STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205134	A. BUILDING 01 B. WING _____	08/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOSEPH'S REHABILITATION AND RESIDENCE	1133 WASHINGTON AVE PORTLAND, ME 04103

(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: 08/20/2024 St. Joseph Rehabilitation and Residence, a long-term care facility, was surveyed pursuant to the National Fire Protection Association 101 Life Safety Code, 2012 Edition as referenced in 42 CFR 483.90 (a - d) - Physical Environment and is not in substantial compliance.	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.	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 (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm 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 Findings: On August 20, 2024, between 9:00 AM and 3:00 PM, a surveyor, with the Director of Nursing	E 015		

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E 015	Continued From page 2 present observed the following: 1. The was no evidence in the emergency preparedness plan for medical and pharmaceutical supplies and how they would get replenished in the event they had to evacuate or shelter in place. The Director of Nursing provided a policy to me not a signed MOU. When I advised I need to see a signed MOU. She expressed frustration stating she is overwhelmed by this and the new building. She asked if I needed it right now, I advised we have been on site for the last 6 hours and requested this. If I do not physically see the documents that it will result in a tag. She stated you do what you have to do. 2. The was no evidence in the emergency preparedness plan for fuel to maintain the generator to run for more then the allotted time of fuel on site. The surveyor confirmed these findings with the Director of Nursing at the time of the observation.	E 015		
K 000	INITIAL COMMENTS Federal Recertification Survey Survey Date: 08/20/2024 St. Josephs Rehabilitation and Residence 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		
K 211 SS=F	Means of Egress - General CFR(s): NFPA 101	K 211		

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K 211	Continued From page 3 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the long-term care facility failed to maintain the aisles, passageways, corridors, exit discharges, exit locations, and accesses free of all obstructions to full use in case of emergency in 3 of 4 resident care wings per NFPA 101, Life Safety Code, 2012 Edition, Sections 19.2.1, and 7.1.10.1 Findings: On 08/20/2024 between 09:00 AM, and 3:00 PM a surveyor, with the Director of Facilities Management present, observed the following: 1. A chair was blocking the marked exit door at the end of the corridor in the A wing. 2. A 3 drawer non wheeled chest is stored in the corridor between resident rooms A13 and A15. 3. A 3 drawer non wheeled chest is stored in the corridor between resident rooms A19 and A21. 4. A chair is stored in the exit corridor that reduced the corridor width to 5' 8" by resident room A17. 5. A linen cart is stored in the corridor between resident rooms A17, and A19. 6. A chair is stored in the exit corridor between resident rooms A4 and A5 that reduced the corridor width to 5' 11".	K 211		

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K 211	Continued From page 4 7. A sphygmomanometer and a linen cart is stored is stored in the exit corridor between resident rooms A4, and A5. 8. A linen cart is stored in the exit corridor between resident rooms B13 and B15. 9. The marked exit discharge to the public way from the C wing dayroom has rotten boards on the ramp, missing handrails, and a 3-inch difference in the walking surfaces where the ramp meets the pavement. The lift to the threshold from the ramp is 6 inches with unstable planking. 10. A brown wheeled linen cart is stored in the exit corridor in the C wing by the blue bulletin board. 11. The paved exit discharge to the public way from wings B and E has a trip hazard crack greater than 1 inch between the smooth pavement and the rough pavement, and a round sunken portion of pavement that is pooling water that is approximately 9 inches in diameter and 3/4 inches deep. The surveyor confirmed these findings with the Director of Facilities Management at the time of the observation.	K 211		
K 222 SS=D	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used,	K 222		

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K 222	Continued From page 5 only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4	K 222		

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K 222	Continued From page 6 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 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 19.2.2.2.5.1, 19.2.2.2.6 for locking. Finding: Observations and Interviews during a facility tour with the Facilities Management Director present on 08/20/2024 from 09:00AM to 3:00 PM identified: 1. E2 wing exit door was locked and marked with delayed egress signage for 15 seconds. Pressed and held panic hardware for greater than 15 seconds and the door did not unlock. The inspector could not exit the building unless staff unlocked the door. Unable to verify if all staff had code to unlock door since wing is unstaffed. The surveyor confirmed this finding with the acting Director of Facilities Management at the time of the observation.	K 222		
K 321 SS=E	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure	K 321		

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K 321	Continued From page 7 Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the long-term care facility failed to maintain hazard areas in 3 of 4 resident care wings per NFPA 101, Life Safety Code, 2012 Edition, Sections 19.3.2.1. Findings: On 08/20/2024 between 09:00 AM, and 3:00 PM a surveyor, with the Director of Facilities	K 321		

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K 321	Continued From page 8 Management present, observed the following: 1. The Hospice suite was found to have half of the space being used as a combustible storage area, and the other half for residential space. There is not proper fire rated seperation between the storage and the residential space. The residential space is currently unoccupied. 2. The doors to the Hospice suite room that is now being used as storage do not self-close and positively latch as there is not self closing hardware attached to the doors. 3. The storage room in the connector wing (E11) has a foot peg installed that prevents the door from self-closing. The surveyor confirmed these findings with the Director of Facilities Management at the time of the observation.	K 321		
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or	K 324		

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K 324	Continued From page 9 * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on observation, the long-term care facility failed to properly install and maintain equipment protected by the kitchen hood extinguishing system NFPA Standard: NFPA 101, Life Safety Code (2012) Sections 19.3.2.5.2*, 9.2.3, NFPA Standard: NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations (2011) Sections 12.1.2.2*, 12.1.2.3, 12.1.2.3.1 Finding: Observations and Interviews during a facility tour with the Facilities Management Director present on 08/20/2024 from 09:00AM to 3:00 PM identified: 1. The wheeled, 6 burner gas-fired stove/oven located on the cooking line in the kitchen were not provided with an approved method that would ensure that the appliances were returned to an approved design location after they had been moved for maintenance and cleaning.	K 324		

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K 324	Continued From page 10 The surveyor confirmed this finding with the acting Director of Facilities Management at the time of the observation.	K 324		
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 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 interview, 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 Findings: Observations and Interviews during a facility tour with the Facilities Management Director present on 08/20/2024 from 09:00AM to 3:00 PM identified: 1. The facility had no documentation or was aware of the fire alarm system having been tested within the last 12 months. The Director of Facilities Management advised the former Director of Facilities Management retired in July 2024 and he is unsure where there paperwork is. 2. The facility had no documentation or was	K 345		

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K 345	Continued From page 11 aware of the fire alarm system ever being sensitivity tested in the past 5 years. The surveyor confirmed these findings with the acting Director of Facilities Management at the time of the observation.	K 345		
K 353 SS=F	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, interview, and inspection documentation review, the long term care facility failed to maintain the wet sprinkler system per NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Sections 5.2.1.1.1-4, 5.2.6, 6.2.3, and NFPA 101, Life Safety Code, 2012 Edition, Sections 19.3.5.1., 4.6.12, and	K 353		

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K 353	Continued From page 12 9.7.5. Findings: Observations and Interviews during a facility tour with the Facilities Management Director present on 08/20/2024 from 09:00 AM to 3:00 PM identified: 1. According to the most recent quarterly sprinkler inspection report and observation at the sprinkler riser the 5-year internal inspection is overdue on both wet risers and both dry risers. (07.18.2019). Call to sprinkler company confirmed this. 2. According to the most recent quarterly sprinkler inspection report and observation at the sprinkler riser the 5-year gauges inspection is overdue on both wet risers and both dry risers. (07.18.2019). Call to sprinkler company confirmed this. 3. The escutcheon ring is missing from the sprinkler head in the administrator's office. 4. There is red non-factory paint on the sprinkler head fusible link in the A-wing sprinkler room on the far left side. The surveyor confirmed these findings with the acting Director of Facilities Management at the time of the observation.	K 353		
K 355 SS=F	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	K 355		

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K 355	Continued From page 13 Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation, documentation review, and interview the facility failed to ensure portable fire extinguishers are installed and maintained in accordance with NFPA 101, Life Safety Code, 2012 edition, Sections 4.6.12, 9.7.4.1, and 19.3.5.12. in 2 of 3 housed resident wings and the service areas. Also reference NFPA 10, Standard for Portable Fire Extinguishers, 2010 edition, sections 5.5.5.3, 6.1.3.4, 6.1.3.8, 7.2.1.2, and 7.3.1.1. Findings: Observations and Interviews during a facility tour with the Facilities Management Director present on 08/20/2024 from 09:00AM to 3:00 PM identified: 1. The portable fire extinguisher in the D wing dayroom was last maintained in December of 2022 making it due for the next annual maintenance in 9 months ago in December of 2023. There are only 6 monthly inspections done on this extinguisher with the last monthly inspection of this extinguisher was in January of 2023. Portable Fire extinguishers shall be subjected to maintenance at intervals of not more than 1 year and inspected at least once per calendar month. 2. A placard shall be conspicuously placed near the class K extinguisher that states that the fire protection system shall be activated prior to using the portable fire extinguisher. Neither Class K portable fire	K 355		

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	205134	A. BUILDING 01 B. WING _____	08/20/2024

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K 355	Continued From page 14 extinguisher in the kitchen has a decal posted. 3. The red ABC extinguisher in the kitchen has no monthly inspections annotated on the attached tag for February, March, April, or May of 2023. 4. The red carbon dioxide extinguisher in the kitchen has no monthly inspections annotated on the attached tag for June or July of 2023. 5. The B wing breakroom fire extinguisher is resting on the floor. In no case shall the clearance between the bottom of the fire extinguisher and the floor be less than 4 inches. 6. The B wing physician's office portable fire extinguisher has no monthly inspections annotated on the attached tag for July of 2023. 7. The B wing salon portable fire extinguisher has no monthly inspections annotated on the attached tag for July of 2023. 8. The central supply portable fire extinguisher has no monthly inspections annotated on the attached tag for May, June, or July of 2023. 9. The C wing nurses station portable fire extinguisher has no monthly inspections annotated on the attached tag for June, or July of 2023. 10. The portable fire extinguisher at the end of the marked exit corridor by resident room C23 has no inspection tag attached to the extinguisher. The surveyor couldn't inspect the annual maintenance or the monthly inspections of this extinguisher, as no other inspection documentation could be provided.	K 355		

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K 355	Continued From page 15 11. The portable fire extinguisher at the C wing chat room has no inspection tag attached to the extinguisher. The surveyor couldn't inspect the annual maintenance or the monthly inspections of this extinguisher as no other inspection documentation could be provided. These findings were verified by the Facilities Management Director at the time of observation.	K 355		
K 363 SS=F	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	K 363		

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K 363	Continued From page 16 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, and interview the facility failed to maintain the corridor doors to close properly to resist the passage of smoke in accordance with NFPA 101, Life Safety Code, 2012 edition, 3.6.3 in 3 of 4 resident wings and the service areas. Interview with the Facilities Management Director revealed that the resident room doors are not looked at unless there is a staff complaint. Findings: Observations and Interviews during a facility tour with the Facilities Management Director present on 08/20/2024 from 09:00 AM to 3:00 PM identified: 1. Resident room A18 door rubs on the striker plate preventing it from fully closing and latching properly. 2. Resident room A14 door is delaminating at the top as well as the upper latch side. 3. Resident room B22 has the striker plate	K 363		

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K 363	Continued From page 17 opening in the door frame full of medical gloves that prevent the door latch from entering the opening in the striker plate on the door frame. 4. Resident room B18 door hits on the frame preventing it from closing and latching properly. 5. Resident room B16 door hits on the frame preventing it from closing and latching properly. 6. Resident room D6 door is delaminating on the hinge side. 7. Resident room D11 latch does not extend out of the door to penetrate the opening in the striker plate on the door frame. These findings were verified by the Facilities Management Director at the time of observation.	K 363		
K 374 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9	K 374		

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K 374	Continued From page 18 This REQUIREMENT is not met as evidenced by: Based on observation, and interview the facility failed to maintain the self closing requirement of cross-corridor smoke barrier doors per NFPA 101, Life Safety Code, 2012 edition, Section 19.3.7.8. Findings: Observations and Interviews during a facility tour with the Facilities Management Director present on 08/20/2024 from 09:00 AM to 3:00 PM identified: 1. The A wing 45 minute cross-corridor smoke barrier doors hit each other when they close which prevents them from fully closing and resisiting the passage of smoke. 2. The C wing 45 minute cross-corridor smoke barrier doors by resident rooms C9 and C11 hit at the top of the door frame when they close which prevents them from fully closing and resisiting the passage of smoke These findings were verified by the Facilities Management Director at the time of observation.	K 374		
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	K 712		

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K 712	Continued From page 19 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 observations and interview, this long-term care facility failed to ensure that fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift per NFPA 101, Life Safety Code, 2012 Edition, Section 19.7.1.6. Finding: Observations and Interviews during a facility tour with the Facilities Management Director present on 08/20/2024 from 09:00AM to 3:00 PM identified, confirmed that the following fire drill for the facility was not completed or missing: 1. The facility was unable to provide any documentation of fire drills performed over last 12 months. Director of Facilities Management states the former Director of Facilities Management (retired July 2024) had all the fire drill paperwork and is unsure where it is. The surveyor confirmed this finding with the Director of Facilities Management at the time of the observation and record review.	K 712		
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	K 918		

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K 918	Continued From page 20 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 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, interview, and record review, the long-term care facility failed to maintain the required documentation to indicate that the emergency generator was tested weekly and monthly per NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.4.4.1.1.3 and NFPA 110, Standard for Emergency and Standby	K 918		

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K 918	Continued From page 21 Power Systems, 2010 Edition, Section 8.4.1. Findings: Observations and Interviews during a facility tour with the Facilities Management Director present on 08/20/2024 from 09:00AM to 3:00 PM identified: 1. The weekly inspections for the generator were not provided. The Director of Facilities Management advised that the former Director of Facilities Management Chuck retired in July of 2024 and did not provide him with the documents. He stated that he has not performed a weekly generator inspection since taking over the role of Director of Facilities Management. 2. The monthly under load tests for the generator were not provided. The Director of Facilities Management advised that the former Director of Facilities ManagementChuck retired in July of 2024 and did not provide him with the documents. The surveyor confirmed these findings with the acting Director of Facilities Management at the time of the observation.	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)	K 919		

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K 919	Continued From page 22 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the long-term care facility failed to test and maintain multiple outlet connections in patient rooms NFPA 99, Healthcare Facilities Code, 2012 Edition, Sections 10.2.3.6 Findings: Observations and Interviews during a facility tour with the Facilities Management Director present on 08/20/2024 from 09:00AM to 3:00 PM identified: 1. Patient bedrooms multiple outlet connections that are not hospital grade and have no record of testing connection. The Director of Facilities Management stated he changes the outlets every year, he has no record that the outlets are hospital grade and when they were replaced. 2. Patient room C14 was missing outlet cover. This was corrected immediately when identified. 3. Rooms throughout the facility have air conditioning units plugged into multiple outlet connections. The surveyor confirmed these findings with the Director of Facilities Management at the time of the observation and record review.	K 919		
K 923 SS=E	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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K 923	Continued From page 23 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, and interview the facility failed to maintain the oxygen cylinder storage areas per NFPA 99, Health Care Facilities Code, 2012 edition, sections 11.3, and 11.6.5.	K 923		

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K 923	Continued From page 24 Findings: Observations and Interviews during a facility tour with the Facilities Management Director present on 08/20/2024 from 09:00 AM to 3:00 PM identified: 1. The oxygen storage area in the E2 wing does not have signage inside the room to segregate full from empty cylinders to avoid confusion and delay if a full cylinder is needed in a rapid manner. 2. The oxygen storage area in the E2 wing is lacking 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." displayed on the door. Currently there is just a label of a cylinder on the door of the oxygen room. 3. Oxidizing gases are not separated from combustibles by 5 feet. Rooms containing more than 300 cubic feet of oxygen shall not have combustible storage or materials within 5 feet of the cylinders. 4. The oxygen door was not locked. The door was not secured to prevent unauthorized entry. 5. The oxygen storage room in the nurse's station in the B wing was held open, and not secured to prevent unauthorized entry. These findings were verified by the Facilities Management Director at the time of observation.	K 923		