VERMONT

AGENCY OF HUMAN SERVICES

DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

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
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Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

October 7, 2019

Mr. Steven Gordon, Ceo
Brattleboro Memorial Hospital
17 Belmont Ave
Brattleboro, VT 05301-3498

Provider #: 470011

Dear Mr. Gordon,

Enclosed is a copy of your acceptable plans of correction for the **Life Safety Code survey** conducted on **August 22, 2019**. 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,

Suzanne Leavitt, RN, MS
Assistant Division Director
State Survey Agency

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	470011	A. BUILDING 01 - BRATTLEBORO MEMORIAL HOSPITAL B. WING _____	08/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRATTLEBORO MEMORIAL HOSPITAL	17 BELMONT AVE BRATTLEBORO, VT 05301

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K 000	INITIAL COMMENTS The Division of Fire Safety conducted an unannounced Life Safety Code inspection on August 21, 2019. The following violations were identified.	K 000		
K 211	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This STANDARD is not met as evidenced by: Per observation on 8/22/2019, the facility failed to ensure that all means of egress are continuously maintained free of all obstructions. The findings include the following: 1. Per observation on 8/22/2019, and accompanied by the Facilities Director, second floor inspection revealed that trash & soiled linen containers are stored in teh protected corridor next to the OR rooms. 2. Per observation on 8/22/2019, and accompanied by the Facilities Director, second floor inspection revealed that a linen cart was blocking the far alarm pull station next to the exit door.	K 211	**Corrective Action:** All corridors have been cleared of clutter, allowing unobstructed egress. **BMH Staff Member Responsible:** Michael H. Geissler, BSN, RN, CNOR, ONC, Peri-operative Services Director **Corrective Action:** All trash and soiled linen containers are currently stored in a locked room within the OR suite. Compliance with this standard is validated by the Perioperative Director who completes daily rounds and monthly EOC around. Item has been added to the *EOC Rounds Form.* **BMH Staff Member Responsible:** Michael H. Geissler, BSN, RN, CNOR, ONC, Peri-operative Services Director **Corrective Action:** Linen containers and trash receptacles are stored away from doorways and all fire alarms. Compliance with this standard will be validated by the Manager of Inpatient Services during daily rounding and review in monthly EOC Rounding. This item has also has been added to the *EOC Rounds Form.* **BMH Staff Member Responsible:** Danielle Piper, RN/BSN	**Date of Completion:** 08/22/2019 **Date of Completion:** 08/22/2019 **Date of Completion:** 08/22/2019
K 226	Horizontal Exits CFR(s): NFPA 101 Horizontal Exits Horizontal exits, if used, are in accordance with	K 226	K211 POC Accepted 10/7/19 S Dumont/ TW	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Chief Medical Officer — (X6) DATE: 10/3/2019

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 226	Continued From page 1 7.2.4 and the provisions of 18.2.2.5.1 through 18.2.2.5.7, or 19.2.2.5.1 through 19.2.2.5.4. 18.2.2.5, 19.2.2.5 This STANDARD is not met as evidenced by: Per observation on 8/22/2019, facility failed to ensure that all horizontal exits are being used in accordance to regulatory requirements. The findings include the following: Per observation on 8/22/2019, and accompanied by the Facilities Director, third floor inspection revealed that waiting room & corridor were renovated to new office space, exit sign shall be removed. (Nursing Director Office)	K 226	**Corrective Action:** Exit sign has been removed. **BMH Staff Member Responsible:** Rob Prohaska, Director of Plant Services K226 POC accepted 10/7/19 S. Dumont/TW.	**Date of Completion:** 08/22/2019
K 300	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 STANDARD is not met as evidenced by: Per observation on 8/22/2019, facility failed to ensure storage rooms sprinklers were free of obstructions. The findings include the following: Per observation on 8/22/2019, and accompanied	K 300	**Corrective Action:** All items stored within 18 inches of the sprinkler head have been removed. Compliance will be validated through scheduled monitoring during monthly EOC Rounds. **BMH Staff Members Responsible:** Rob Prohaska, Director of Plant Services Laurie Kuralt, APRN Manager Respiratory Services Jaqueline Amidon, Director of Inpatient Services K300 POC accepted 10/7/19 S. Dumont/TW	**Date of Completion:** 09/30/2019

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K 300	Continued From page 2 by the Facilities Director, inspection revealed that storage rooms on the first, second and third floors have obstructions to sprinkler discharge pattern. NFPA 13 Figure A.8.5.5.1 Obstructions to Sprinkler Discharge Pattern Development for Standard Upright or Pendent Spray Sprinklers. Storage within 18 inches of the sprinkler head will reduce the distribution of the water and hinder the effectiveness of the automatic sprinkler system to control and contain fire.	K 300		
K 311	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 STANDARD is not met as evidenced by: Per observation on 8/22/2019, facility failed to ensure that vertical openings are enclosed with construction have a fire-resistant rating of at least 1 hour. The findings include the following: Per observation on 8/22/2019. and accompanied by the Facilities Director, third floor inspection revealed that the fire doors have penetrations that are not properly fire stopped above the ceilings in the smoke barrier walls.	K 311	**Corrective Action:** Smoke barriers have been evaluated for any open areas. All penetrations have been sealed with fire caulking. **BMH Staff Member Responsible:** Rob Prohaska, Director of Plant Services K311 Poc Accepted 10/7/19 S. Dumont/TW	**Date of Completion:** 09/20/2019
K 362	Corridors - Construction of Walls CFR(s): NFPA 101	K 362		

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K 362	Continued From page 3 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 STANDARD is not met as evidenced by: Per observation on 8/22/2019 the facility failed to ensure that corridors are separated from use areas by walls constructed with at least 1/2-hour fire resistance rating. The findings include the following: 1. Per observation on 8/22/2019, and accompanied by the Facilities Director, first floor corridor inspection revealed that there are penetrations above the corridor smoke barrier door walls above the ceiling that are not properly fire stopped. 2. Per observation on 8/22/2019, and accompanied by the Facilities Director, first floor inspection revealed that there is an acoustical	K 362	**Corrective Action:** 1. First Floor Corridor- All penetrations have been sealed and appropriately fire caulked. 2. First Floor IT Room- BMH is currently seeking an equivalency to ensure	**Date of Completion:** 09/20/2019 **Date of Completion:** 09/20/2019

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K 362	Continued From page 4 ceiling tile missing in the ceiling in the IT room. 3. Per observation on 8/22/2019, and accompanied by the Facilities Director, first floor inspection revealed that there is an acoustical ceiling tile missing in the ceiling in the housekeeping closet. 4. Per observation on 8/22/2019, and accompanied by the Facilities Director, first floor medical gas storage room inspection revealed that there are penetrations on the outside wall that are not properly fire stopped.	K 362	fire safety. The proposed equivalency would be the installation of a heat or smoke detector in the IT closet. 3. First Floor Housekeeping Closet- The acoustical tile has been replaced. 4. First Floor Medical Gas Storage Room- All penetrations have been sealed and appropriately fire caulked. K362 POC Accepted 10/7/19 S Dumont/TW	Date of Completion: 09/20/2019 Date of Completion: 09/20/2019
K 363	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates	K 363		

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K 363	Continued From page 5 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 STANDARD is not met as evidenced by: Per observation on 8/22/2019, the facility failed to ensure that doors close and latch according to regulatory requirements. The findings include the following: 1. Per observation on 8/22/2019, and accompanied by the Facilities Director, inspection of the first-floor lobby cafeteria revealed that the doors to the kitchen would not close as designed due to an impediment at the bottom of the door. A doorstop was being used to keep the doors in the open position. 2. Per observation on 8/22/2019, and accompanied by the Facilities Director, first floor inspection revealed that the door leading to and from the kitchen did not latch when closed. 3. Per observation on 8/22/2019, and accompanied by the Facilities Director, first floor inspection revealed that the door leading to and from the pharmacy did not latch when closed.	K 363	1. Kitchen- A magnetized latch has been installed on kitchen doors that will release in case of fire, allowing the doors to safely close. 2. Kitchen- The doorstop has been removed. Staff have been educated regarding fire safety and the prohibition against propping doors open permanently. Compliance will be ensured through the Department Director's review on daily rounds. 3. Pharmacy- A latch closure has been installed in the Pharmacy door.	**Date of Completion:** 09/20/2019 **Date of Completion:** 09/20/2019 **Date of Completion:** 09/20/2019

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K 363	Continued From page 6 4. Per observation on 8/22/2019, and accompanied by the Facilities Director, first floor inspection revealed that the fire doors located next to the elevator lobby did not close and latch. 5. Per observation on 8/22/2019, and accompanied by the Facilities Director, first floor inspection revealed that the red suite fire doors did not close and latch.	K 363	4. First Floor Fire Doors/ Elevator- A latch closure has been installed in the first floor fire doors allowing them to properly close and latch. 5. Radiology-. A latch closure has been installed in the Radiology Suite fire doors did not close and latch. **BMH Staff Member Responsible:** Rob Prohaska, Director of Plant Services K363 Poc accepted S. Dumont 10/7/19 TW	**Date of Completion:** 09/20/2019 **Date of Completion:** 09/20/2019
K 911	Electrical Systems - Other CFR(s): NFPA 101 Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) This STANDARD is not met as evidenced by: Per observation on 8/22/2019, facility failed to ensure that all regulatory requirements in NFPA 99 Chapter 6 Electrical Systems are being met. Findings include the following: Per observation on 8/22/2019, and accompanied by the Facilities Director, second floor inspection revealed that next to the OR room a storage cart was blocking an electrical panel.	K 911	**Corrective Action:** Storage carts and other receptacles are stored away from all electrical panels. Compliance with this standard is validated by the Director of Perioperative Services during daily rounding and review in monthly EOC Rounding. This item has also has been added to the *EOC Rounds Form* **BMH Staff Member Responsible:** Rob Prohaska, Director of Plant Services **BMH Staff Member Responsible:** Michael H. Geissler, BSN, RN, CNOR, ONC, Peri-operative Services Director	**Date of Completion:** 08/22/2019
K 930	Gas Equipment - Liguid Oxygen Equipment CFR(s): NFPA 101 Gas Equipment - Liquid Oxygen Equipment The storage and use of liquid oxygen in base reservoir containers and portable containers comply with sections 11.7.2 through 11.7.4 (NFPA 99).	K 930	**Corrective Action:** Full and empty oxygen canisters are now stored in a locked room in the OR Suite. Compliance with this standard is validated by the	

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K 930	Continued From page 7 11.7 (NFPA 99) This STANDARD is not met as evidenced by: Per observation on 8/22/2019, the facility failed to ensure storage and use of liquid oxygen are in compliance with regulatory requirements. Findings include the following: Per observation on 8/22/2019, and accompanied by the Facilities Director, second floor inspection revealed full and empty oxygen containers stored in the protected corridor next to the exit door.	K 930	Director of Perioperative Services during daily rounding and review in monthly EOC Rounding. This item has also has been added to the *EOC Rounds Form* **BMH Staff Member Responsible:** Rob Prohaska, Director of Plant Services **BMH Staff Member Responsible:** Michael H. Geissler, BSN, RN, CNOR, ONC, Perioperative Services Director K930 Poc accepted 10/7/19 S. Dumont / TPO	**Date of Completion:** 08/22/2019