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
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line (888) 700-5330
To Report Adult Abuse: (800) 564-1612

June 20, 2023

Ms. Suzanne Anair, Administrator
Center For Living & Rehabilitation
160 Hospital Drive
Bennington, VT 05201-2279

Provider ID #: 475029

Dear Ms. Anair:

On **June 13, 2023,** the Vermont Department of Public Safety, Division of Fire Safety, conducted a revisit to the Centers for Medicaid and Medicare Services (CMS) Federal Monitoring Survey that was conducted on **April 25, 2023,** to verify that your facility had achieved substantial compliance. The revisit revealed that substantial compliance has been achieved as tags K-0271-Discharge from Exits; K-0351-Sprinkler System-Installation and K-0372-Subdivion of Building Space-Smoke Barrier have been approved for a Time Limited Waivers to correct these deficiencies.

Sincerely,

tammy wehmeyer

Tammy Wehmeyer
Administrative Services Manager

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 ___	R **06/13/2023**

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 Vermont Division of Fire Safety conducted an unannounced, onsite revisit survey on June 13, 2023, to the Centers for Medicare and Medicaid Services (CMS) Federal Monitoring Survey that was conducted April 25, 20223. Inspection revealed that tags not covered under the time limited waiver are found to be corrected.	{K 000}		
{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 facility failed to provide a discharge pathway from an exit that was a level walking surface of hard packed all-weather travel surface in accordance with CMS Survey and Certification Letter 05-38, LSC 7.7, 7.1.7 and 19.2.7. This deficient practice could affect exiting from one smoke compartment, 5 residents, as well as an indeterminable number of staff. Findings Include: Observation on 04/25/2023 at approximately 3:50pm during the facility tour identified the facility designated exit (exit sign above the door) from the basement level below the Rockwell Lounges, containing rehabilitation therapy exited to a	{K 271}		

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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{K 271}	Continued From page 1 grass/lawn path, unleveled ground walking surface with no hard path to the public way. The exit discharge pathway was across an uneven grass path (with a gate) and trip hazards. Interview at the time of observation with the Maintenance Director confirmed there was no hard path to the public way. The findings were verified by the Maintenance Director at the time of observation.	{K 271}		
{K 351} SS=E	Sprinkler System - Installation CFR(s): NFPA 101 Sprinkler 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 facility failed to provide sprinkler protection for the hydraulic elevator shaft and a section of the attic in accordance with 42 CFR 483.90(a)(6)(i), NFPA	{K 351}		

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{K 351}	Continued From page 2 13, 2010 Edition, Section 8.3.2.5, 8.15.5, 11.3.1.5, and LSC Section 19.3.5.1, 19.3.5.4 and 9.7.1.1. The deficient practice could affect four smoke zones, 40 residents, as well as an indeterminable number of staff and visitors. Findings Include: Observation on 04/25/2023 at approximately 3:20pm during the facility tour identified the attic section over the subacute unit two was not sprinkler protected. Observation identified marked plywood with sprinklers to the floor below, but no identified sprinklers to protect the attic. Interview with the Maintenance Director at the time of observation confirmed that there was no identified sprinkler to the attic at the time of survey. Observation on 04/25/2023 at approximately 3:40pm during the facility tour identified the facility hydraulic elevator shaft was not sprinkler protected. Failure to have sprinkler coverage in this required area impacts the level of sprinkler protection for the facility. Interview with the Maintenance Director at the time of observations during the facility tour confirmed there was no identified sprinkler. The findings were verified by the Maintenance Director at the times of observation.	{K 351}		
{K 372} SS=D	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour	{K 372}		

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{K 372}	Continued From page 3	{K 372}		

fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier.
19.3.7.3, 8.6.7.1(1)
Describe any mechanical smoke control system in REMARKS.
This REQUIREMENT is not met as evidenced by:
Based on observation and interview, the facility failed to provide smoke barriers with a 1/2 hour fire resistance rating in accordance with LSC Section 8.5.3 and Section 19.3.7.3. This deficient practice affected one sampled facility identified smoke barrier, as well as 26 residents, and an indeterminable number of staff and visitors.

Findings Include:

Observation on 04/25/2023 at approximately 2:20pm during the facility tour identified the facility specified smoke barrier wall between the Moses Hall and the Solarium observed flammable expandable foam in the rated wall not sealed with the proper through penetration system. The observation was verified by the Maintenance Director as penetrations providing no through penetration system to ensure the integrity of a smoke barrier. Interview with the Maintenance Director at the times of observations stated that the identified wall as a smoke barrier wall (gap at the leading edge of the double doors).

The findings were verified by the Maintenance Director at the times of observation.