STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205053	A. BUILDING 01 RECEIVED FEB 07 2024 B. WING	01/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S D'YOUVILLE PAVILION	102 CAMPUS AVE BY LEWISTON, ME 04240

(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: 01.23.24 & 01.24.24 St. Mary's D'Youville Pavilion, 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 004 SS=D	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.542(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness	E 004		3/1/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Phyllis D. Hickey | TITLE: President NHA | (X6) DATE: 2/6/2024

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 004	Continued From page 1 requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the long-term care facility failed to conduct the annual review of the Emergency Preparedness Plan in accordance with 42 CFR §483.73(a). Finding: On January 24, 2024, between 9:00 AM and 11:30 AM, a surveyor, with the Maintenance Director present, observed the following: 1. The annual review of the emergency preparedness plan had not been reviewed since 2022. The surveyor confirmed this finding with the Maintenance Director at the time of the observation.	E 004		

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K 000	Continued From page 2	K 000		
K 000	INITIAL COMMENTS	K 000		
	Federal Recertification Survey: Survey Dates: 01.23/24 & 01.24.24 St. Mary's D'Youville Pavilion, a Long Term Care Facility, was surveyed to the National Fire Protection Association 101 Life Safety Code 2012 Edition as reference on 42 CFR 483.90 (a-d) physical environment and is not in substantial compliance.			
K 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 7.7 Finding: On 01.23.2024, between 9:30 AM and 2:00 PM, a surveyor, with the Maintenance Director and QAPI Manager present, observed the following: 1. The exit pathway serving stairwell C does not discharge to the public way.	K 271		5/31/24

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K 271	Continued From page 3 The surveyor confirmed this finding with the Maintenance Director and QAPI Manager at the time of the observation.	K 271		
K 311 SS=D	Vertical Openings - Enclosure CFR(s): NFPA 101 Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the long-term care facility failed to maintain the stairwell enclosure in the West Wing dining area to the outside yard to a minimum 1-hour fire resistance per NFPA 101, Life Safety Code, 2012 Edition, Sections 8.3.4.2, and 19.3.1.1, NFPA 80 Standard for Fire Doors and Other Opening Protectives, 2010 Edition, Section 6.3.1.7.1 Finding: On 01.23.2024, between 9:30 AM and 2:00 PM, a surveyor, with the Maintenance Director and QAPI Manager present, observed the following: 1. The 60-minute fire door protecting the stairwell	K 311		6/30/24

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RECEIVED FEB 07 2024 BY:

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K 311	Continued From page 4 B on the second floor does not self-close and positively latch when released from 90 degree opening. The surveyor confirmed this finding with the Maintenance Director and QAPI Manager at the time of the observation.	K 311		
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) 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	K 321		6/30/24

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K 321	Continued From page 5 Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the long-term care facility failed to ensure all hazard areas are constructed to meet a 1-hour fire-rated assembly with all fire-rated doors positively latching per NFPA 101, Life Safety Code, 2012 Edition, Section 19.3.2.1. Finding: On 01/23/2024, between 09:30 AM and 2:00 PM, a surveyor, with the D'Youville Manager of QAPI present, observed the following: 1. The 90-minute door to the dry food storage room by the employee time clock was held open with a wooden wedge on the floor. When the wedge was removed, the door wouldn't fit inside the frame. The door was damaged on the spine, and the top/latch side of the door hit the front of the frame, not allowing it to self-close and positively latch. The surveyor confirmed this finding with the D'Youville Manager of QAPI and the maintenance manager at the time of the observation.	K 321		
K 342 SS=F	Fire Alarm System - Initiation CFR(s): NFPA 101 Fire Alarm System - Initiation Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system. Manual alarm boxes are provided in the path of egress near each required exit. Manual alarm boxes in patient sleeping areas shall not be	K 342		2/1/24

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K 342	Continued From page 6 required at exits if manual alarm boxes are located at all nurse's stations or other continuously attended staff location, provided alarm boxes are visible, continuously accessible, and 200' travel distance is not exceeded. 18.3.4.2.1, 18.3.4.2.2, 19.3.4.2.1, 19.3.4.2.2, 9.6.2.5 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the long-term care facility failed to ensure all fire alarm detection devices are serviceable per NFPA 101, Life Safety Code, 2012 Edition, Section 19.3.4.2., and 9.6.2.5. Finding: On 01/23/2024, between 09:30 AM and 2:00 PM, a surveyor, with the D'Youville Manager of QAPI, and the maintenance manager present observed the following: 1. According to the display on the Fire Alarm Control Unit in the main lobby, the fire alarm is in trouble mode showing a 2nd floor detector mismatch. Upon interview with the QAPI manager and the maintenance manager, the deficiency occurred three weeks ago from resident activations, and the alarm company should be on site by the end of next week to reset the alarm system. (February 2nd, 2023). The remote annunciator panels in the Nurse's stations show "ground fault" on the screens. The surveyor confirmed this finding with the D'Youville Manager of QAPI and the maintenance manager at the time of the observation.	K 342		
K 351 SS=D	Sprinkler System - Installation	K 351		1/30/24

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K 351	Continued From page 7 CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the long-term care facility failed to maintain the required ceiling assembly for a sprinkler protected facility per NFPA 13, Standard for the Installation of Sprinkler Systems, 2010 Edition, Section 8.6.4.1.1 and NFPA 101, Life Safety Code, 2012 Edition, Section 19.3.5.1. Finding: On 01/23/2024, between 09:30 AM and 2:00 PM, a surveyor, with the D'Youville Manager of QAPI, and the maintenance manager present, observed the following: 1. The main lobby by the fire alarm control unit	K 351		

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K 351	Continued From page 8 has two ceiling tiles out of place. The surveyor confirmed this finding with the D'Youville Manager of QAPI, and maintenance manager at the time of the observation.	K 351		
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 documentation review, observation, and interview, the long-term care facility failed to maintain the sprinkler system per, NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems, 2011 Edition, Sections 5.2.1.1.1, 6.3.2.1, 13.8.1 and NFPA 101, Life Safety Code, 2012 Edition, Section 9.7.5.	K 353		4/1/24

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K 353	Continued From page 9 Findings: On 01/23/2024, between 09:30 AM and 2:00 PM, a surveyor, with the D'Youville maintenance manager present, observed the following: 1. The hydrostatic test for the fire department connection is due every 5 years, and the most recent completion is 11/10/18, making it due in November of 2023. 2. The sprinkler heads show loading of foreign material in the laundry room. 3. The sprinkler heads show loading of foreign material in the corridor between rooms 403, and 413. 4. The sprinkler heads show loading of foreign material in the Nurses station in 4 East, and 3 East, and 2 West. The surveyor confirmed these findings with the maintenance manager at the time of the observation.	K 353		
K 374 SS=D	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	K 374		5/31/24

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K 374	Continued From page 10 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 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the long-term care facility failed to ensure that the smoke barrier doors self-closed and positively latched per NFPA 101, Life Safety Code, 2012 Edition, Sections 19.3.7.8. and NFPA 80, 2010 Edition, Standard for Fire Doors and Other Opening Protectives, Sections 5.2.3.5.2(6) and 6.3.1.7.2 Findings: On 01.23.2024, between 9:30 AM and 2:00 PM, a surveyor, with the Maintenance Director and QAPI Manager present, observed the following: 1. The 1 hr. cross corridor smoke barrier door closest to Room 415, didn't latch at the top or the bottom. 2. The 1 hr. cross corridor smoke barrier door closest to Room 445 - didn't latch at the top or the bottom.. 3. The 1 hr. cross corridor smoke barrier door closest to Room 345 - didn't latch at the top or the bottom. 4. The 1 hr. cross corridor smoke barrier door closest to Room 244 - didn't latch at the top or bottom. The surveyor confirmed these findings with the Maintenance Director and QAPI Manager at the time of the observation.	K 374		
K 511 SS=D	Utilities - Gas and Electric	K 511		2/1/24

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K 511	Continued From page 11 CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the long-term care facility was drying mops and rags in the dryer, which is prohibited per NFPA 101, Life Safety Code, 2012 Edition, Sections 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Finding: On 01.23.2024, between 9:30 AM and 2:00 PM, a surveyor, with the Maintenance Director and QAPI Manager present, observed the following: 1. The facility was drying mop heads and cleaning rags in the dryer after washing them, this deficient practice could affect residents, guest and staff if this practice lead to the rags or mops catching fire while in the dryer. The surveyor confirmed this finding with the Maintenance Director and QAPI Manager at the time of the observation.	K 511		
K 541 SS=F	Rubbish Chutes, Incinerators, and Laundry Chu	K 541		4/1/24

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K 541	Continued From page 12 CFR(s): NFPA 101 Rubbish Chutes, Incinerators, and Laundry Chutes 2012 EXISTING (1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor shall be sealed by fire resistive construction to prevent further use or shall be provided with a fire door assembly having a fire protection rating of 1-hour. All new chutes shall comply with 9.5. (2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, shall be provided with automatic extinguishing protection in accordance with 9.7. (3) Any trash chute shall discharge into a trash collection room used for no other purpose and protected in accordance with 8.4. (Existing laundry chutes permitted to discharge into same room are protected by automatic sprinklers in accordance with 19.3.5.9 or 19.3.5.7.) (4) Existing fuel-fed incinerators shall be sealed by fire resistive construction to prevent further use. 19.5.4, 9.5, 8.4, NFPA 82 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the long-term care facility failed to maintain 1-hour protection rating of laundry chute per NFPA 101, Life Safety Code, 2012 Edition, Sections 19.5.4, 9.5, 8.4 NFPA 82 On 01.23.2024, between 9:30 AM and 2:00 PM, a surveyor, with the Maintenance Director and QAPI Manager present, observed the following: Findings:	K 541		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S D'YOUVILLE PAVILION	102 CAMPUS AVE LEWISTON, ME 04240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 541	Continued From page 13 1. Third floor laundry chute door did not self-close and positively latch when door was released. 2. Second floor laundry chute door did not positively latch when door was released. Latch handle is broken, and latch is duct taped to not allow door to latch. The surveyor confirmed these findings with the Maintenance Director and QAPI Manager at the time of the observation.	K 541		
K 712 SS=D	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on observations and interview, the 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:	K 712		2/1/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205053	A. BUILDING 01 B. WING	01/24/2024

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FEB 07 2024
BY

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S D'YOUVILLE PAVILION	102 CAMPUS AVE LEWISTON, ME 04240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 712	Continued From page 14 On January 24, 2024, between 9:00 AM and 11:30 AM, a surveyor, with the Maintenance Director present. 1. The following fire drills for the facility were not completed or missing: A. Third shift drill during the 3rd quarter of 2023. The surveyor confirmed this finding with the Maintenance Director at the time of the observation and record review.	K 712		
K 902 SS=D	Gas and Vacuum Piped Systems - Other CFR(s): NFPA 101 Gas and Vacuum Piped Systems - Other List in the REMARKS section any NFPA 99 Chapter 5 Gas and Vacuum 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 5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the Long-term care facility failed to provide documentation to indicate outstanding items in the February 1, 2023 medical gas inspection report had been remedied or scheduled for repair per NFPA 99, Health Care Facilities Code, 2012 Edition, Chapters 5. Findings: On January 24, 2024, between 9:00 AM and 11:30 AM, a surveyor, with the Maintenance	K 902		3/1/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205053	A. BUILDING 01 _____ B. WING _____ BY: _____	01/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S D'YOUVILLE PAVILION	102 CAMPUS AVE LEWISTON, ME 04240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 902	Continued From page 15 Director present, observed the following: The medical gas inspection report from William G. Frank Medical Gas Testing & Consulting, LLC. completed on February 1, 2023, indicates the following outstanding Maintenance and Compliance Deficiencies: MAINTENANCE DEFICIENCIES Surgical Services 1. Room 101 Oxygen outlet leaks with adapter attachment. 2. Room 102 Oxygen outlet leaks with adapter attachment. 3. Room 105 Oxygen outlet leaks with adapter attachment. The surveyor confirmed these findings with the Maintenance Director at the time of the observation.	K 902		
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36	K 918		3/1/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205053	A. BUILDING 01 B. WING	01/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S D'YOUVILLE PAVILION	102 CAMPUS AVE LEWISTON, ME 04240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 918	Continued From page 16 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 observations and interview, the facility failed to ensure that the generator had proper maintenance records and was being exercised in accordance with the auxiliary generator power per NFPA 99, (2012) 6.4.4, 6.5.4, 6.6.4, NFPA 110, NFPA 111, NFPA 70 700.10 Findings: On January 24, 2024, between hours of 9:00 AM and 11:30 AM. this surveyor accompanied with the Maintenance Director did observe the following: 1. No generator records were on file showing the generator was ran December 2023 exercise and also ran under load to ensure the generator	K 918		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205053	A. BUILDING 01 RECEIVED B. WING FEB 07 2024	01/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S D'YOUVILLE PAVILION	102 CAMPUS AVE BY: LEWISTON, ME 04240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 918	Continued From page 17 is exercised. The facility failed to have on file or show the following, Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. 2. No generator records were on file showing the generator was run weekly after November 1, 2023. The surveyor confirmed these observations with the Maintenance Director at the time of the observation.	K 918		

K353

High Tech Fire Protection

PO Box 156
Minot, ME 04258

Proposal

Date	Proposal #
1/30/2024	8211

Name / Address
St. Mary's Regional Medical Center C/O St. Joseph Hospital Attn: Accounts Payable Dept. 172 Kinsley St. Nashua, NH 03060

RECEIVED
FEB 07 2024
BY:

Project
102 Campus Ave. - D'Youville Pavilion

Description

(1) Labor and material for Technician to perform a 5 Year Assessment of the Internal Condition of Piping of the fire sprinkler system in Accordance with NFPA 25, 2017, 14.2.1.1, which includes changing gauges (NFPA 25, 2017, 13.2.7.2). A report will be provided upon completion.

CODE REFERENCE:
*14.2 Assessment of Internal Piping Condition
*14.2.1.1 An assessment of the internal condition of piping shall be conducted at a minimum of every 5 years or in accordance with 14.2.1.2 for the purpose of inspecting for the presence of foreign organic and inorganic material.
*13.2.7 Gauges
*13.2.7.2 Gauges shall be replaced every 5 years or tested every 5 years by comparison with a calibrated gauge.

(2) Technician to perform a 5 Year Hydrostatic Test of (2) two Fire Department Connection (FDC) in accordance with NFPA 25, 2017, 13.8.5. (*one at front of building and one at rear of building*)

CODE REFERENCE:
*13.8 Fire Department Connections
13.8.5 The piping from the fire department connection to the fire department check valve shall be hydrostatically tested at 150 psi (10 bar) for 2 hours at least once every 5 years.

(3) Technician to inspect Valve Body in accordance with NFPA 25, 2017 (Table 13.1.1.2)

Code Reference:
*13.4.1.2 Alarm valves and their associated strainers, filters and restriction orifices shall be inspected internally every 5 years unless tests indicate a greater frequency is necessary.
*13.4.2.1 Valves shall be inspected internally every 5 years to verify that all valve components operate correctly.
*14.3.2.2 Internal examination shall be performed at the System valve

Proposal Amount

If you do NOT wish to accept this Proposal, please check the box at the right, sign & date, then return to HTFP. ☐

Signature & Title

Phone #	Fax #
207-998-2551	207-998-4187

If you have any questions concerning this proposal, please contact Amie Bixby in our office. Abixby@htfp.me

K353

High Tech Fire Protection

PO Box 156
Minot, ME 04258

Proposal

Date	Proposal #
1/30/2024	8211

Name / Address
St. Mary's Regional Medical Center C/O St. Joseph Hospital Attn: Accounts Payable Dept. 172 Kinsley St. Nashua, NH 03060

RECEIVED
FEB 07 2024
BY:

Project
102 Campus Ave. - D'Youville Pavilion

Description
This work to be performed during normal working hours. PLEASE NOTE: THIS PROPOSAL ADDRESSES THE MOST COMMON 5 YEAR ITEMS ON FIRE SPRINKLER SYSTEMS. THERE MAY BE ADDITIONAL ITEMS DUE ON YOUR SYSTEM THAT ARE NOT INCLUDED IN THIS PROPOSAL. NOTE: To identify ownership responsibility, we recommend that the system owner/authorized representative have a copy of NFPA 25 Standards/Regulations Handbook in possession for review of any and all related Fire Sprinkler requirements. THIS PROPOSAL IS GOOD FOR 30 DAYS FROM THE ABOVE DATE. Please SIGN, DATE and RETURN immediately if you accept our proposal. We will not schedule this scope of work until we have a signed proposal in our file.

Proposal Amount $1,607.00

If you do NOT wish to accept this Proposal, please check the box at the right, sign & date, then return to HTFP. ☐

Signature & Title

Date

Phone #	Fax #
207-998-2551	207-998-4187

If you have any questions concerning this proposal, please contact Amie Bixby in our office. Abixby@htfp.me

K353

COVENANT HEALTH

Our Name is Our Promise

PO Number: 630124-466919
PO Date: 02/01/2024

Vendor:	Ship To:	Bill To:
HIGH TECH FIRE PROTECTION PO BOX 156 MINOT,ME 04258 Phone:207-998-2551 AIME BIXBY Fax:	**ST MARYS REG MED CTR - RECEIVING** **318 SABATTUS ST** LEWISTON, ME 04240 **GLN:** Phone: 207-777-8659 Fax: 207-777-8864	**ACCOUNTS PAYABLE SML** **172 KINSLEY STREET** PO BOX 2013 NASHUA, NH 03060 Phone: 603-882-3000 Fax: 603-579-5698

Terms & Conditions : Note to Vendor:
If shipping charges contractually apply, ship via FedEx account #477693644, FOB Destination. Insert our PO# in recipient 2nd address field. If combined shipping weight exceeds 150lbs, call 888-457-5851 for carrier instructions prior to shipping.

*Please E-Mail or Fax confirmation to 207-777-8864.
LORI M CLOUTIER

lcloutier1@covh.org

1. Include in ALL shipments a packing slip showing contents and PO #.
2. Show PO # on all invoices, packages, shipping papers and correspondence.
3. Purchase order is subject to all terms and conditions as provided to the vendor.
4. Vendor certifies that it is not debarred, excluded or otherwise ineligible for participation in federally funded healthcare programs.

71904194200

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FEB 07 2024
BY:

Print Date: 02/01/2024 3:36PM

COVENANT HEALTH

Our Name is Our Promise

PO Number: 630124-466919
PO Date: 02/01/2024

Vendor:	Ship To:	Bill To:
HIGH TECH FIRE PROTECTION PO BOX 156 MINOT,ME 04258 Phone:207-998-2551 AIME BIXBY Fax:	**ST MARYS REG MED CTR - RECEIVING** **318 SABATTUS ST** LEWISTON, ME 04240 **GLN:** Phone: 207-777-8659 Fax: 207-777-8864	**ACCOUNTS PAYABLE SML** **172 KINSLEY STREET** PO BOX 2013 NASHUA, NH 03060 Phone: 603-882-3000 Fax: 603-579-5698

Vendor Code: HTECH
PO Type: GEN
PO Status: Draft
Customer No:

Comment:

Composed By: LORI M CLOUTIER
Terms: INV NET 1
FOB:
Delivery Date:
Tax ID Number: 01-0211551

Line Modified	Vendor Catalog GTIN	Order Quantity	Mfr Catalog Contract	Charge Dept. Sub-Ledger	Project Sub-Project	Price Discount List Price	Ext. Price Tax Ext Price w/ Tax
Item: [non-catalog]		INSPECTION AND REPAIR OF SPRINKLER SYSTEM					
1		1 EA		6301-87650-635900		$1,607.00	$1,607.00 $0 $1,607.00

PO Sub Total:	$1,607.00	Tax Total:	$0	Purchase Order Total:	$1,607.00

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FEB 07 2024
BY: _____

Signature(s): _____ _____

Print Date: 02/01/2024 3:36PM

BRAND SERVICES
LIFE SAFETY COMPLIANCE & ACCREDITATION

K 311
K 321
K 541
K 374

February 2, 2022

Job #: JC23-C-4402

RECEIVED
FEB 07 2024
BY:

Teague Adams
St. Mary's Regional D'Youville Pavilion
102 Campus Ave
Lewiston, ME 04240
tadams3@covh.org | (207) 440 5912

LOCATION: ST. MARYS REGIONAL D'YOUVILLE PAVILION | 102 CAMPUS AVE, LEWISTON, ME 04240

FIRE & SMOKE DOOR REPAIR SERVICES

We appreciate the opportunity to offer BRAND's **Door Fire & Smoke Door Repair** Services. BRAND's Door services incorporate all State, Local, CMS, NFPA 80, and 101 criteria, as well as Joint Commission standards and requirements. Our standard complement of services includes Fire/Smoke Door and Damper inspections, testing, repairs, replacements, Firestopping, Fireproofing, Rate Barrier wall upgrades and extensions, SOC and PFI management, and general facility maintenance. BRAND's documentation program is designed to support AHJ and Joint Commission inspection and reporting requirements. Note: BRAND does not use consultants; our in-house personnel provide all services.

SCOPE OF SERVICES: Replace the below identified doors with hollow metal steel doors.:
FD1-6; FD1-10; FD1-14; FD2-7; FD2-4; FD2-5; FD2-3; FD2-2; FD3-3

COST: $ 62,300.00
Note conditions 14 - 18

CONDITIONS & EXCEPTIONS:

1. **Work will not commence until this proposal is signed, the Billing Information is filled out, and the purchase order has been received.**
2. Any changes to the scope of work will require a written change request. The new work will not be performed until all written change request(s) are approved with signature and/or purchase order number.
3. There will be no work stoppages due to circumstances beyond the BRAND's control.
4. It is assumed that all doors cited for missing labels are of suitable construction to be recertified. If, during the recertification process, it is determined that the door is not constructed properly, a quote to replace the door will be provided.
5. Doors cited for excessive gaps- BRAND will attempt to shim the doors into compliance. If the shimming is unsuccessful, a price to replace the door will be provided.
6. If double doors are cited for rubbing/gaps at the meeting edge, it is assumed they can be shimmed into compliance. If the frame needs to be adjusted, pricing will be provided.
7. It is assumed if a door is cited for adjustments, BRAND will be able to adjust the hardware properly. If it is impossible, a new hardware quote will be provided.
8. Painting and/or staining of wood doors is to be provided by others.
9. Any doors requiring a factory stain will require customers to sign off accepting the color selected.
10. BRAND does not perform electrical tie-ins; we will mount devices only.
11. Others shall provide a dumpster to dispose of old doors. If a dumpster is unavailable and the door needs to be removed from the facility, BRAND has a $250 fee per door(s) to dispose of properly.
12. When new frames are installed, the adjacent walls may be scratched, and others shall repair the walls.

13. All work locations must be accessible. Additional fees will apply if areas are inaccessible, causing BRAND a delay or additional work to access.
14. A 50% deposit is required to order the doors. Typical material lead time is a minimum of 2/3 weeks. **Wood doors may be up to 6-8 weeks.**
15. Work will be scheduled once the doors are received.
16. Final billing will occur on the last day of the project.
17. **The payment terms are Due Upon Receipt of the invoice date.** BRAND reserves the right to charge 1.5% on all late invoices.
18. BRAND's price does not include sales tax. **If you are a tax-exempt facility, BRAND must receive the tax-exempt certificate with this signed proposal or purchase order, or all invoices will include taxes.**
19. Travel time is part of the workday.
20. A $4.50 shift differential is charged for scheduled back-shift work.
21. Medical Screening, vaccinations, badging, and background check costs are not included and will be billed at cost.
22. Additional insurance requirements beyond BRAND's coverage will be billed at cost.
23. The owner is responsible for all permits.
24. A door wrap-around is non-compliant hardware and must be removed. If the door is non-compliant without the wrap-around, a quote for a new door will be provided.
25. All documentation will be released within five business days of receiving the final payment.
26. BRAND's price is based on the owner providing current and accurate Life Safety drawings/plans. If BRAND is provided with inaccurate, incomplete, outdated, or no Life Safety drawings/plans, and BRAND is required to return to the facility due to issues that arise from the plans provided (or no plans), there will be an additional charge for a return to the facility.
27. Pricing is only good for 60 days from the date of this proposal. After 60 days, doors will need to be re-inspected to determine if there is further damage.
28. For T&M projects – due to rising materials costs, BRAND will evaluate and adjust the current material pricing on a bi-annual basis. Customers will receive notice in writing within 30 days if there is a pricing increase.
29. All reports shall be provided in a digital format, and hard copies will be charged $1 per page.

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FEB 07 2024
BY:

2

We appreciate having the opportunity to offer our services. If you have questions or require additional details, please give us a call.

Sincerely
John Coughlin
John Coughlin
Facility Services Manager
860.388.7494
JCoughlin@BRAND-svc.com
Job#: JC23-C-4402

Customer Approval:

Printed Name: _____ **Date:** _____

Signature: _____ **Purchase Order #:** _____

WORK WILL NOT START WITH OUT A PURCHASE ORDER NUMBER & BILLING INFO. FILLED OUT BELOW

Accounts Payable (Billing) Information:

Invoice should be: Emailed ◯ Mailed ◯

AP Contact:		**Phone:**	
AP Email:			
Billing Address:			
Billing City, State, Zip:			

Tax exempt: Yes ◯ No ◯ - If Tax exempt certificate MUST be attached.

02/01/24
Revised 02/07/2024

ST. MARY'S d'YOUVILLE PAVILION

Provider ID# 205053

Facility ID# 0104

Event ID# ZE1621

PLAN OF CORRECTION

Disclaimer

D'Youville Pavilion submits this Plan of Correction (POC) in accordance with specific regulatory requirements. It shall not be construed as an admission of any alleged deficiency cited. The Provider submits this POC with the intention that it be inadmissible by any third party in any civil or criminal action against the Provider or any employee, agent, officer, director, or shareholder of the Provider. The Provider hereby reserves the right to challenge the findings of this survey if at any time the Provider determines that the disputed findings: (1) are relied upon to adversely influence or serve as a basis, in any way, for the selection and/or imposition of future remedies, or for any increase in future remedies, whether such remedies are imposed by the Centers for Medicare and Medicaid Services, the State of Maine or any other entity; or (2) serve, in any way, to facilitate or promote action by any third party against subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and should be inadmissible in any proceeding on that basis.

E 004 Develop EP Plan, Review and Update Annually

Findings:

The annual review of the Emergency Preparedness Plan had not been reviewed since 2022.

Plan of Correction:

The Emergency Preparedness Plan will be reviewed, revised as need and approved by required committees in February of 2024.

A DYP Safety and Infection Control Committee will be established in 2024. This multi-disciplinary committee will assure that all Emergency Preparedness, Safety and Infection Control plans, policies, and procedures are up to date. The DYP Safety and Infection Control Committee will report to the DYP QAPI Committee no less than quarterly.

As a department of St. Mary's Health System, Safety and Emergency Preparedness Plans and Policies will be monitored by the Environment of Care Committee no less than quarterly.

Performance will be monitored through the Quality Assurance and Performance Improvement Program. Performance will be reported through the Quality and Performance Improvement Committee no less than quarterly.

Compliance Date: March 1, 2024.

02/01/24
Revised 02/07/2024

K 271 Discharge from Exits

Findings:

The exit pathway serving stairwell C does not discharge to the public way.

Plan of Correction:

An exit discharge will be created serving stairwell C so that it discharges to the public way.

Asphalt Services of Auburn Maine visited DYP on 01/31/24 to provide a quote for services described. (See Attached).

An annual inspection of all exit pathways serving emergency exits shall be conducted by the Facilities Department.

Compliance Date: Project to be completed by May 31, 2024 due to weather restrictions.

K 311 Vertical Openings – Enclosure EXISTING

Findings:

The 60 minute fire door protecting stairwell B on the second floor does not self-close and positively latch when released from 90 degree opening.

Plan of Correction:

Door can not be repaired and will be replaced. Brand Door Company has been retained to provide estimates and replacement. (See attached)

An annual inspection of all Fire Rated and Smoke Barrier Doors, Closers, Vertical Openings and Chute's will be conducted by a third-party vendor.

Compliance Date: Contracted items are currently being quoted and scheduled. Project to be completed prior to June 30, 2024.

K 321 Hazardous Areas -Enclosure

Findings:

The 90-minute door to the dry food storage room by the employee time clock was held open with a wooden wedge. When the wedge was removed, the door wouldn't fit inside the frame. The door was damaged on the spine, and the top/latch side of the door hit the front of the frame, not allowing it to self-close and positively latch.

02/01/24
Revised 02/07/2024

Plan of Correction:

Wooden wedge has been removed.

Door cannot be repaired and will be replaced. Brand Door Company has been retained to provide estimates and replacement. (See Work Order and Quote attached)

An annual inspection of all Fire Rated and Smoke Barrier Doors, Closers, Vertical Openings and Chute's will be conducted by a third-party vendor.

Compliance Date: Contracted items are currently being quoted and scheduled. Project to be completed prior to June 30, 2024.

K 342 Fire Alarm Initiation

Findings:

According to the display on the Fire Alarm Control Unit in the main lobby, the fire alarm is in trouble mode showing a 2nd floor detector mismatch. Upon interview with the QAPI Manager and the Maintenance Manager, the deficiency occurred three weeks ago from resident activations, the alarm company should be on site by the end of next week to reset the alarm system. The remote annunciator panels in the Nurse's Stations show "ground fault" on the screens.

Plan of Correction:

Facilities has been working with R.B. Allen to resolve this situation. They visited 01/24/2024 to evaluate the current system. Potential system improvements were identified. Competed on 02/01/2024.

Compliance Date: 02/01/2024

K 351 Sprinkler System – Installation

Findings:

The main lobby by the fire alarm control unit has two ceiling tiles out of place.

Plan of Correction:

Tiles have been removed and new tiles placed.

Compliance Date: January 30, 2024

02/01/24
Revised 02/07/2024

K 353 Sprinkler system – Maintenance and Testing

Findings:

1. The hydrostatic test for the fire department connection is due every 5 years, and the most recent completion is 11/10/18, making it due in November of 2023.
2. The sprinkler heads show loading of foreign material in the laundry room.
3. The sprinkler heads show loading of foreign material in the corridor between rooms 403 and 413.
4. The sprinkler heads show loading of foreign material in the Nurses Station in 4 East, 3 East, and 2 West.

Plan of Correction:

A five-year assessment of the Internal Condition of Piping of the sprinkler system which includes changing gauges will be performed by High Tech Fire Protection of Minot, Maine as soon as possible. (See attached proposal #8211, conducted 1/30/24)

All sprinkler heads have been inspected and cleaned.

All sprinkler heads will be inspected no less than monthly and cleaned as needed.

An annual inspection of Sprinkler Heads will be performed.

Compliance Date: May 31, 2024 Revised Compliance Date: April 1, 2024

K 374 Subdivision of Building Spaces – Smoke Barrier Doors

Findings:

Cross Corridor Doors closest to Rooms 415, 445, 345, 244 did not latch at the top or the bottom.

Plan of Correction:

The four Cross Corridor Doors will be evaluated for repair or replacement as needed. Doors will be inspected on a rotating basis as part of Environment of Care Rounds.

Performance will be monitored through the Quality Assurance and Performance Improvement Program. Performance will be reported through the Quality and Performance Improvement Committee no less than quarterly.

Compliance Date: May 31, 2024

K 511 Utilities – Gas and Electric

Findings:

The facility was drying mop heads and cleaning rags in the dryer after washing them, this deficient practice could affect residents, guests, and staff if this practice led to the rags or mops catching fire while in the dryer.

Plan of Correction:

Mops and rags will be air dried effective immediately. The team will be informed in daily huddles and reminded every huddle to not dry mops and rags in the dryer.

Completion Date: 02/01/2024

K 541 Rubbish Chutes, Incinerators, and Laundry Chutes

Findings:

Third floor laundry chute door did not self-close and positively latch when door was released.

Second floor laundry chute door did not positively latch when door was released. Latch handle is broken, and latch is duct taped to not allow door to latch.

Plan of Correction:

Second and Third floor laundry chute doors will be replaced as soon as possible. In the meantime, doors will be manually closed and latched. Latch will be repaired to allow closure. Both laundry chute rooms are secured by keypad locking systems.

Staff education will be provided to support manual closure until replacement can be completed.

Completion Date: May 31,2024 Revised Compliance Date: April 01, 2024

K 712 Fire Drills

Findings:

The following fire drills for the facility were not completed or missing: third shift drill during the 3rd quarter of 2023.

Plan of Correction:

DYP does not staff 3 shifts. Shifts are scheduled 7:00 AM-7:00 PM and 7:00PM – 7:00 PM. Records demonstrate failure to conduct a fire drill on the second shift in the 4th Quarter of 2023.

Fire drills will be conducted no less than quarterly on each shift. Performance during Fire drills will be reported through the Safety and Infection Control Committee no less than quarterly.

Completion Date: February 1, 2024

02/01/24
Revised 02/07/2024

K 902 Gas and Vacuum Piped Systems

Findings:

The medical gas inspection report from William G. Frank Medical Gas testing & Consulting, LLC completed on February 1, 2023 indicates the following outstanding Maintenance and Compliance Deficiencies:

Room 101 Oxygen outlet leaks with adapter attachment.

Room 102 Oxygen outlet leaks with adapter attachment.

Room 105 Oxygen outlet leaks with adapter attachment.

Plan of Correction:

Johnson and Jordon is currently working on the gas system in that area. They will repair the three areas that are leaking as part of that work.

Completion Date: March 1, 2024

K 918 Electrical Systems- Essential Electric System Maintenance Testing

Findings:

No generator records were on file showing the generator was run December 2023 exercise and run under load to ensure the generator is exercised. The facility failed to have on file or show the following: Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. No generator records were on file showing the generator was run weekly after November 1, 2023.

Plan of Correction:

A weekly evaluation of all generator logs will be implemented.

Monthly testing and inspection of the generator will be implement.

Completion Date:

Weekly evaluation was initiated January 25, 2024.

Monthly testing and inspection will begin no later than March 1, 2024.

02/01/24
Revised 02/07/2024