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

March 15, 2022

Mr. J. Michael River, Administrator
Center For Living & Rehabilitation
160 Hospital Drive
Bennington, VT 05201-2279

Provider #: 475029

Dear Mr. Rivers:

Enclosed is a copy of your acceptable plans of correction for the **Life Safety Code survey** completed on **February 14, 2022**. 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

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
	475029	A. BUILDING 01 B. WING	02/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTER FOR LIVING & REHABILITATION	160 HOSPITAL DRIVE BENNINGTON, VT 05201

(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 Division of Fire Safety completed an unannounced onsite Life Safety Code inspection on February 14, 2022. Entry and exit interviews were conducted with the Facility Administrator. While the facility was found to be in substantial compliance with applicable Life Safety Code Requirements,the following issues were identified that require a correction by the facility.	K 000		
K 223 SS=C	Doors with Self-Closing Devices CFR(s): NFPA 101 Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This REQUIREMENT is not met as evidenced by: Per observation on February 14, 2022, the facility failed to ensure doors in an exit passageway or horizontal exit comply with regulatory compliance. Findings include the following: Per observation on February 14, 2022, and accompanied by the Facility Administrator and the Facilities Maintenance Director, inspection revealed keypads are provided on three fire exit	K 223	**K 223** *1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice?* To meet NFPA 101 Standard 19.2.2.2.4 Adams Lock visited the facility and has been in contact with Assistant State Fire Marshall to order parts for an upgrade to 3 fire doors. *2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?* All residents have the potential to be affected. Monthly audits of all egress doors will be entered into the TELs system.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Mike Rines	Administrator	3/11/22

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 223	Continued From page 1 locations in the facility to exit/access fire exit stairs, which is not in compliance with NFPA 101 LSC 19.2.2.2.4.	K 223	*3. What measures will be put into place or what systematic changes will you make to ensure that the deficient practice does not reoccur?* Monthly checklist is maintained of all egress doors. Person responsible for monthly checks is the Maintenance Technician. *4. How will the corrective actions will be monitored to ensure the deficient practice will not recur (ie: what quality assurance program will be put into place)?* Monthly audits performed by the Maintenance Department through the TELs system. *5. The dates corrective action will be completed.* June 1st, 2022 K223 POC Accepted 3/15/2022 M. Steele/ T Wehmeyer	