, Joanne
**Sent:** Wednesday, November 29, 2023 2:58 PM
**To:** 'adminmm@firstatlantic.com'
**Cc:** Day, Gregory J; Peaslee, Ronald J
**Subject:** 205006 Montello Manor Statement of Deficiencies
**Attachments:** 205006 Montello Manor Statement of Deficiencies.pdf

Good Afternoon Administrator Luddy,

On November 28, 2023, your facility was found not to be in substantial compliance with the participation requirements for Life Safety Code only.

**Please sign, date, and affix your title on the bottom of the CMS 2567.**

**Please do not send your plan of correction to the office via US Mail or fax**

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

**Joanne Cummings**
**Office Associate II**
**Maine State Fire Marshal's Office**
**45 Commerce Drive, Suite 1**
**Augusta, ME 04330**
**O (207) 626-3882**
**F (207) 287-6251**

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 29, 2023

Montello Manor
Attn: Nancy Luddy, Administrator
540 College St
Lewiston, ME 04240

Provider ID#: 205006
Facility ID#: 0109
Event ID#: QCWE21

Administrator Luddy

On **November 28, 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, 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 **January 15, 2024** (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 28, 2023** the following remedy(ies) are being imposed:

The State Agency directs the plan of correction noted on the attached CMS-2567 for deficiencies K211(SS=D), K363(SS=D), K712(SS=D), K754(SS=D) & K923(SS=D) (Tags). [42 CFR 488.424]

If you do not achieve substantial compliance by **February 29, 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 29, 2024,** if substantial compliance is not achieved by that time. [42 CFR 488.456]. **Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.**

**ALLEGATION OF COMPLIANCE**

The Plan of Correction will serve as your allegation of compliance until substantiated by a revisit or other means. If upon revisit your facility has not achieved substantial compliance, recommended remedies may be imposed as determined by the CMS Regional Office and continue until substantial compliance is acheived. 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 findings of 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. State Fire Marshal Gregory J. Day** (at the address below). This request must be sent during the same 10 calendar days you have for submitting a POC for the cited deficiencies. An incomplete IDR process will not delay the effective date of any enforcement action. IDR in no way is to be construed as a formal evidentiary hearing. It is an informal administrative process to discuss deficiencies. If counsel will accompany you, you must indicate this in your request for IDR so that we may also have counsel present.

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

If you have any questions, please contact me at 207-626-3880.

Yours for Better Fire Prevention,

Gregory J. Day
Assistant State Fire Marshal

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 205006 | A. BUILDING 01<br>B. WING _____ | 11/28/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MONTELLO MANOR | 540 COLLEGE ST<br>LEWISTON, ME 04240 |

| (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 |
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| E 000 | Initial Comments<br><br>Federal Recertification Survey<br>Survey Dates: 11-28-23<br><br>Montello Manor, a long term care facility, is in substantial compliance with 42 Code of Federal Regulations Part 483.73 Requirement for Long Term Care Facilities for Emergency Preparedness. | E 000 | | |
| K 000 | INITIAL COMMENTS<br><br>Federal Recertification Survey:<br>Survey Date: 11-28-23<br><br>Montello Manor, a Long Term Care Facility, was surveyed to the National Fire Protection Association 101 Life Safety Code 2012 Edition as reference on 42 CFR 483.90 (a-d) physical environment and is not in substantial compliance. | K 000 | | |
| K 211 SS=D | Means of Egress - General<br>CFR(s): NFPA 101<br><br>Means of Egress - General<br>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.<br>18.2.1, 19.2.1, 7.1.10.1<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and interview, the long-term care facility failed to maintain the means of egress per NFPA 101, Life Safety Code, 2012 Edition, Sections 7.1.10.1, and 7.1.5.<br><br>Findings: | 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<br><br>On November 28, 2023, between 09:30 AM and 11:30 AM, surveyors, with the Director of Environmental Services present, observed the following:<br><br>1. The North Wing 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.<br><br>2. The North Wing exterior exit pathway has tree limbs and branches project into the pathway greater than 6" providing headroom less than 6'8".<br><br>The surveyor confirmed these findings with the Director of Environmental Services at the time of the observation. | K 211 | | |
| K 363 SS=D | Corridor - Doors<br>CFR(s): NFPA 101<br><br>Corridor - Doors<br>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 | K 363 | | |

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| K 363 | Continued From page 2<br>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.<br><br>19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485<br>Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, the long-term care facility failed to ensure there were no impediments to the closing of a patient room corridor door per NFPA 101, Life Safety Code, 2012 Edition, Section 19.3.6.3.5.<br><br>Finding:<br><br>On November 28, 2023, between 09:30 AM and 11:30 AM, surveyors, with the Director of Environmental Services present, observed the following:<br><br>1. West Wing resident room door 30 does not positive latch when door is closed. | K 363 | | |

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| K 363 | Continued From page 3<br>The surveyor confirmed this finding with the Director of Environmental Services at the time of the observation. | K 363 | | |
| K 712 SS=D | Fire Drills<br>CFR(s): NFPA 101<br><br>Fire Drills<br>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.<br>19.7.1.4 through 19.7.1.7<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and record review, the long term care facility failed to conduct fire drills once per quarter and per shift per NFPA 101, Life Safety Code, 2012 Edition, Section 19.7.1.6.<br><br>Findings:<br><br>On November 28, 2023 between 9:30 am and 11:30 am, a surveyor, with the Director of Enviromental Services present, observed the following:<br><br>1. A 2nd shift fire drill was not conducted in the 1st quarter of 2023.<br><br>2. A 3rd shift fire drill was not conducted in the 2nd quarter of 2023. | K 712 | | |

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| K 712 | Continued From page 4<br><br>The surveyor confirmed these findings with the Director of Enviromental Services at the time of the observation and record review. | K 712 | | |
| K 754 SS=D | Soiled Linen and Trash Containers<br>CFR(s): NFPA 101<br><br>Soiled Linen and Trash Containers<br>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.<br>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.<br>18.7.5.7, 19.7.5.7<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, the long-term care facility failed to maintain mobile soiled linen collection receptacles in room protected as a hazard area per NFPA 101, Life Safety Code, 2012 Edition, Sections 19.7.5.7.<br><br>Finding:<br><br>On November 28, 2023, between 09:30 AM and 11:30 AM, surveyors, with the Director of Environmental Services present, observed the | K 754 | | |

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| K 754 | Continued From page 5<br>following:<br><br>1. West Wing soiled linen closet has rated door, there is no self-closure present at the time of the inspection.<br><br>The surveyor confirmed this finding with the Director of Environmental Services at the time of the observation. | K 754 | | |
| K 923 SS=D | Gas Equipment - Cylinder and Container Storag<br>CFR(s): NFPA 101<br><br>Gas Equipment - Cylinder and Container Storage<br>Greater than or equal to 3,000 cubic feet<br>Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3.<br>>300 but <3,000 cubic feet<br>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.<br>Less than or equal to 300 cubic feet<br>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.<br>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) | K 923 | | |

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| K 923 | Continued From page 6<br>STORED WITHIN NO SMOKING."<br>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.<br>11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, the long-term care facility failed to maintain Gas Equipment - Cylinder and Container Storage per NFPA 99, Healthcare Facilities Code, 2012 Edition, Section 11.6.5.2<br><br>On November 28, 2023, between 09:30 AM and 11:30 AM, surveyors, with the Director of Environmental Services present, observed the following:<br><br>Findings:<br><br>1. All oxygen storage closet throughout the facility, have no signage as required, designating tanks on whether they are full or empty.<br><br>The surveyor confirmed these findings with the Director of Environmental Services at the time of the observation. | K 923 | | |