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
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		

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 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		

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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		

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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		

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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		

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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		

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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		

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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		

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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		

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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		

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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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ST MARY'S D'YOUVILLE PAVILION	102 CAMPUS AVE LEWISTON, ME 04240

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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		

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
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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		

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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		

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	205053	A. BUILDING 01 B. WING _____	01/24/2024

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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		

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	205053	A. BUILDING **01** B. WING _____	**01/24/2024**

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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		