STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205132	A. BUILDING **01** B. WING _____	**03/10/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DURGIN PINES	**9 LEWIS RD** **KITTERY, ME 03904**

(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: 03.10.2025 Durgin Pines, 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 037 SS=F	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	E 037		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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

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E 037	Continued From page 1 procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The 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	E 037		

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E 037	Continued From page 2 procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF 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	E 037		

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E 037	Continued From page 3 preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The 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	E 037		

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E 037	Continued From page 4 roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency 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(d)(1). Finding: Based on interview and documentation review on 03.10.2025, between the hours of 10:00 AM and 2:00 PM, this surveyor accompanied with the Administrator, and the Assistant Director of Nursing observed the following: 1. No documentation of initial training in emergency preparedness policies and	E 037		

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E 037	Continued From page 5 procedures to all individuals providing services under arrangement, with temporary staffing needs "clipboard", consistent with their expected roles could be produced in the Emergency Preparedness Plan.. The surveyor confirmed this finding with the Administrator, and the Assistant Director of Nursing, at the time of the observation and record review.	E 037		
K 000	INITIAL COMMENTS Federal Recertification Survey: Date: 03.10.2025 Durgin Pines, 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=C	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on Observations the facility failed to ensure doors at the means of egress meet the requirement of NFPA 101, Life Safety Code, 2012 Edition, Sections 19.2.2.2.4, 7.1.6.2, and 7.1.10.1	K 211		

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K 211	Continued From page 6 Findings: On 03.10.2025, between 10:00 AM and 2:00 PM, a surveyor, with the Administrator and Director of Environmental Services present, observed the following: 1. The Marion Way Wing corridor exit door leading to Service Wing exit corridor was locked and the inspector could not exit the building unless staff unlocked the door. The doors are not delayed egress and have a keypad with no code posted. This affected 1 of 2 smoke compartments. 2. The exterior exit discharge paths from the Gillis Wing and Out Patient to the public way has pavement that is excessively cracking 2" gap, greater than 1/4 inch elevation difference. The surveyor confirmed these findings with the Administrator and Director of Environmental Services at the time of the observation.	K 211		
K 291 SS=D	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, interview and document review the facility failed to provide operational emergency lighting for the duration of the testing in accordance with NFPA 101, Life Safety Code, 2012 edition, sections 19.2.9, and 7.9.3.1.1(4).	K 291		

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K 291	Continued From page 7 Finding: On 03.10.2025, between 10:00 AM and 2:00 PM, a surveyor, with the Administrator and Director of Environmental Services present, observed the following: 1) The facility was unable to provide documentation of monthly and annual emergency light testing. The surveyor confirmed this finding with the Administrator and Director of Environmental Services at the time of the observation.	K 291		
K 293 SS=D	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observations and interviews and record review the facility failed to maintain the illuminated exit signage in accordance with National Fire Protection Association (NFPA) 101, Life Safety Code, 2012 edition sections 19.2.10 and 7.10.9.1 Finding: On 03.10.2025, between 10:00 AM and 2:00 PM,	K 293		

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K 293	Continued From page 8 a surveyor, with the Administrator and Director of Environmental Services present, observed the following: 1. The facility was unable to provide documentation of monthly and annual exit light testing. The surveyor confirmed this finding with the Administrator and Director of Environmental Services at the time of the observation.	K 293		
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames	K 363		

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K 363	Continued From page 9 shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation, the long-term care facility failed to maintain 1 of 58 resident room doors to resist the passage of smoke to and from the corridor as referenced by NFPA 101, Life Safety Code 2012 edition, Section 19.3.6.3 Finding: Observation and interview during a facility tour with the Administrator and Director of Environmental Services present on 03/10/2025, between 10:00 AM and 2:00 PM identified: 1. Resident room #127 door at the exit end of the Hand Wing didn't latch when we closed the door because the latching mechanism in the door did not line up with the hole in the striker plate in the door frame. The surveyor confirmed this finding with the Administrator and Director of Environmental Services at the time of the observation on 03/10/2025, between 10:00 AM and 2:00 PM	K 363		

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K 712	Continued From page 10	K 712		
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on documentation review, and interview, the long-term care facility failed to conduct fire drills in accordance with NFPA 101, Life Safety Code, 2012 edition, section 19.7.1.7. in 9 of the last 12 months. Findings: Documentation review and interview during a facility tour with the Administrator and Director of Environmental Services present on 03/10/2025, between 10:00 AM and 2:00 PM identified: 1. The fire drill in March for the third shift in the first quarter of 2024 was a silent drill conducted at 04:00. There was no coded announcement. Interview with the Director of Environmental Services revealed that there is no intercom or Public Address system in the building. He didn't know how the coded announcements were done in the past.	K 712		

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K 712	Continued From page 11 2. The 1st shift drill in April, 2024 at 10AM was a silent training event and was not a fire drill. There was no drill done for the 1st shift in the second quarter of 2024. Activation of the fire alarm system is required during the hours of 0600-2100. 3. The 2nd shift drill in May, 2024 at 15:35 was a silent training event and was not a fire drill. There was no drill done for the 1st shift in the second quarter of 2024. Activation of the fire alarm system is required during the hours of 0600-2100. 4. The fire drill for the 3rd shift in the second quarter in June was a silent drill. Drills that are not done by the activation of the fire alarm system shall be a coded announcement. This drill occurred at 16:15. Activation of the fire alarm is only permitted to be omitted to a coded announcement during the hours of 2100-1600. 5. The 1st shift drill in the third quarter in July was an actual event and did not constitute a fire drill. There was no fire drill done for the 1st shift during the third quarter of 2024. 6. The fire drill for the 2nd shift in the third quarter in August was a silent drill. Drills that are not done by the activation of the fire alarm system shall be a coded announcement. This drill occurred at 16:15. Activation of the fire alarm is only permitted to be omitted to a coded announcement during the hours of 2100-1600. 7. The fire drill in September for the third shift in the third quarter was a silent drill. There was no coded announcement. Interview with the Director of Environmental Services revealed that there is no intercom or Public Address system in the building. He didn't know how the coded	K 712		

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K 712	Continued From page 12 announcements were done in the past. 8. The fire drill in November on the second shift during the fourth quarter of 2024 was done at 1930 hours, and it was recorded as a silent drill. Activation of the fire alarm system is required during the hours of 0600-2100. Coded announcements are only permitted from 2100-1600. 9. The fire drill in December for the third shift in the fourth quarter of 2024 at 04:30 was a silent drill. There was no coded announcement. Interview with the Director of Environmental Services revealed that there is no intercom or Public Address system in the building. He didn't know how the coded announcements were done in the past. The surveyor confirmed these findings with the Administrator and Director of Environmental Services present at the time of the documentation review on 03/10/2025, between 10:00 AM and 2:00 PM. A picture of the code reference was taken on the phone of the Director of Environmental Services at the time of documentation review.	K 712		
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	K 753		

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K 753	Continued From page 13 100 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 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 present. 19.7.5.6. Finding: On 03.10.2025, between 10:00 AM and 2:00 PM, a surveyor, with the Administrator and Director of Environmental Services present, observed the following: 1. The Marion Way Wing near the Hogan Wing had a large afghan displayed in 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	K 753		

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	205132	A. BUILDING **01** B. WING _____	**03/10/2025**

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K 753	Continued From page 14 requirements of NFPA 701 (2010) or NFPA 289 (2009). This affected 1 or 2 smoke compartments. The surveyor confirmed this finding with the Administrator and Director of Environmental Services at the time of the observation.	K 753		
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on interview and documentation review, the long-term care facility failed to conduct an annual fire door inspection that ensures that all fire rated doors and hardware are inspected, tested, and maintained by individuals performing the door inspections that possess knowledge, training or experience that demonstrates ability in accordance with NFPA 80, Standard for Fire Door and Other Opening Protectives, 2010 edition Section 5.2 as referenced by NFPA 101, Life Safety Code, 2012 Edition, Sections 19.7.6, and	K 761		

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K 761	Continued From page 15 8.3.3.1 Finding: Documentation review and interview during a facility tour with the Administrator and Director of Environmental Services present on 03/10/2025, between 10:00 AM and 2:00 PM identified: 1. The facility failed to complete the annual assessment of all fire doors in the facility. The facility had no documentation that the doors had been inspected by a trained employee or a qualified outside vendor since Exactitude did the inspection on 01/02/2024. Interview with the Director of Environmental Services revealed that the annual door inspection is not done in house, and they haven't scheduled an outside vendor to come in as of 03/10/2025. This surveyor confirmed this finding with the Administrator and Director of Environmental Services present on 03/10/2025, between 10:00 AM and 2:00 PM	K 761		
K 914 SS=F	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	K 914		

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K 914	Continued From page 16 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 documentation review and interview the facility, failed to ensure that inspection of the receptacles in patient care rooms not listed as hospital-grade, was conducted at intervals not exceeding 12 months in accordance with NFPA 99, Healthcare Facilities Code, 2012 edition, Sections 6.3.3.2.4., and 6.3.4.1.3. Finding: Documentation review and interview during a facility tour with the Administrator and Director of Environmental Services present on 03/10/2025, between 10:00 AM and 2:00 PM identified: 1. There is no documentation showing any annual testing of the receptacles in Resident Care rooms. No past testing of the physical integrity, grounding continuity, polarity and retention force of the receptacles could be produced. 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 Administrator and Director of Environmental Services at the time of	K 914		

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K 914	Continued From page 17 interview and document review on 03/10/2025, between 10:00 AM and 2:00 PM. A photograph of the code reference was taken by the Director of Environmental Services at the time of the exit interview.	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 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	K 918		

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K 918	Continued From page 18 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 8.4.1 and 8.4.2, as referenced by NFPA 99, Healthcare Facilities Code, 2012 edition, section 6.4.4.1.1.3. This deficient practice could affect the patients/residents, visitors, and members of facility staff in this location. Finding: Documentation review and interview during a facility tour with the Administrator and Director of Environmental Services present on 03/10/2025, between 10:00 AM and 2:00 PM identified: 1) There are no monthly load testings and inspections being conducted by the maintenance staff at this long-term care facility. The only inspection documentation is the annual professional inspection and the weekly inspection. Interview with the director of Environmental Services revealed that the generator is not tested under load. The Inspection and Testing of Generators .pdf from the CMS website was issued to the Director at the time of the documentation review. This finding was verified by the Administrator and Director of Environmental Services present on	K 918		

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K 918	Continued From page 19 03/10/2025, between 10:00 AM and 2:00 PM at the exit interview.	K 918		