State of Maine
Department of Public Safety
Office of Fire Marshal
52 State House Station
Augusta, ME 04333-0052

JANET T. MILLS
GOVERNOR

MICHAEL SAUSCHUCK
COMMISIONER

RICHARD MCCARTHY
STATE FIRE MARSHAL

October 12, 2023

Orchard Park Rehab & Living
Attn: Theresa Riley, Administrator
107 Orchard St
Farmington, ME 04938

Provider ID#: 205168
Facility ID#: 0702
Event ID#: XUOF21

Administrator Riley,

On **October 11, 2023**, the Office of the Fire Marshal conducted a Life Safety Code and Emergency Preparedness survey to determine if your facility complies with Federal participation requirements for nursing facilities in the Medicare and/or Medicaid program (In which you will be receiving a Form CMS-2567 for Life Safety Code and Emergency Preparedness). Your facility was found not to be in substantial compliance with the participation requirements for Life Safety Code only.

The Federal regulatory requirements referenced in this letter are found in Title 42, Code of Federal Regulations (CFR) and in the National Fire Protection Association (NFPA)101 Life Safety Code Standard, 2012 Edition.

PLAN OF CORRECTION

Attached is Form CMS-2567 "Statement of Deficiencies" which enumerates the deficiencies found as a result of the survey. A Plan of Correction (POC) must be submitted by the **tenth (10th) calendar day** from your receipt of this letter. **Please note that a POC is not needed for isolated deficiencies which cause no harm (S/S of A).** Your POC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- **Include dates when corrective action will be completed**. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility;

- Include documentation to support a waiver request (if appropriate).

You are required to record your plan of correction in the appropriate column on the enclosed Form(s) CMS-2567. **Sign, date, and indicate your title in the blocks provided on page one.** Return the forms(s) with the POC to **State of Maine, Department of Public Safety, Office of State Fire Marshal, 45 Commerce Drive, 52 State House Station, Augusta, ME 04330-0052**.

Remedies will be recommended for imposition by the Centers for Medicare & Medicaid Services (CMS) Regional Office if your facility has failed to achieve substantial compliance by **November 26, 2023,** (Opportunity to Correct). Informal dispute resolution for the cited deficiencies will not delay the imposition of the recommended enforcement actions. A change in the seriousness of the noncompliance may result in a change in the remedy selected. When this occurs, you will be advised of any change in remedy.

RECOMMENDED REMEDIES

Based on the deficiencies cited during the Life Safety Code and Emergency Preparedness Survey of **October 11, 2023**, we are recommending to CMS the imposition of the following remedy(ies):

A Civil Monetary Penalty per day to be determined by CMS.

Directed Plan of Correction (DPOC) effective immediately. The State Agency directs the plan of correction noted on the attached CMS-2567 for deficiencies K271(SS=D), K321(SS=D), K761(SS=F), K911(SS=D) & K923(SS=D) (Tags). [42 CFR 488.424]

If you do not achieve substantial compliance by **January 10, 2024,** the CMS Regional Office or State Medicaid Agency must deny payments for new (Medicare/Medicaid) admissions. In addition, we may recommend that **termination of your provider agreement be effective on April 10, 2024,** if substantial compliance is not achieved by that time. [42 CFR 488.456]. **Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination**.

ALLEGATION OF COMPLIANCE

The Plan of Correction will serve as your allegation of compliance until substantiated by a revisit or other means. If upon revisit your facility has not achieved substantial compliance, recommended remedies may be imposed as determined by the CMS Regional Office and continue until substantial compliance is achieved. Additionally, CMS Regional Office may impose revised/additional remedies, if appropriate.

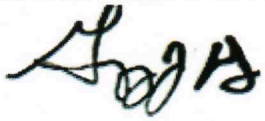
INFORMAL DISPUTE RESOLUTION

In accordance with 42 Code of Federal Regulations §488.331, you have one opportunity to question cited deficiencies through an IDR process. You may also contest scope and severity assessments for deficiencies, which may have resulted in a finding of substandard quality of care (SQC) or immediate jeopardy. To be given such an opportunity, you are required to send your written request, along with the specific deficiencies (or why you are disputing the scope and severity assessments of deficiencies which have been found to constitute SQC or immediate jeopardy) to **Asst. Fire Marshal Gregory J. Day** at the address below. This request must be sent during the same 10 calendar days you have for submitting a POC for the cited deficiencies. An incomplete IDR process will not delay the effective date of any enforcement action. IDR in no way is to be construed as a formal evidentiary hearing. It is an informal administrative process to discuss deficiencies. If counsel will accompany you, you must indicate this in your request for IDR so that we may also have counsel present.

Please email back the plan of correction to: FMOHealthcare@maine.gov..

If you have any questions, please contact me at (207) 626-3880.

Yours for Better Fire Prevention,



Gregory J. Day
Assistant State Fire Marshal

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205168	A. BUILDING 01 B. WING _____	10/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ORCHARD PARK REHAB & LIVING	107 ORCHARD ST FARMINGTON, ME 04938

(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 Dates: 10/11/2023 Orchard Park Rehab & Living Center, a long-term care facility, is in substantial compliance with 42 Code of Federal Regulations Part 483.73 Requirement for Long Term Care Facilities Emergency Preparedness.	E 000		
K 000	INITIAL COMMENTS 10/11/2023 Orchard Park Rehab and Living Center, 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.	K 000		
K 271 SS=D	Discharge from Exits CFR(s): NFPA 101 Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the long-term care facility failed to maintain all egress paths level, slip resistant and clear of obstructions per NFPA 101, Life Safety Code, 2012 Edition, Sections 7.1.6, 7.1.7, and 7.7 Finding:	K 271		

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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K 271	Continued From page 1 On 10/11/2023, between 10:00 AM and 13:30 PM, a surveyor, with the Maintenance Director present, observed the following: 1. The exit pathway from the service exit to the public way has portions of pavement missing with the abrupt changes in elevation exceeding 1/2 inch. The surveyor confirmed this finding with the Maintenance Director at the time of the observation.	K 271		
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet)	K 321		

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K 321	Continued From page 2 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, on 10/11/2023 between 10:00 AM and 13:30 PM, the long-term care facility failed to ensure that hazardous areas were safeguarded in accordance with NFPA 101, Life Safety Code, section 19.3.2.1 in one hazardous areas of 10 hazardous areas inspected in the facility. The doors in hazard areas shall self close and latch as part of their fire rating assembly. Finding: 1. The soiled linen closet door hits the frame on the top latch side, not allowing it to self close and positively latch upon release. This finding was confirmed with the Maintenance Director present at the time of the observation.	K 321		
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	K 761		

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K 761	Continued From page 3 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 observation, document review, and interview, on 10/11/2023 between 10:00 AM and 13:30 PM, the long-term care facility failed to inspect and test fire door assemblies in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives, 2010 edition, section 5.2.1. Fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ by a certified person. NFPA 101 LSC 2012 edition sections, 19.7.6, 4.6.12 Findings: 1. The facility did not have a record of annual inspection of the fire doors completed by a certified person. The most recent door inspections were conducted on 02/10/2023, but the inspector wasn't certified. The last inspection before was 09/22/2022 by a certified inspector. 2. The 90-minute fire-rated doors in Cortland Wing are not equipped with floor strikes for the latching device at the bottom of the doors. These findings were confirmed with the Maintenance Director present at the time of the observation.	K 761		

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K 911 SS=D	Electrical Systems - Other CFR(s): NFPA 101 Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems 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 6 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the long-term care facility failed to equip the generator with an emergency stop device outside the generator enclosure per NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, section 5.6.5.6, and NFPA 99, Health Care Facilities Code, 2012 edition, Section 6.4.1.1. Finding: On October 11, 2023, between 10:00 AM and 1:30 PM, a surveyor, with the Maintenance Director present, observed the following: 1. The only generator remote emergency stop station/device is inside the generator enclosure/housing. There is no labeled remote emergency stop station/device elsewhere. The surveyor confirmed this finding with the Maintenance Director at the time of the observation.	K 911		
K 923 SS=D	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage	K 923		

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K 923	Continued From page 5 Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and 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 long-term care facility failed to maintain Gas	K 923		

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K 923	Continued From page 6 Equipment - Cylinder and Container Storage per NFPA 99, Healthcare Facilities Code, 2012 Edition, Section 11.3.1, 11.3.2, 11.3.3, 11.6.5.2 On October 11, 2023, between 10:00 AM and 1:30 PM, the surveyors, with the Maintenance Director, observed the following: Findings: 1. Oxygen storage closet in August Wing physical therapy room has oxygen storage greater than 300 cubic feet. Observation at time of inspection was 16 E cylinders totaling 384 cubic feet. a. The oxygen storage is not located in a 1-hour fire-rated room. b. There is no markings designating and separating tanks whether they are full or empty. c. The oxygen storage is stored within 5 ft of combustible storage. 2. Oxygen tanks were not segregated full cylinders from empty cylinders. The surveyor confirmed these findings with the Maintenance Director at the time of the observation.	K 923		