STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205116	A. BUILDING **01** B. WING _____	**01/13/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STILLWATER HEALTH CARE	**335 STILLWATER AVE BANGOR, ME 04401**

(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 Date of Survey 01/13/2025 Stillwater Healthcare, 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 015 SS=F	Subsistence Needs for Staff and Patients CFR(s): 483.73(b)(1) §403.748(b)(1), §418.113(b)(6)(iii), §441.184(b)(1), §460.84(b)(1), §482.15(b)(1), §483.73(b)(1), §483.475(b)(1), §485.542(b)(1), §485.625(b)(1) [(b) Policies and procedures. [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 every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm	E 015		

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 015	Continued From page 1 systems. (D) Sewage and waste disposal. *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the long term care facility failed to maintain provision of subsistence needs for staff and patients whether they evacuate or shelter in place for Emergency Preparedness Plan in accordance with 42 CFR 483.73 Finding: On 01/13/2025, between 11:00 AM and 4:30 PM, a surveyor, with the Maintenance Director and the Administrator present, observed the following:	E 015		

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E 015	Continued From page 2 1. No documentation was provided in the emergency preparedness plan for food, water, medical and pharmaceutical supplies, or waste disposal with updated Memorandums of Understanding to verify how they would get replenished in the event they had to evacuate or shelter in place. When I asked for documentation, no other MOUs could be produced. The only MOU provided was one for water dated 2018. There were no others provided. The surveyor confirmed this finding with the Maintenance Director and the Administrator at the time of the observation.	E 015		
E 029 SS=F	Development of Communication Plan CFR(s): 483.73(c) §403.748(c), §416.54(c), §418.113(c), §441.184(c), §460.84(c), §482.15(c), §483.73(c), §483.475(c), §484.102(c), §485.68(c), §485.542(c), §485.625(c), §485.727(c), §485.920(c), §486.360(c), §491.12(c), §494.62(c). (c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the long term care facility failed to maintain a communication plan for Emergency Preparedness Plan in accordance with 42 CFR 483.73 Finding:	E 029		

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E 029	Continued From page 3 On 01/15/2025, between 11:30 AM and 4:30 PM, a surveyor, with the Maintenance Director, and Administrator present, observed the following: 1. The facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every year. The communication plan shown was last updated in April of 2018. The surveyor confirmed this finding with the Maintenance Director and Administrator at the time of the observation.	E 029		
E 035 SS=F	LTC and ICF/IID Sharing Plan with Patients CFR(s): 483.73(c)(8) §483.73(c)(8); §483.475(c)(8) *[For LTC Facilities at §483.73(c):] [(c) The LTC facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually. The communication plan must include all of the following:] *[For ICF/IIDs at §483.475(c):] [(c) The ICF/IID must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years. The communication plan must include all of the following:] (8) A method for sharing information from the emergency plan, that the facility has determined	E 035		

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E 035	Continued From page 4 is appropriate, with residents [or clients] and their families or representatives. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the long term care facility failed to maintain a means to share the emergency preparedness plan with residents and their families for Emergency Preparedness Plan in accordance with 42 CFR 483.73 Finding: On 03/27/2023, between 10:00 AM and 3:00 PM, a surveyor, with the Maintenance Director and Administrator present, observed the following: 1. During record review, no documentation in the emergency preparedness plan regarding a method for sharing information from the emergency plan with residents and their families or representatives upon intake or in case of a disaster. During the interview with the Administrator and Maintenance Director, they were unable to tell me how they share information regarding the emergency preparedness plan during the intake process. The surveyor confirmed this finding with the Maintenance Director, and Administrator at the time of the observation.	E 035		
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),	E 037		

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E 037	Continued From page 5 §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 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	E 037		

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E 037	Continued From page 6 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 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	E 037		

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E 037	Continued From page 7 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 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	E 037		

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E 037	Continued From page 8 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 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	E 037		

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E 037	Continued From page 9 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 maintain a training and testing program for Emergency Preparedness Plan in accordance with 42 CFR 483.73 Finding: On 01/15/2025, between 11:30 AM and 4:30 PM, a surveyor, with the Maintenance Director and Administrator present, observed the following: 1. During record review of employee training files, there was a lack of initial and annual training for some employees since 2023 regarding the emergency preparedness plan. The surveyor confirmed this finding with the Maintenance Director and Administrator at the time of the observation.	E 037		
K 000	INITIAL COMMENTS Federal Recertification Survey Date of Survey 01/13/2025 Stillwater Healthcare, a long-term care facility, was surveyed pursuant to the National Fire Protection Association, 101 Life Safety Code, 2012 Edition as referenced in Part 483.90(a-d) - Physical Environment, and is not in substantial compliance.	K 000		

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K 133 SS=F	Multiple Occupancies - Construction Type CFR(s): NFPA 101 Multiple Occupancies - Construction Type Where separated occupancies are in accordance with 18/19.1.3.2 or 18/19.1.3.4, the most stringent construction type is provided throughout the building, unless a 2-hour separation is provided in accordance with 8.2.1.3, in which case the construction type is determined as follows: * The construction type and supporting construction of the health care occupancy is based on the story in which it is located in the building in accordance with 18/19.1.6 and Tables 18/19.1.6.1 * The construction type of the areas of the building enclosing the other occupancies shall be based on the applicable occupancy chapters. 18.1.3.5, 19.1.3.5, 8.2.1.3 This REQUIREMENT is not met as evidenced by: The Long Term Care Facility failed to meet the requirements of the National Fire Protection Association (NFPA) 101, Life Safety Code, 2012 edition chapter 19 section 19.1.3.5 and Chapter 8 section 8.1.2.3 for construction type and supporting construction for health care and/or other building occupancies. Findings: Based on observation, on 01/13/2025 between 11:00 AM and 4:30 PM, in the presence of this surveyor and the Maintenance Director the following was not met: 1. The Two- Hour fire barrier wall located between the apartments and the nursing home had pipe penetrations penetrations. A listed fire stopping system is required to be installed at all penetrations.	K 133		

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K 133	Continued From page 11 This was confirmed by this surveyor and the Maintenance Director at the time of the survey.	K 133		
K 211 SS=F	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure that aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with NFPA 101, Life Safety Code, 2012 edition, Chapter 7, and that the means of egress is continuously maintained free of all obstructions to full use in case of emergency unless modified by NFPA 101, Life Safety Code, 2012 edition, sections 19.2.2 through 19.2.11, 19.2.1, and 7.1.10.1. Findings: Observations and Interviews during a facility tour on 01/13/2025 from 11:00 AM to 4:30 PM identified: 1) The medical carts stored in the resident wing A corridor between rooms 2 and 4 are obstructing the means of egress. They were charging and not in constant use. This is not in accordance with NFPA 101, Life Safety Code, 2012 edition,	K 211		

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K 211	Continued From page 12 section 7.1.10.1 - Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. This failure occurred in 2 of 2 resident room wings in the facility. This deficient practice could affect all residents, visitors, and members of facility staff in this location. 2) The storage of paint and furniture in the C wing exit corridor by the kitchen and maintenance area is obstructing the means of egress. This is not in accordance with NFPA 101, Life Safety Code, 2012 edition, section 7.1.10.1 - Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. This failure occurred in 1 of 1 service room wings in the facility. This deficient practice could affect all residents, visitors, and members of facility staff in this location. These findings were verified by the Maintenance Director at the time of observations on 01/13/2025 between 11:00 AM and 4:30 PM.	K 211		
K 223 SS=D	Doors with Self-Closing Devices CFR(s): NFPA 101 Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect	K 223		

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K 223	Continued From page 13 smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to ensure that doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of required manual fire alarm system, and local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and automatic sprinkler system, if installed; and loss of power per the requirements of NFPA 101, Life Safety Code, 2012 edition, sections 19.2.2.2.7 and 19.2.2.2.8 Findings: On 01/13/2025 between hours of 11:00 AM and 4:30 PM. this surveyor accompanied with Maintenance Director did observe the following: 1. The door to the Janitor Closet located in A Wing was being held open with a magnet that was not self releasing upon activation of the fire alarm system. 2. The door to the Janitor Closet located in B Wing was being held open with a magnet that was not self releasing upon activation of the fire alarm system.	K 223		

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	205116	A. BUILDING **01** B. WING _____	**01/13/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 223	Continued From page 14 3. The twenty minute labeled fire rated door leading into the sprinkler room requires a self closing device to be installed. 4. The door to the kitchen area that exited into the corridor was propped open with a wet floor sign. The surveyor confirmed these findings with the Maintenance Director at the time of the observation.	K 223		
K 347 SS=D	Smoke Detection CFR(s): NFPA 101 Smoke Detection 2012 EXISTING Smoke detection systems are provided in spaces open to corridors as required by 19.3.6.1. 19.3.4.5.2 This REQUIREMENT is not met as evidenced by: The Long Term Care Facility failed to comply with the 2012 NFPA 101 Life Safety code regarding smoke detection as required by 19.3.4.1, and NFPA 72, National Fire Alarm and Signal Code, 2010 Edition, Section 17.7.5.6.1. Finding: During a facility tour on 01/13/2025 from 11:00 am to 4:30 pm this surveyor and the Maintenance Director observed the following: 1. The Dietician's office is equiped with a self-closing door that was observed held open with a magnetic hold-open and release device. Smoke detection was not observed on both sides of the door opening..	K 347		

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K 347	Continued From page 15 This finding was confirmed during a tour of the facility by this surveyor and the Maintenance Director at the time of the survey.	K 347		
K 353 SS=E	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 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 observation and record review, the long-term care facility failed to ensure that 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 sections 7.3.1 and 14.2.1.1 Findings: On 01/13/2025, a surveyor between 11:00 AM	K 353		

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K 353	Continued From page 16 and 4:30 PM, with the Maintenance Director observed the following: 1. The facility failed to complete the assessment of the flow trip test during the required 3 year time interval since the completion of the most recent test. Documentation revealed only a partial trip test was completed on 10/14/2024. 2. The facility failed to provide an escutcheon ring on a sprinkler head located in the sprinkler room. 3. The facility failed to maintain an escutcheon ring that has separated from the ceiling located in patient room 33. 4. The sprinkler head in the kitchen area is loaded with foreign material. 5. The sprinkler box, located in the sprinkler room, did not have a list of what spare sprinkler heads were located in the box with the description and quantities of the heads included. These findings were verified by the Maintenance Director at the time of the observation and at the exit conference on 01/13/2025.	K 353		
K 355 SS=D	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by:	K 355		

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	205116	A. BUILDING 01 B. WING	01/13/2025

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K 355	Continued From page 17 Based on observation and interview, the facility failed to select, install, and maintain Class K fire extinguishers in accordance with NFPA 101, Life Safety Code, 2012 edition, section 19.3.5.12, and NFPA 10, Standard for Portable Fire Extinguishers, 2010 edition, Sections 5.5.3, and 6.6.1 in two locations in the facility. This deficient practice could affect the patients/residents, visitors, and members of facility staff in these locations. Deficient practices have the potential of being able to extinguish a cooking fire. Findings Include: Observations and Interviews during a facility tour with the Maintenance Director on 01/13/2025 between the hours of 11:00 AM and 4:30 PM found the following: 1) Class K fire extinguishers shall be provided for hazards where there is a potential for fires involving combustible cooking media such as vegetable or animal oils and fats. Discussion of the cooking menu during an interview with therapy staff, in the therapy stove area revealed that there is cooking that releases grease laden vapors and there is no class K extinguisher in the room with a decal. 2) A placard shall be conspicuously placed near the Class K extinguishers that states that the fire protection system shall be activated prior to using the fire extinguisher. The kitchen class K extinguisher has a generic fire extinguisher arrow sign, and not a class K type specific decal as referenced. These findings were verified by the Maintenance Director at the time of the observation and at the	K 355		

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K 355	Continued From page 18 exit conference on 01/13/2025.	K 355		
K 363 SS=E	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 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	K 363		

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K 363	Continued From page 19 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 and interview, the facility failed to ensure that all doors protecting corridor openings resist the passage of smoke in accordance with NFPA 101, Life Safety Code, 2012 edition, Section 19.3.6.3 in 2 of 2 resident care wings. This deficient practice could affect the all residents, visitors, and members of facility staff in these locations. Findings: Observations and Interviews during a facility tour with the Maintenance Director present on 01/13/2025 from 11:00AM to 4:30 PM identified: 1) Resident room 3 in A Wing was prevented from closing with a walker blocking the door. 2) Resident Room 15 in A wing was prevented from closing with a trash can blocking the door. 3) Resident Room 15 door also has a 1/2-inch gap on the top latch side that does not resist the passage of smoke. Light was clearly visible through the gap and one could see from the corridor to the room and from the room to the corridor. 4) Resident Room 14 door has a 1/2-inch gap on the top latch side that does not resist the passage of smoke. Light was clearly visible through the gap and one could see from the corridor to the room and from the room to the corridor. 5) Resident Room 20 was prevented from closing with a folded up walker blocking the door. 6) Resident Room 23 door has a 33/64 inch gap on the top latch side that does not resist the	K 363		

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K 363	Continued From page 20 passage of smoke. Light was clearly visible through and one could see from the corridor to the room and from the room to the corridor. 7) Resident Room 15 in A wing was prevented from closing with a trash can blocking the door. 8) The corridor door to patient room 2 in A Wing was unable to close and positively latch due to added material located on the lower left side of the door inhibiting the door from fully closing. 9) The corridor door marked as coat room in area C is required to latch. These findings were verified by the Maintenance Director at the time of observations and on 01/13/2025.	K 363		
K 372 SS=D	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: The Long Term Care facility failed to meet the requirements of the National Fire Protection Association (NFPA) 101, Life Safety Code, 2012 edition for smoke barrier enclosures in	K 372		

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K 372	Continued From page 21 accordance with 19.3.7.3. and 8.5.6.3 During the facility tour conducted on 01/13/2025 between the hours of 11:00 AM and 4:30 PM this surveyor and Maintenance Director observed the following: 1. Penetrations sealed with non-compliant sealant were observed in the 1 hour smoke barrier separating "C" wing from the "B" wing. 2. Openings and penetrations (Wires, sprinkler piping, insulated duct work and an approximate a 2 inch by 4 inch hole, etc.) were observed passing through the one-hour fire barrier wall located in the attic separating "C" wing from "B". This observation was confirmed by the surveyor and Maintenance Director at the time of the tour.	K 372		
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:	K 761		

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K 761	Continued From page 22 Based on record review and interview, the long-term care facility failed to provide documentation that the Maintenance Director had been trained to conduct fire door inspections program that ensure they are inspected, tested, and maintained in accordance with 2010 edition NFPA 80, Standard for Fire Door and Other Opening Protectives and in accordance with 2012 edition NFPA 101 19.7.6, 8.3.3.1, NFPA 80 5.2, 5.2.3. Finding: On 01/13/2025 between 11:00 AM and 4:30 PM, the surveyor, observed the following: 1. Documentation was not provided showing that trained and knowledgable person conducted the fire door testing. This surveyor confirmed this finding with Maintenance Director at the time of the interview and record review.	K 761		
K 918 SS=D	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	K 918		

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K 918	Continued From page 23 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 the facility failed to ensure that the generator for the Essential Electric System has a remote manual stop station of a type to prevent inadvertent or unintentional operation located outside the room housing the prime mover, where so installed, or elsewhere on the premises in accordance with NFPA 110, Life Safety Code, 2010 edition, Chapter 5.6.5.6. This deficient practice could affect the emergency responders that respond to the facility in case the power needs to be disconnected from the facility, patients/residents, visitors, and members of facility staff in this location.	K 918		

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K 918	Continued From page 24 Finding: Observation and Interview during a facility tour on 01/15/2025 from 11:00 AM to 4:30 PM identified: 1) The generator was not equipped with a remote shut off device outside the generator compartment. These findings were verified by the Maintenance Director at the time of observation on 01/15/2025.	K 918		
K 919 SS=D	Electrical Equipment - Other CFR(s): NFPA 101 Electrical Equipment - Other List in the REMARKS section any NFPA 99 Chapter 10, Electrical Equipment, requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 10 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the long term care facility failed to comply with NFPA 99, Healthcare Facilities Code, 2012 sections 10.5.2.7, 10.5.3.1, in 2 of 3 smoke compartments. Findings: Based on interview and documentation review on 01/13/2025, between the hours of 11:00 AM and 4:30 PM, this surveyor, accompanied with the Maintenance Director observed the following: 1. Two electric wheelchairs are being charged in	K 919		

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K 919	Continued From page 25 the dining room. The facility could not provide an manufactures instructions to provide if charging of the battery is a safety issue. The risk is the release of combustible and/or toxic gases. Batteries should also be charged with the guidelines set forth by the manufacturer's recommendations. 2. In the generator room there was a piece of conduit that was not connected to the junction box and electrical wires were exposed. The surveyor confirmed these findings with the Maintenance Director at the time of the observation.	K 919		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
K 293	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 observation and interview, the facility failed to ensure that illuminated exit signage in all locations are continuously illuminated to mark the means of egress in all aisles, passageways, corridors, and exit locations, and accesses are in accordance with NFPA 101, Life Safety Code, 2012 edition, Chapter 7.10.5.2, and NFPA 101, Life Safety Code, 2012 edition, 19.2.10. Finding: Observations and Interview during a facility tour on 01/13/2025 from 11 AM to 4:30 PM identified: 1) The illuminated exit sign by the main entrance/exit lobby was not illuminated. There was no indication that the sign was receiving AC power to charge the internal battery. Upon pushing the test button on the device, the sign remained unilluminated. This is not in accordance NFPA 101, Life Safety Code, 2012 edition, section 7.10.5.2 - Every sign that is required to be illuminated, shall be continuously illuminated. This failure occurred in 1 of 3 wings in the facility. This deficient practice could affect all residents, visitors, and members of facility staff in this location. This finding was verified by the Maintenance Director at the time of observation on 01/13/2025 between 11:00 AM and 4:30 PM.

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

The above isolated deficiencies pose no actual harm to the residents