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PRINTED: 04/10/2025
FORM APPROVED
OMB NO. 0938-0391

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

APR 16 2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205070	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 BY: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/07/2025
NAME OF PROVIDER OR SUPPLIER PINE POINT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 67 PINE POINT RD SCARBOROUGH, ME 04074		
(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: 04.07.2025 Pine Point Center, 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			
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	E039 Administrator re-educated Maintenance Director on 4/14/25 on the need to conduct emergency exercises two times per year. Administrator/Designee will conduct a second annual exercise as required by regulation. E039 will be reviewed monthly at QAPI for 3 months and then quarterly for review and consideration. Corrections to be done by May 22, 2025		

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

TITLE

(X6) DATE

Todd J. Beaulieu

Z.D.

4/16/2025

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			

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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			

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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			

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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	

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IDENTIFICATION NUMBER:

205070

(X2) MULTIPLE CONSTRUCTION
A. BUILDING 01 BY: _____

B. WING _____

(X3) DATE SURVEY
COMPLETED

04/07/2025

NAME OF PROVIDER OR SUPPLIER

PINE POINT CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

67 PINE POINT RD

SCARBOROUGH, ME 04074

(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 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

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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			

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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			

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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. *[RNHCIs 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			

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STREET ADDRESS, CITY, STATE, ZIP CODE

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SCARBOROUGH, ME 04074

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E 039

Continued From page 9

Based on observation, interview and record review, the long term care facility failed to conduct exercises to test the emergency plan annually. The facility must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures in accordance with 42 CFR 483.73.

Finding:

On 04.07.2025, between 9:30 AM and 13:00 PM, a surveyor, with the Senior Maintenance Director, Maintenance Director and Executive Director present, observed the following:

1. The facility was only able to provide documentation of one severe weather event on 2.16.2025, and unable to provide any other documentation of drills or table top exercises to test the emergency plan at least twice per year including unannounced staff drills using emergency procedures doing any of 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 challenge an emergency plan.

The surveyor confirmed this finding with the Senior Maintenance Director, Maintenance Director and Executive Director at the time of the observation.

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K 000	INITIAL COMMENTS Federal Recertification Survey: Date: 04.07.2025 Pine Point Center, 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 6 egress corridors per NFPA 101, Life Safety Code, 2012 Edition, Sections 18.2.1, 19.2.1, 7.1.10.1 and section 7.7.1.1 Findings: On 04.07.2025, between 9:30 AM and 13:00 PM, a surveyor, with the Senior Maintenance Director, Maintenance Director and Executive Director present, observed the following: 1. In the Service Wing of the facility a wheeled 96 gallon bin full of shredded papers was stored in	K 211	K211 The 96 gallon storage bin, 32 gallon soiled linen carts and 5 gallon trash containers have been removed from hallways. Staff will be educated on the need to keep means of egress free from obstructions. Administrator or designee will complete random weekly audits for 3 weeks and then monthly for 3 months to ensure compliance. The results of these audits will be brought to QAPI monthly for further review and consideration. Corrections to be done by May 22, 2025.		

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K 211	Continued From page 11 the hallway creating an obstacle to egress. This is not in accordance with NFPA 101. 2. Sunrise Point Wing has soiled linen 32 gallon cart and 5 gallon trash container stored in exit corridor. The storage units were removed prior to leaving the facility. The surveyor confirmed these findings with the Senior Maintenance Director, Maintenance Director and Executive Director at the time of the observation.	K 211			
K 271 SS=D	Discharge from Exits CFR(s): NFPA 101 Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to ensure that 1 of 6 smoke compartments exit discharge is arranged in accordance with NFPA 101 Life Safety Code 2012 edition chapter 19 section 19.2.7 Chapter 7 section 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface in accordance with survey and and certification letter 05-38. Finding:	K 271	K271 The service wing exterior pathway will be extended to the parking lot with a hard packed, all-weather and level travel surface. All exits will be audited to ensure compliance with regulation and reviewed at QAPI for further review and consideration. Corrections to be done by May 22, 2025.		

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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: 205070	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 04/07/2025
NAME OF PROVIDER OR SUPPLIER PINE POINT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 67 PINE POINT RD SCARBOROUGH, ME 04074		
(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 271	Continued From page 12 On 04.07.2025, between 9:30 AM and 13:00 PM, a surveyor, with the Senior Maintenance Director, Maintenance Director and Executive Director present, observed the following: 1. Service Wing exterior exit discharge pathway extended approximately 10 feet and terminated on to a lawn, causing navigation on an uneven grass surface and not on a hard packed, all-weather, level travel surface. The surveyor confirmed these findings with the Senior Maintenance Director, Maintenance Director and Executive Director at the time of the observation.	K 271			
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure 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	K 321	K321 The Sunrise Point Tub Room is cleared of storage items. Staff will be educated not to use tub rooms for storage. Center plans to order and install smoke door for Sunrise Tub Room in accordance with NFPA 101 2012 edition. Administrator or designee will complete random weekly audits for 3 weeks and then monthly for 3 months to ensure compliance, or until the new door is installed. The results of these audits will be brought to QAPI monthly for further review and consideration. Corrections to be done by May 22, 2025.		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205070	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 04/07/2025
NAME OF PROVIDER OR SUPPLIER PINE POINT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 67 PINE POINT RD SCARBOROUGH, ME 04074		
(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 321	Continued From page 13 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, in 1 of 6 smoke compartments, the facility failed to ensure that hazardous areas are protected per the requirements of NFPA 101 2012 edition 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 19.3.2.1.5. 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. Finding: On 04.07.2025, between 9:30 AM and 13:00 PM, a surveyor, with the Senior Maintenance Director, Maintenance Director and Executive Director present, observed the following: 1. Sunrise Point Tub Room was converted into a storage area in excess of 50 square feet of combustible materials The surveyor confirmed this finding with the Senior Maintenance Director, Maintenance Director and Executive Director at the time of the	K 321			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205070	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 BY: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/07/2025
NAME OF PROVIDER OR SUPPLIER PINE POINT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 67 PINE POINT RD SCARBOROUGH, ME 04074		
(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 321	Continued From page 14 observation.	K 321			
K 753 SS=D	Combustible Decorations CFR(s): NFPA 101 Combustible Decorations Combustible decorations shall be prohibited unless one of the following is met: o Flame retardant or treated with approved fire-retardant coating that is listed and labeled for product. o Decorations meet NFPA 701. o Decorations exhibit heat release less than 100 kilowatts in accordance with NFPA 289. o Decorations, such as photographs, paintings and other art are attached to the walls, ceilings and non-fire-rated doors in accordance with 18.7.5.6(4) or 19.7.5.6(4). o The decorations in existing occupancies are in such limited quantities that a hazard of fire development or spread is not present. 19.7.5.6 This REQUIREMENT is not met as evidenced by: Based on observation, the long-term care facility in 1 of 6 smoke compartment failed to ensure that combustible decorations shall be prohibited unless one of the following is met: Flame retardant or treated with approved fire-retardant coating that is listed and labeled for product. Decorations meet NFPA 701 (2010). Decorations exhibit heat release less than 100 kilowatts in accordance with NFPA 289 (2009). Decorations, such as photographs, paintings and other art are attached to the walls, ceilings and non-fire-rated doors in accordance with 18.7.5.6(4) or 19.7.5.6(4). The decorations in existing occupancies are in such limited quantities that a hazard of fire development or spread is not	K 753	K753 The dart board was removed immediately upon survey exit. Maintenance Director and Maintenance Assistant have been re-educated on the need to treat combustible decorations with a flame retardant coating. The dart board has since been treated. Administrator or designee will complete random weekly audits for 3 weeks and then monthly for 3 months to ensure compliance. The results of these audits will be brought to QAPI monthly for further review and consideration. Corrections to be done by May 22, 2025.		

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FORM APPROVED
OMB NO. 0938-L

(X3) DATE SURVEY COMPLETED

04/07/2025

STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA
IDENTIFICATION NUMBER:

205070

(X2) MULTIPLE CONSTRUCTION

A. BUILDING 01

B. WING

NAME OF PROVIDER OR SUPPLIER

PINE POINT CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

67 PINE POINT RD

SCARBOROUGH, ME 04074

(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 753

Continued From page 15
present. 19.7.5.6.

Finding:

On 04.07.2025, between 9:30 AM and 13:00 PM,
a surveyor, with the Senior Maintenance,
Maintenance Director and Executive Director
present, observed the following:

1. Higgins Beach Wing physical therapy area
had a large cloth dart board displayed in an
alcove open to the egress corridor and no
evidence could be provided to show that it had
been sprayed with a fire-retardant coating, or that
it met the requirements of NFPA 701 (2010) or
NFPA 289 (2009).

The surveyor confirmed this finding with the
Senior Maintenance, Director, Maintenance
Director and Executive Director at the time of the
observation.

K 753