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MAR 03 2025
PRINTED: 02/25/2025
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205006	A. BUILDING 01 BY: _____ B. WING _____	02/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTELLO MANOR	540 COLLEGE ST 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
E 000	Initial Comments Federal Recertification Survey Survey Date:02.18.2025 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	**Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this POC is not an admission that a deficiency exists or that one was cited correctly.** **This POC is submitted to meet requirements established by state and federal law.**	
K 000	INITIAL COMMENTS Federal Recertification Survey: Date: 02.18.2025 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 CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the long-term care facility failed to maintain the Exit Corridor required width in 2 of 3 egress corridors per NFPA 101, Life Safety Code, 2012 Edition, Sections 19.2.1, 7.1.10.1	K 211	K211 Means of Egress-General The facility failed to maintain the West wing exit corridor free of obstructions in case of emergency in 2 of 3 egress corridors per NFPA 101. While no residents were impacted, all residents have the potential to be affected. Items included were cat cage, cat tree & litter box. Items were relocated to the West wing activity room with approval from the Fire Marshall on day of survey. Environmental rounds of corridors and common areas will be conducted weekly and findings addressed by the Director of Environmental Services or designee. Rounds will be reviewed and evaluated for effectiveness at monthly QAPI for 3 consecutive months. **Correction 2-18-25**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Nancy Luddy — TITLE: Administrator — (X6) DATE: 3-3-25

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 Finding: On 02/18/2025, between 9:30AM and 12:30 PM, a surveyor, with Environmental Services Director present, observed the following: 1. In the corridor outside of the west wing nurses station, there was storage of a cat cage, a cat tree, and a litter box. This deficient practice could effect residents, guest and staff from proper egress in the event of an emergency. The surveyor confirmed this finding with Environmental Services Director at the time of the observation.	K 211		
K 293 SS=D	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observations and interviews with the Environmental Services Director, the facility failed to maintain the illuminated exit signage in accordance with National Fire Protection Association (NFPA) 101, Life Safety Code, 2012 edition sections 7.10.5.2.1, and 19.2.10.	K 293	K293 Exit Signage The facility failed to maintain the illuminated exit signage in accordance with NFPA 101. While no residents were impacted, all residents have the potential to be affected. The defective bulb was replaced on the sign to provide continuous illumination on day of survey. Environmental rounds of corridors and common areas will be conducted weekly and findings addressed by the Director of Environmental Services or designee (ongoing). Rounds will be reviewed and evaluated for effectiveness at monthly QAPI for 3 consecutive months. **Correction 2-18-25**	

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K 293	Continued From page 2 Findings include: Observations and Interviews, of exits signage during a facility tour on 02/18/2025 between 9:30 AM and 12:30 PM with the Environmental Services Director present: 1. The illuminated exit sign outside of the nurse's station, leading to the west wing, was not illuminated. The signs shall provide continuous illumination. These findings were verified by the Environmental Services Director at the time of observation on 02/18/2025 between 9:30 AM and 12:30 PM .	K 293		
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 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	K 363	K363 Corridor- Doors Two doors on the West wing were found to have nonconformance for the passage of smoke. The activities closet in the hallway has 3 holes and the activities office door has a gap of ½ inch that could allow the passage of smoke. While no residents were impacted, all residents have the potential to be affected. Door vendor was contacted to repair 2 doors. Both doors can be repaired to provide barrier for passage of smoke by 3-7-25. Environmental rounds of corridors and common areas will be conducted weekly and findings addressed by the Director of Environmental Services or designee (ongoing). Rounds will be reviewed and evaluated for effectiveness at monthly QAPI for 3 consecutive months. **Correction 3-7-25**	

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K 363	Continued From page 3	K 363		

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, the long-term care facility failed to maintain the corridor doors to resist the passage of smoke to and from the corridor as referenced by NFPA 101, Life Safety Code 2012 edition, Section 19.3.6.3

Finding:

Observation and interview during a facility tour with the Envirmonental Serices Director present on 02/18/2025, between 9:30AM and 12:30 PM identified:

1. The west wing activities room door has 3 holes penetrating straight through the door, at the top of the door where a self-closure was removed, allowing the passgage of smoke.

2. The activities office door has a gap greater

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K 363	Continued From page 4 than 1/2" on the top of the latch side, allowing for the passage of smoke The surveyor confirmed this finding with the Enviromental Services Director at the time of the observation on 02/18/2025, between 9:30 AM and 12:30 PM.	K 363		
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 interview and record review, the long-term care facility failed to test non-hospital grade receptacles at patient bed locations at intervals not exceeding 12 months in all three	K 914	K914 Electrical Systems Facility failed to test non hospital grade receptacles at patient bed locations annually in accordance with NFPA 99. While no residents were impacted, all residents have the potential to be affected. Director of Environmental Services and designee conducted the receptacle test throughout all units and documented as required. Environmental rounds of resident rooms will be conducted weekly to identify faulty receptacles and findings addressed by the Director of Environmental Services or designee (ongoing). Rounds will be reviewed and evaluated for effectiveness at monthly QAPI for 3 consecutive months. **Correction 2-28-25**	

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K 914	Continued From page 5 resident care wings in accordance with NFPA 99, Health Care Facilities Code, 2012 edition, Section 6.3.4.1.3. Finding: On 02.18.2025, between the hours of 09:30 AM and 12:30 PM this surveyor, accompanied by the Enviromental Services Director, observed the following: 1. The most recent receptacle test was conducted from April to May of 2023. No documentation could be provided to show that the deficiencies noted on those reports were corrected. No additional documentation of any testing could be produced. The Enviromental Services Director advised that a sister facility just received this tag and they were planning on performing the test soon. The surveyor confirmed this finding with the Enviromental Services Director at the time of the observation.	K 914		
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for	K 920		

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K 920	Continued From page 6 PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the long-term care facility failed to ensure that power strips are not used for non-PCREE (Patient-care-related electrical equipment) and that power strips are not used as a substitute for fixed wiring in accordance with NFPA 99 Chapter 10, NFPA 70 chapter 4 {400.8(1)} On 02.18.2025, between 9:30 AM and 12:30 PM, surveyor, with the Enviromental Services Director present observed the following: 1. In the Nurse's station outside the West Wing, a mini fridge and air conditioning unit was found plugged into the same power strip as a permanent power source. The surveyor confirmed this finding with the Enviromental Services Director at the time of the observation.	K 920	K920 Electrical Equipment- Power Cords & Extension Cords Facility failed to ensure that power strip was not used for non-PCREE or as a substitute for fixed wiring in the Southwest Nurse's station. While no residents were impacted, all residents have the potential to be affected. Director of Environmental Services removed power strip and replaced with permanent fixed wiring. Environmental rounds will be conducted weekly to identify any non-compliant power strips in office areas or resident rooms. Findings will be addressed by the Director of Environmental Services or designee(ongoing). Rounds will be reviewed and evaluated for effectiveness at monthly QAPI for 3 consecutive months. **Correction 2-28-25**	