Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

September 3, 2021

Mr. Timothy Urich, Administrator
The Pines At Rutland Center For Nursing And Rehab
99 Allen Street
Rutland, VT 05701-4501

Provider #: 475018

Dear Mr. Urich:

Enclosed is a copy of your acceptable plans of correction for the **Life Safety Code survey** conducted on **July 12, 2021**. Please post this document in a prominent place in your facility.

We will follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475018	A. BUILDING 01 B. WING _____	07/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PINES AT RUTLAND CENTER FOR NURSING AND REHABI	99 ALLEN STREET RUTLAND, VT 05701

(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 000	INITIAL COMMENTS The Divison of Fire Safety completed an unannounced onsite Life Safety Code inspection on July 12, 2021. Entry and Exit interviews were conducted with Timothy Urich, Administrator, and Eric Davis, Facility Maintenance. The following violations were identified.	K 000		
K 300 SS=D	Protection - Other CFR(s): NFPA 101 Protection - Other List in the REMARKS section any LSC Section 18.3 and 19.3 Protection 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. This REQUIREMENT is not met as evidenced by: Per observation on July 12, 2021, the facility failed to ensure adquate fire rating per 33.3.3.2 Protection from Hazards. 33.3.3.2.1 Rooms containing high-pressure boilers, refrigerating machinery, transformers, or other service equipment subject to possible explosion shall not be located directly under or adjacent to exits, and such rooms shall be effectively separated from other parts of the building as specified in Section 8.7. 33.3.3.2.2 Hazardous areas, which shall include, but shall not be limited to, the following, shall be separated	K 300	Corrective Action: The door(s) identified during the survey will be replaced with appropriate fire-rated doors. Identify Others: Any fire-rated door that has modifications that prevent a tight smoke seal are at risk. Systemic Change: All fire-rated doors throughout the facility will be inspected to ensure there are no modifications that will prevent a tight smoke seal. Monitoring: All fire-rated doors throughout the facility will be inspected monthly to ensure there are no modifications that prevent a tight smoke seal. The results of the inspections will be submitted to the facility's QA Committee for review and the need for further auditing beyond the three months will be determined by the Committee. Responsible Party: Director of Maintenance Completion Date: 9/24/2021 K300 POC Accepted 9/2/2021 S. Dumont/ T Wehmeyer	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 8/24/2021

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 300	Continued From page 1 from other parts of the building by construction having a minimum 1-hour fire resistance rating, with communicating openings protected by approved self-closing fire doors, or such areas shall be equipped with automatic fire-extinguishing systems: 1. Boiler and heater rooms 2. Laundries 3. Repair shops 4. Rooms or spaces used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction. The findings include the following: Per observation on July 12, 2021, and accompanied by the Administrator and Facility Maintenance inspection revealed that the fire rated door to the elecrical room has been modified to accept a vent, thereby not providing a tight smoke seal.	K 300		
K 346 SS=D	Fire Alarm System - Out of Service CFR(s): NFPA 101 Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 This REQUIREMENT is not met as evidenced by: Per review on July 12, 2021, the facility failed to ensure there is an appropriate fire watch plan is	K 346	Corrective Action: The facility does in fact have a Fire Watch Policy which is part of the facility's Safety Plan. The specific book inspected as part of the survey did not have the policy in it however, it has been added to that book. Identify Others: Each Safety Plan book throughout the facility could be affected by the same practice. Systemic Change: Each Safety Plan book located in the facility will be audited to ensure that the facility's Fire Watch Policy is included in the book. Monitoring: Each Fire Plan book located in the facility will be audited once per month for three months to ensure that the facility's Fire Watch Policy is included. The audits will be submitted to the facility's QA Committee for review and the need for further auditing beyond the three months will be determined by the committee. Responsible Party: Director of Maintenance Competion Date: 9/24/2021	

K346 POC Accepted 9/2/2021
S. Dumont/ T Wehmeyer

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K 346	Continued From page 2 in place. Findings include the following: Per review on July 12, 2021, accompanied by the Administrator and Facility Maintenance, inspection revealed that there are no fire watch details outlined in the Evacuation & Relocation Plan in the event that the fire alarm system is out of service for longer then the allowed 4 hours in a 24 hour period.	K 346		
K 354 SS=D	Sprinkler System - Out of Service CFR(s): NFPA 101 Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) This REQUIREMENT is not met as evidenced by: Per review on July 12, 2021, the facility failed to ensure there is an appropriate fire watch plan is in place. Findings include teh following: Per review on July 12, 2021, accompanied by the Administrator and Facility Maintenance, inspection revealed that there are no fire watch details outlined in the Evacuation & Relocation Plan in the event that the sprinkler system is out	K 354	Corrective Action: The facility does in fact have a Fire Watch Policy which is part of the facility's Safety Plan. The specific book that was inspected as part of the survey did not have the policy in it however, it has since been added to that particular book. Identify Others: Each Safety Plan book throughout the facility could be affected by the same practice. Systemic Change: Each Safety Plan book in the facility will be audited to ensure that the facility's Fire Watch Policy is included in the book. Monitoring: Each Safety Plan book located in the facility will be audited once per month for three months to ensure that the facility's Fire Watch Policy is included. The audits will be submitted to the facility's QA Committee for review and the need for further auditing beyond the three months will be determined by the committee. Responsible Party: Director of Maintenance Completion Date: 9/24/2021 K354 POC Accepted 9/2/2021 S. Dumont/ T Wehmeyer	

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K 354	Continued From page 3 of service for longer then the allowed 10 hours in a 24 hour period.	K 354		
K 362 SS=D	Corridors - Construction of Walls CFR(s): NFPA 101 Corridors - Construction of Walls 2012 EXISTING Corridors are separated from use areas by walls constructed with at least 1/2-hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the transfer of smoke. In nonsprinklered buildings, walls extend to the underside of the floor or roof deck above the ceiling. Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Fixed fire window assemblies in corridor walls are in accordance with Section 8.3, but in sprinklered compartments there are no restrictions in area or fire resistance of glass or frames. If the walls have a fire resistance rating, give the rating _____ if the walls terminate at the underside of the ceiling, give brief description in REMARKS, describing the ceiling throughout the floor area. 19.3.6.2, 19.3.6.2.7; This REQUIREMENT is not met as evidenced by: Per observation on July 12, 2021, the facility failed to ensure that corridors are separated from use areas by walls with at least 1/2 fire residence rating. Findings include the following: 1. Per observation on July 12, 2021, and accompanied by the Administrator and Facility Maintenance, inspection revealed that there are penetrations above the corridor smoke barrier door walls above the ceiling that are not properly	K 362	Corrective Action: 1) The penetrations above the corridor smoke barrier door walls above the ceiling on the 1st, 2nd, 3rd and 4th floors will be sealed with the approved/appropriate product. 2) The penetrations above the ceilings in the smoke barrier walls on 1st, 2nd, 3rd and 4th floor will be sealed with the approved/appropriate product. 3) The acoustical ceiling tile noted to be missing in the 3rd floor janitor closet and oxygen room will be replaced. 4) The wall penetrations near the ceiling level of the 4th floor air handling room and storage closet will be sealed with the approved/appropriate product. 5) The penetrations in the walls and ceiling of the 1st floor freezer compressor room will be sealed with the approved/appropriate product. Identify Others: 1) All smoke barrier walls located in the facility must be free from penetrations. 2) All ceilings must not have missing ceiling tiles. Systemic Change: 1) All smoke barrier walls will be inspected to ensure there are no penetrations. 2) All ceilings within the facility will be inspected to ensure no tiles are missing. Monitoring: 1) An inspection of all smoke barrier walls will be completed monthly for three months to ensure there are no penetrations. 2) An inspection of all ceilings will be completed monthly for three months to ensure no missing tiles. The results of the inspections will be submitted to the facility's QA Committee for review and the need for further auditing will be determined by the committee. Responsible Party: Director of Maintenance Completion Date: 9/24/2021 K362 POC Accepted 9/2/2021 S. Dumont/ T Wehmeyer	

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K 362	Continued From page 4 fire stopped. This involves the smoke barrier doors on the first, second, third, and fourth floors. 2. Per observation on July 12, 2021, and accompanied by the Administrator and Facility Maintenance, inspection revealed that there are penetrations that are not properly fire stopped above the ceilings in the smoke barrier walls on the first, second, third, and fourth floors. 3. Per observation on July 12, 2021, and accompanied by the Administrator and Facility Maintenance, inspection revealed there is an acoustical ceiling tile missing in the ceiling on thrid-floor in the janitor's closet and the oxygen room. 4. Per observation on July 12, 2021, and accompanied by the Administrator and Facility Maintenance, inspection revealed that there are wall penetrations near the ceiling level of the fourth-floor air handling room and storage closet. 5. Per observation on July 12, 2021, and accompanied by the Administrator and Facility Maintenance, inspection revealed that there are penetrations in the walls and ceiling of the first-floor freezer compressor room.	K 362		
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered	K 363	Corrective Action: 1) The identified doors on the 2nd, 3rd and 4th floors have been corrected to ensure proper closure. 2) The 3rd floor clean linen room door has been corrected to ensure that it proper latches. 3) The door to the 2nd floor nourishment room has been corrected to ensure that it properly latches. 4) The door to the respiratory office has been corrected to ensure that it properly latches. 5) The north door leading to and from the the kitchen has been corrected to ensure that it properly latches. 6) The door stop being used to keep the door to the 1st floor Human Service Office has been removed. 7) The door stop being used to keep the door to the 1st floor Environmental Services Office open has been removed.	

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K 363	Continued From page 5 smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Per observation on July 12, 2021, the facility failed to ensure that doors protecting corridor openings failed to close and/or latch properly. The findings include the following: 1. Per observation on July 12, 2021, and accompanied by the Administrator and Facility	K 363	Continued from page 5 Identify Others: All doors protecting corridor openings within the facility must close and/or latch properly. Systemic Change: An inspection of all doors protecting corridor openings within the facility will be completed to ensure proper closure/latching. Monitoring: An inspection of all doors protecting corridor openings within the facility will be completed monthly for three months to ensure proper closure/latching. The inspections will be submitted to the QA Committee for review and the need for futher audting beyond the three months will be determined by the committee. Responsible Party: Director of Maintenance Completion Date: 9/24/2021 K363 POC Accepted 9/2/2021 S. Dumont/ T Wehmeyer	

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K 363	Continued From page 6 Maintenance, inspection revealed that doors on the second, third and fourth floors failed to latch when closed and many of them failed to close properly due to impediments at the top level of the doorway. These include: patient rooms 201, 203, 204, 205, 206, 207 on the second floor; storage room on the third floor and rooms 403 an oxygen room on the fourth floor. 2. Per observation on July 12, 2021, and accompanied by the Administrator and Facility Maintenance, inspection revealed that the door to the third floor clean linen room did not latch when closed. 3. Per observation on July 12, 2021, and accompanied by the Administrator and Facility Maintenance, inspection revealed that the right door leaf to the second floor nourishment room did not latch when closed. 4. Per observation on July 12, 2021, and accompanied by the Administrator and Facility Maintenance, inspection revealed that the first floor respiratory office door did not latch when closed. 5. Per observation on July 12, 2021, and accompanied by the Administrator and Facility Maintenance, inspection revealed that the north door leading to and from the kitchen did not latch when closed. 6. Per observation on July 12, 2021, and accompanied by the Administrator and Facility Maintenance, inspection revealed that the first floor Human Services Office would not close as designed due to an impediment at the bottom of the door. A door stop was being used to keep	K 363		

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K 363	Continued From page 7 the door in the open positon. 7. Per observation on July 12, 2021, and accompanied by the Administrator and Facility Maintenance, inspection revealed that the first floor Enviornmental Services Office would not close as designed due to an impediment at the bottom of the door. A door stop was being used to keep the door in the open positon. This door also did not latch when closed.	K 363		
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 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: Per observation on July 12, 2021, the facility failed to ensure that smoke barrier doors had a tight smoke seal. Findings include the following: 1. Per observation on July 12, 2021, and accompanied by the Administrator and Facility Maintenance, inspection revealed that the smoke barrier doors leading to the fourth-floor dining	K 374	Corrective Action: 1) The smoke barrier doors leading to the 4th floor dining room will be corrected to ensure proper closure. 2) The 4th floor corridor smoke barrier doors by room 418 will be corrected to ensure proper closure. 3) The 3rd floor corridor smoke barrier doors will be corrected to ensure proper closure. 4) The smoke barrier door located at the 4th floor soiled linen room will be appropriately corrected. 5) The smoke barrier doors located at the 4th floor dining room have been corrected to ensure proper closure. Identify Others: All smoke barrier doors in the facility must have a tight smoke seal. Systemic Change: All smoke barrier doors in the facility will be inspected to ensure a tight smoke seal. Monitoring: An inspection of all smoke barrier doors will be completed monthly for three months to ensure each has a tight smoke seal. The inspections will be submitted to the facility's QA Committee for review and the need for further inspections beyond the three months will be determined by the committee. Responsible Party: Director of Maintenance Completion Date: 9/24/2021 K374 POC Accepted 9/2/2021 S. Dumont/ T Wehmeyer	

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K 374	Continued From page 8 room did not close tightly, thereby not providing a tight smoke seal. 2. Per observation on July 12, 2021, and accompanied by the Administrator and Facility Maintenance, inspection revealed that the fourth-floor corridor smoke barrier doors by room 418 did not close tightly, thereby not providing a tight smoke seal. 3. Per observation on July 12, 2021, and accompanied by the Administrator and Facility Maintenance, inspection revealed that the third-floor corridor smoke barrier doors did not close tightly, thereby not providing a tight smoke seal. 4. Per observation on July 12, 2021, and accompanied by the Administrator and Facility Maintenance, inspection revealed that the smoke barrier door located at the fourth-floor soiled linen room has a hole on the door due to the removal of a locking device, creating a path for the smoke to travel. 5. Per observation on July 12, 2021, and accompanied by the Administrator and Facility Maintenance, inspection revealed that the smoke barrier doors located at the fourth-floor dining room did not close tightly, thereby not providing a tight smoke seal.	K 374		
K 511 SS=D	Utilities - Gas and Electric 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	K 511	Corrective Action: 1) The junction box located behind the door of the 4th floor air handling room will receive an appropriate cover. 2) The electrical outlets located above the ceiling at room 423 will receive appropriate covers. Identify Others: All junction boxes and electrical outlets should have covers.	

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K 511	Continued From page 9 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: Per observation on July 12, 2021, the facility failed to ensure that electrical wiring and equipment meets regulatory requirements. Findings include the following: 1. Per observation on July 12, 2021, and accompanied by the Administrator and Facility Maintenance, inspection revealed that the junction box located behind the door of the fourth-floor air handling room is missing a cover. 2. Per observation on July 12, 2021, and accompanied by the Administrator and Facility Maintenance, inspection revealed that the electrical outles located above the ceiling at room 423 is missing a cover. Due to the missing electrical box covers above the ceilings of the corridors, the entire ceiling cavity of each floor must be inspected for missing covers.	K 511	Continued from page 9 Systemic Change: An inspection of the entire ceiling cavity of each floor will be completed to ensure that there are no missing electrical box covers. Monitoring: An inspection of the entire ceiling cavity of each floor will be completed monthly for three months to ensure that there are no missing electrical box covers. The inspections will be submitted to the facility's QA Committee for review. The need for futher inspections beyond the three months will be determined by the committee. Responsible Party: Director of Maintenance Completion Date: 9/24/2021 K511 POC Accepted 9/2/2021 S. Dumont/ T Wehmeyer	