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PRINTED: 02/27/2025

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: 205137	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 BY: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/25/2025
NAME OF PROVIDER OR SUPPLIER LEDGEWOOD MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 200 ROUTE 115 WINDHAM, ME 04062		
(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: 02.25.2025 Ledgewood Manor, 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 025 SS=F	Arrangement with Other Facilities CFR(s): 483.73(b)(7) §403.748(b)(7), §418.113(b)(5), §441.184(b)(7), §460.84(b)(8), §482.15(b)(7), §483.73(b)(7), §483.475(b)(7), §485.625(b)(7), §485.920(b)(6), §494.62(b)(6). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] *[For Hospices at §418.113(b), PRFTs at §441.184,(b) Hospitals at §482.15(b), and LTC Facilities at §483.73(b):] Policies and procedures. (7) [or (5)] The development of arrangements with other [facilities] [and] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients.	E 025			

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

TITLE

(X6) DATE

[Signature] GEN. MGR. / M42658 3/17/25

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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E 025	Continued From page 1 *[For PACE at §460.84(b), ICF/IIDs at §483.475(b), CAHs at §486.625(b), CMHCs at §485.920(b) and ESRD Facilities at §494.62(b):] Policies and procedures. (7) [or (6), (8)] The development of arrangements with other [facilities] [or] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. *[For RNHCIs at §403.748(b):] Policies and procedures. (7) The development of arrangements with other RNHCIs and other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of non-medical services to RNHCI patients. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the long term care facility failed to develop an arrangements with other LTC facilities and other providers to receive residents in the event of limitations or cessation of operations to maintain the continuity of services to LTC residents for Emergency Preparedness Plan in accordance with 42 CFR 483.73 Finding: On 02.25.2025, between 9:00 AM and 12:00 PM, a surveyor, with the General Manager present, observed the following: 1. There was no evidence in the emergency preparedness plan of arrangements and/or any agreements the facility has with other facilities to receive patients in the event the facility is not able to care for them during an emergency place.	E 025			

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E 025	Continued From page 2	E 025			
E 037 SS=F	The surveyor confirmed this finding with the General Manager at the time of the observation. EP Training Program CFR(s): 483.73(d)(1) §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.542(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, REHs at §485.542, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The	E 037			

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E 037	Continued From page 3 hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF	E 037			

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E 037	Continued From page 4 must conduct training on the updated policies and procedures. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. (v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The	E 037			

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E 037	Continued From page 5 CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency	E 037			

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E 037	Continued From page 6 procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the long term care facility failed to provide Emergency Preparedness training annually in accordance with 42 CFR 483.73 Finding: Based on interview and documentation review on 02.25.2025, between the hours of 9:00 AM and 12:00 PM, this surveyor accompanied with the General Manager observed the following: 1. No documentation of initial training in emergency preparedness policies and procedures to all individuals providing services under arrangement consistent with their expected roles. The surveyor confirmed this finding with the General Manager at the time of the observation.	E 037			

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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 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	E 039			

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E 039	Continued From page 8 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. (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	E 039			

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E 039	Continued From page 9 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 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.	E 039			

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E 039	Continued From page 10 *[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 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):]	E 039			

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E 039	Continued From page 11 (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, 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	E 039			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205137	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 BY: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/25/2025
NAME OF PROVIDER OR SUPPLIER LEDGEWOOD MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 200 ROUTE 115 WINDHAM, ME 04062		
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E 039	Continued From page 12 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 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	E 039			

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E 039	Continued From page 13 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. *[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.	E 039			

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E 039	Continued From page 14 (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. *[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	E 039			

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E 039	Continued From page 15 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. *[RNCHIs 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: Based on observation, record review, and interview, the long term care facility failed to participate in a full-scale exercise and a table top exercise of the Emergency Preparedness Plan in accordance with 42 CFR 483.73 Finding: On 02.25.2025, between the hours of 9:00 AM and 12:00 PM, this surveyor accompanied with the General Manager observed the following:	E 039			

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E 039	Continued From page 16	E 039			
K 000	1. Must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The facility was unable to provide any documentation of conducted exercises within the last year. The surveyor confirmed this finding with the General Manager at the time of the observation.	K 000			
K 291 SS=D	Federal Recertification Survey: Survey Date: 02.25.2025 Ledgewood Manor, 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. Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9.18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the long-term care facility failed to maintain emergency lighting per NFPA 101, Life Safety Code, 2012 Edition, Sections 19.2.9.1 Finding: On 02.25.2025, between 9:00 AM and 12:00 PM,	K 291			

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K 321	Continued From page 18 (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: The facility failed to protect hazardous area fire barrier walls and ceiling, having 1-hour fire resistance rating in accordance with NFPA 101 Section 19.3.2.1 and Section 8.4 Finding: Based on interview and observation on 02.25.2025 between hours of 9:00 AM and 12:00 PM. this surveyor accompanied with Director of Maintenance and the General Manager did observe the following: 1. The arm of the self-closing device on the laundry room door was removed therefore the door does not self close and positively latch. These observations were observed by this surveyor, Director of Maintenance and the General Manager.	K 321			
K 342 SS=D	Fire Alarm System - Initiation CFR(s): NFPA 101 Fire Alarm System - Initiation Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system. Manual alarm boxes are provided in the path of egress near each required exit. Manual alarm boxes in patient sleeping areas shall not be required at exits if manual alarm boxes are	K 342			

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K 342	Continued From page 19 located at all nurse's stations or other continuously attended staff location, provided alarm boxes are visible, continuously accessible, and 200' travel distance is not exceeded. 18.3.4.2.1, 18.3.4.2.2, 19.3.4.2.1, 19.3.4.2.2, 9.6.2.5 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the long-term care facility failed to maintain the proper height for 1 of the 7 the fire alarm manual initiation devices in the facility per NFPA 101, Life Safety Code, 2010 edition, sections 19.3.4.2.1, 19.3.4.2.2, 9.6.1.3 and NFPA 72, National Fire Alarm and Signal Code, 2010 edition, Section 17.14.4. Finding: Based on observation and interview on 02.25.2025, between 9:00 AM and 12:00 PM, a surveyor, with the General Manager and the Maintenance Director present observed the following: 1. The operable part of each manual fire alarm box shall be not less than 42 inches and not more than 48 inches above floor level. The fire alarm pull station in the sprinkler riser area measured 58.5 inches above the finished floor to the operable part of the device. The surveyor confirmed this finding with the General Manager and the Maintenance Director at the time of the observation on 02.25.2025, between 9:00 AM and 12:00 PM.	K 342			
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101	K 345			

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K 345	Continued From page 20 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on observation and record review, the long-term care facility failed to ensure that the fire alarm was maintained in accordance with NFPA 101, Life Safety Code, 2012 Edition, Sections 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 Based on interview and observation and record review on 02.25.2025 between hours of 9:00 AM and 12:00 PM. this surveyor accompanied with the Maintenance Director and General Manager did observe the following: 1. The facility had no documentation of the fire alarm system ever being sensitivity tested in the past 5 years. 2. The facility was unable to provide documentation for the last annual alarm system test. The surveyor confirmed this finding the Maintenance Director and General Manager at the time of the observation.	K 345			
K 353 SS=D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101	K 353			

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K 353	Continued From page 21 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observations and interview, the facility failed to ensure that Sprinkler System was inspected, tested, and maintained in accordance with NFPA 13, , 2010 edition, Chapter 6, section 6.2.7.2. This deficient practice could affect the entire facility, patients/residents, visitors, and members of facility staff in this location(S). Findings: Based on interview and observation on 02.25.2025 between hours of 9:00 AM and 12:00 PM. this surveyor accompanied with Director of Maintenance and the General Manager did observe the following: 1. Observed gaps between the escutcheons and the ceiling in room 117 allowing the passage of	K 353			

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K 353	Continued From page 22 heat and smoke.	K 353			
K 914 SS=F	2. Observed gaps between the escutcheons and the ceiling in multiple areas in the kitchen allowing the passage of heat and smoke. These findings were verified by the Director of Maintenance and the General Manager at the time of observations and document review. 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	K 914			

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K 914	Continued From page 23 grade receptacles at patient bed locations at intervals not exceeding 12 months in all three resident care wings in accordance with NFPA 99, Health Care Facilities Code, 2012 edition, Section 6.3.3.2. Finding: Documentation review and interview during a facility tour with the facilities director and the General Manager and Maintenance Director present on 02.25.2025 from 09:00 AM to 12:00 PM identified: 1. There is no annual testing of the non-hospital grade receptacles on file that could be reviewed. The interview with the Maintenance Director and Administrator revealed that the annual receptacle testing for physical integrity, continuity, polarity and retention force is not being done. This deficient practice could pose an electrical hazard to all residents, visitors, and members of facility staff in these locations. This finding was verified by the General Manager and the Maintenance Director at the time of interview and document review on 02.25.2025 from 09:00 AM to 12:00 PM.	K 914			
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this	K 918			

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K 918	Continued From page 24 capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on observation, and interview, and generator inspection documentation review during the facility tour, the long-term care facility failed to maintain the Essential Electric System Generator per NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, sections 8.3.7., 8.3.8, and 8.4.1, and NFPA 99, Healthcare Facilities Code, 2012 edition, section 6.4.4.1.1.3. This deficient practice could affect the patients/residents, visitors, and	K 918			

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K 918	Continued From page 25 members of facility staff in this location. Findings: Review of documentation and interview with the Maintenance Director and the General Manager present on 02.25.2025 between 9:00 AM and 12:00 PM identified the following deficiencies: 1) Emergency Power Supply Systems, including all appurtenant components, shall be inspected weekly. The weekly generator inspection reports did not show any generator testing since 01/23/2025. 2) No voltage conductance test for sealed batteries or an electrolyte specific gravity reading for unsealed automotive batteries are annotated on the documentation of the weekly or monthly inspections. 3) No documentation showing an annual fuel quality test was provided on the generator testing and maintenance documentation. A fuel quality test shall be performed at least annually using appropriate ASTM standards or the manufacturer 's recommendations. These findings were verified by the Maintenance Director and the General Manager at the time of observation on 02.25.2025 between 9:00 AM and 12:00 PM.	K 918			
K 923 SS=D	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and	K 923			

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CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 02/27/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205137	(X2) MULTIPLE CONSTRUCTION A. BUILDING 04 BY: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/25/2025
NAME OF PROVIDER OR SUPPLIER LEDGEWOOD MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 200 ROUTE 115 WINDHAM, ME 04062		
(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 923	Continued From page 26 ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet 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. Less than or equal to 300 cubic feet 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. 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) STORED WITHIN NO SMOKING." 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. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation, the health care facility failed to ensure that Oxygen storage requirements for storage greater than 300 cubic feet are achieved in accordance with NFPA 99,	K 923			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205137	(X2) MULTIPLE CONSTRUCTION A. BUILDING BY: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/25/2025
NAME OF PROVIDER OR SUPPLIER LEDGEWOOD MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 200 ROUTE 115 WINDHAM, ME 04062		
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K 923	Continued From page 27 Health Care Facilities Code, 2012 edition, Sections 11.3.2.3, 11.3.4.2 Finding: On 02.25.2025, between 09:00 AM and 12:00 PM, a surveyor, with the General Manager and Maintenance Director, observed the following: 1. The oxygen cylinder storage room contained 13 E tanks equating approximately 312 cubic feet was not marked with a sign readable from 5 ft stating "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING" 2. The oxygen cylinders were not separated from combustibles such as wooden shelving and cardboard boxes with a distance of at least 5 feet. The surveyor confirmed this finding with the General Manager and the Maintenance Director at the time of the observation on 02.25.2025, between 09:00 AM and 1:00 PM.	K 923			

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PLAN OF CORRECTION (POC) -- Ledgewood Manor

Provider ID #: 205137

Facility ID #: 0514

Event ID #: WH5J21

Survey Completed: February 25, 2025

Date Statement of Deficiencies (SOFD) Received: February 27, 2025

Date Plan of Correction (POC) Due: March 8, 2025

Completed by Nathaniel Bennett, MLA, General Manager

Submitted by Email: March 7, 2025 (FMOHealthcare@maine.gov)

Updated and Resubmitted by Email: March 17, 2025

E025 (SS=F) Arrangement with Other Facilities

a. What corrective action will be accomplished?

Ledgewood has made mutual arrangements with two other facilities - Gorham House (Senior Lifestyle) in Gorham and Odd Fellows Home in Lewiston – located south and north of Ledgewood and within a reasonable distance to cooperate in relocating residents to each other's facility in the event of an emergency that might require evacuating and/or temporarily relocating residents.

In addition, a sheet entitled "EMERGENCY PARTNERSHIPS Quick Reference" has been placed in each of our Emergency Plan binders that summarizes each of the MOUs or arrangements we have with various facilities and vendors to make it easier to know who to contact in case of emergency food, water, transportation, evacuation, etc. become necessary.

b. How will other residents potentially affected be identified and what corrective action will be taken?

Any resident who may need to be evacuated/relocated in an emergency could potentially be affected.

c. How will the facility monitor performance for solution sustainability?

Ledgewood will maintain/renew an arrangement with at least one facility annually at the time the Emergency Plans are also annually reviewed.

d. When will corrective action be completed?

As of **Wednesday, March 6, 2025**, two facilities have agreed by email to have an arrangement with Ledgewood. A written, non-binding agreement or MOU has been mutually signed by one other facility (Gorham House), and the other (Odd Fellows) is to be received by or before Friday, March 14, 2025.

See attached:

- MOU – Gorham House
- MOU – Odd Fellows

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- EMERGENCY PARTNERSHIPS Quick Reference

E037 (SS=F) EP Training Program

a. What corrective action will be accomplished?

At the time of the survey, two of our staff members were chosen at random to determine who had had emergency training. One was a new hire and one was our Dietary Director.

It's important to note that all our new hires receive an orientation packet ("Ledgewood Manor General Orientation") they are expected to complete and be familiar with. That packet includes two sections apt to emergency procedures:

Page 23 – Emergency Fire Procedures

Page 24 – Fire Safety Information

Page 25 – Disaster Preparedness Test

We've had new hires complete this for 8+ years.

In addition, we expect all staff to participate in a monthly annual in-service conducted on the fourth Wednesday of each month, ideally, on the date closest to their date of hire anniversary date. This inservice includes a section on "Emergency Preparedness" (see attached "Annual In Service" page) during which the contents of the Emergency Plans (EP) binder is reviewed and discussed. The training also includes a walkthrough of the entire building, pointing out locations of extinguishers, identifying the boiler room, generator and the riser locations, and taking any questions along the way with regard to how we handle emergencies.

The second person selected randomly, the Dietary Director, has participated in this annual in-service in the past, but she also helps to teach on that day for the dietary review part, so she hasn't been at a full inservice for at least a year. So it certainly was time for her to review EP training. On March 5, 2025, she participated in the Tabletop Exercise conducted with the other directors. That comprehensive EP exercise included an overview of the EP binder and specific more extensive mock training/discussion of how to handle an emergency.

In addition, to ensure that all staff are familiar with emergency procedures training consistent with their expected roles at Ledgewood, the three pages of the orientation training (above) will be consolidated and an "Emergency Preparedness Test" given to every staff member during the week of Monday, March 10, 2025. This will be a very good update and refresher for everyone. They will be expected to complete these worksheets as a review in order to ensure that all staff receive a refresher and annual training in EP procedures. The "Test" involves knowledge of the building and the EP binder.

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b. How will other residents potentially affected be identified and what corrective action will be taken?

All residents are potentially affected if staff is unfamiliar with emergency procedures. Training of all staff will be completed annually and documented.

c. How will the facility monitor performance for solution sustainability?

Documentation of training will be maintained.

d. When will corrective action be completed?

At the time of survey, one person who had been chosen randomly had already received updated training as a new hire, and the other person has received updated emergency procedures training as of Wednesday, March 5, 2025. They will both receive and be expected to complete the "Test" that will be handed out in the coming weeks.

Annual Inservice training of Emergency Procedures will continue to be conducted monthly, and to ensure that everyone receives annual training, the worksheets that will be handed out during the week of Monday, March 10, 2025 with the expectation that they will be handed back completed by or before **Friday, March 21, 2025**.

These worksheets will be updated and completed annually during the month of March to ensure everyone gains at least a basic familiarity of the building and EP procedures. New hires will continue to complete the form upon hire. Volunteers, through our Activities Director, will be expected to review these worksheets as well. They will also be shared with all nursing agencies we cooperate with. They will be expected to disseminate this information to their staff prior to working with us. We want to be sure everybody who works at Ledgewood receives EP training.

See attached:

- "Ledgewood Manor General Orientation" contents and specific pages
- "Annual In Service" contents
- "Emergency Preparedness Test (2025-03-10)"

E039 (SS=F) EP Testing Requirements

a. What corrective action will be accomplished?

A mock Tabletop Exercise was conducted with the leadership of Ledgewood on Wednesday, March 5, 2025 to simulate a disaster scenario and evacuation/relocation of residents. An after action report was completed.

A second exercise is in the process of being scheduled to include the Windham Police and Fire Departments. We're working with Windham's Fire Chief, Brent

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Libby, to arrange an "Active Shooter" drill that might also include other aspects of our Emergency Plan.

b. How will other residents potentially affected be identified and what corrective action will be taken?

Being prepared for emergencies affects all residents and staff. We will continue training.

c. How will the facility monitor performance for solution sustainability?

We will test the emergency plan at least twice per year and maintain documentation.

d. When will corrective action be completed?

*One exercise has been completed – **Wednesday, March 5, 2025**. A second, community-based exercise is in the process of being arranged, and we expect to complete it by or before **Wednesday, April 30, 2025**.*

UPDATE 2025-03-17: We expect this second exercise, with the cooperation of the Windham Fire and Police Departments to be completed by or before Friday, April 11, 2025.

See attached:

- Tabletop Exercise and After Action Report

K291 (SS=D) Emergency Lighting

a. What corrective action will be accomplished?

A new emergency light was purchased and installed in the generator room by Bob Palowski, an electrical engineer, and owner of Reliable Communications to meet NFPA Safety Code

b. How will other residents potentially affected be identified and what corrective action will be taken?

Not applicable.

c. How will the facility monitor performance for solution sustainability?

Not applicable.

d. When will corrective action be completed?

The action was completed and tested **Tuesday, March 4, 2025**.

See attached:

- Photo of newly installed emergency light in generator room

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K321 (SS=D) Hazardous Areas - Enclosure

a. What corrective action will be accomplished?

The arm of the self-closing device on the laundry room door had been in the process of being repaired by the maintenance supervisor. Our maintenance director will complete the repair and make it functional.

b. How will other residents potentially affected be identified and what corrective action will be taken?

Not applicable.

c. How will the facility monitor performance for solution sustainability?

Not applicable. The door will continue to be used and repaired as necessary.

d. When will corrective action be completed?

Repair and testing of the self-closing device on the door of the laundry room will be completed by or before **Tuesday, March 12, 2025.**

K342 (SS=D) Fire Alarm System - Initiation

a. What corrective action will be accomplished?

The fire alarm pull station in the sprinkler riser area that has been there for 45 years was moved down by Bob Palowski, an electrical engineer, and owner of Reliable Communications to meet NFPA Safety Code.

b. How will other residents potentially affected be identified and what corrective action will be taken?

Not applicable.

c. How will the facility monitor performance for solution sustainability?

Not applicable.

d. When will corrective action be completed?

*The fire alarm pull station was moved, rewired and tested **Tuesday, March 4, 2025.***

UPDATE 2025-03-17: Bob Palowski did test the fire alarm pull station that was moved and rewired. Please, see his revised invoice. A facility-wide fire drill was also conducted Wednesday, March 12, 2025 at 7:12pm using this particular pull station to activate the fire alarm, and it worked properly.

See attached:

- Photos pull-station move to proper height

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K345 (SS=F) Fire Alarm System - Testing and Maintenance

a. What corrective action will be accomplished?

The fire alarm company that normally inspects our system, Maine Fire & Security (Encore Fire Protection), was phoned on the day of the inspection to provide the inspection report. Later, the representative returned the phone call and stated that the inspection was scheduled for November 2024, but that, due to staff changes, etc. it hadn't been completed. An immediate inspection was scheduled and completed the following day, Thursday, February 27, 2025 at 8 a.m.

The report was completed and submitted to Ledgewood by email on March 4, 2025.

b. How will other residents potentially affected be identified and what corrective action will be taken?

Corrective action has been taken and inspections will continue annually.

c. How will the facility monitor performance for solution sustainability?

The fire alarm inspection must be completed annually and documented.

d. When will corrective action be completed?

Corrective action was completed **Thursday, February 27, 2025.**

See attached:

- Fire alarm report by Maine Fire & Security

K353 (SS=D) Sprinkler System - Maintenance and Testing

a. What corrective action will be accomplished?

The gaps between the escutcheons and the ceiling in Room 117 and multiple areas in the kitchen will be filled. In room 117, the escutcheon was loose. It has been tightened and put back in place.

b. How will other residents potentially affected be identified and what corrective action will be taken?

Not applicable.

c. How will the facility monitor performance for solution sustainability?

An annual inspection of all the escutcheons in the building will be conducted by the maintenance director and/or the administrator at the same time as the receptacle inspections are completed.

d. When will corrective action be completed?

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Room 117's sprinkler escutcheon was repaired and put back in place Friday, March 7, 2025. The kitchen escutcheons will be repaired and put back into place by or before **Tuesday, March 11, 2025**.

UPDATE 2025-03-17: The escutcheon repair and replacement was rescheduled to follow the work that's currently being completed on the kitchen dishwashing room ceiling. An agreement was signed Friday, March 14, 2025 between LedgeWood and Encore Fire Protection in Lewiston to perform all fire-related functions at LedgeWood, including the fire alarm inspection, extinguisher inspections, sprinkler inspections, suppression system inspections, and all things related. They will be doing the work on the sprinkler escutcheons in question along with inspecting all other sprinklers in the building and bring them proper function and NFPA regulation. We expect this work to be completed by or before Friday, April 4, 2025.

K914 (SS=F) Electrical Systems - Maintenance and Testing

a. What corrective action will be accomplished?

An annual inspection checklist was created for all receptacles in the corridors and resident rooms of Wings 1 and 2, the core area, and the dining room on March 3, 2025. These receptacles are in all areas of the building accessible by residents.

Receptacle inspections include testing for physical integrity, continuity, polarity, and retention force.

b. How will other residents potentially affected be identified and what corrective action will be taken?

All receptacles in all areas accessible by residents are being inspected.

c. How will the facility monitor performance for solution sustainability?

The checklist will be completed at least annually.

Housekeeping and nursing staff also monitor the physical condition and use of receptacles as they work through resident rooms and other areas of the building, notifying the maintenance department of problems.

d. When will corrective action be completed?

Inspections of all receptacles in areas accessible by residents began Monday, March 3, 2025, and receptacles in need of repair have been fixed or replaced to be in safe use by residents and staff. This was completed **Friday, March 6, 2025**.

See attached:

- "Annual Receptacle Testing" form, page 1 of many

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K918 (SS=F) Electrical Systems - Essential Electric System Maintenance and Testing**a. What corrective action will be accomplished?**

The weekly generator testing will be completed and brought up to the current week and continued forward on a weekly basis.

The generator testing will also include a monthly inspection of the voltage conductance of the battery.

The fuel used in the generator is liquid natural gas (LNG). Cat Milton was phoned and consulted Thursday, March 6 on testing the fuel. Chad Heath stated that he was unaware of a test that could be completed on this "pipeline quality fuel". If the Fire Marshal's office can recommend a means of testing the fuel, we would comply.

In addition, we went forward and scheduled an oil change and filter change with Cat Milton (Scarborough) that will be completed Wednesday, March 12, 2025, as well as a 4 hour load test on the system as required every 36 months by NFPA 110. The tech will assess the general condition of the system as well.

b. How will other residents potentially affected be identified and what corrective action will be taken?

Operation of the generator affects all residents should normal power fail.

c. How will the facility monitor performance for solution sustainability?

The documentation for weekly and monthly inspections is located onsite at the generator and will be completed weekly and monthly as required.

d. When will corrective action be completed?

*Completion of this is scheduled for **Wednesday, March 12, 2025**. Weekly and monthly testing and documentation are ongoing.*

UPDATE 2025-03-17: The weekly generator testing (including voltage conductance) will be updated and current to the week of Monday, March 17, 2025 on that date.

Also, the 4-hour load test that was scheduled for Wednesday, March 12, 2025 had to be rescheduled by Cat Milton due to an emergency with another facility's generator, and is now rescheduled for Wednesday, March 19, 2025.

K923 (SS=D) Gas Equipment - Cylinder and Container Storage**a. What corrective action will be accomplished?**

We do our best to follow regulations and have a sign in our oxygen room that a maximum of 10 cylinders may be stored in the room at any one time. At the time of

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the Fire Marshal's visit, some of our staff must have rolled in too many in order to accommodate the space for residents in their rooms.

On Thursday, February 27, 2025, a Securall Oxygen Cylinders Storage Cabinet was purchased. It's a green, model MG309FL, Self-Closing, Self Latching Safe-T-Door cabinet that can contain a maximum of 12 D/E oxygen cylinders. It will be placed in the oxygen room. Allowing only 12 cylinders, it also meets NFPA 99 (2018) and NFPA 101 (2018) requirements.

A sign was also placed on the door stating "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING". The same signage is on the oxygen cabinet (see photo) that we received and put into service.

b. How will other residents potentially affected be identified and what corrective action will be taken?

Purchase and proper use of this new oxygen cabinet by nursing staff will provide additional safeguards to all residents and staff.

c. How will the facility monitor performance for solution sustainability?

The charge nurse on duty will monitor the oxygen room periodically for proper storage. No oxygen tanks should be stored in the oxygen room outside of the oxygen cabinet.

d. When will corrective action be completed?

The new oxygen cabinet was ordered February 27, 2025. The oxygen cabinet was received on Thursday, March 6, 2025 at 2:30pm. It was put into service **Friday, March 7, 2025**. Training and signage for how we expect oxygen tanks to be handled and stored will be completed and maintained.

See attached:

- Oxygen cabinet product description
- Oxygen cabinet receipt
- Photo of "CAUTION" sign on door
- Photos of oxygen tank in place

Reliable Communications

P.O. Box 1571
Scarborough, Maine.04070-1571
207-883-5918

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BY: _____

Invoice

Date	Invoice #
3/4/2025	9614

Bill To
Ledgewood Manor, Inc. P.O. Box 760 200 Tandberg Trail Windham, Maine 04062-0760

P.O. No.	Terms	Project
Nate	Due on receipt	

Quantity	Description	Rate	Amount
3	Hourly rate for Service labor, 3/4/25, 1:20 to 4:40 PM, by Bob. Moved FA pull switch at Kitchen entrance to regulation height (41" to 48"). and tested; Works fine.	88.00	264.00
	Installed Emergency LED Light in Garage & test.		
1	Blank Plate	0.99	0.99T
1	Single Gang cut-in wall Box	4.95	4.95T
1	Travel Charge	25.00	25.00T
	Sales Tax in Maine	5.50%	1.70
		Total	\$296.64

Tech America

GENERATOR LOG

Normal 3 phase
208

Voltage
Conductance

Monday	Sunday	Recommended Test Type	Date	Tested by	Start Time	End Time	Run Time (actual minutes)	Run Time (decimal minutes)	Notes
12/30/24	- 01/06/25	Maintenance	1/2/25	EG	164.32	164.52	9.00	0.15	
01/07/25	- 01/14/25	LOAD	1/9/25	EG	164.52	164.74	13.00	0.22	
01/15/25	- 01/22/25	Maintenance	1/15/25	EG	164.74	165.02	17.00	0.28	
01/23/25	- 01/30/25	Maintenance	1/23/25	EG	165.02	165.20	10.8	0.18	
01/31/25	- 02/07/25	Maintenance	2/5/25	EG	165.20	165.31	7.00	0.11	Voltage Tested OK
02/08/25	- 02/15/25	LOAD	2/13/25	EG	165.31	165.55	14.00	0.24	X 208
02/16/25	- 02/23/25	Maintenance	2/18/25	EG	165.55	165.65	6.00	0.10	X 208
02/24/25	- 03/03/25	Maintenance	2/27/25	EG	165.65	165.86	13.00	0.21	X 208
03/04/25	- 03/11/25	Maintenance	3/5/25	EG	165.86	166.08	13.00	0.22	X 208
03/12/25	- 03/19/25	LOAD	3/17/25	EG	166.08	166.28	12.00	0.20	X 208

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