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

December 11, 2019

Ms. Suzanne Anair, Administrator
Centers For Living And Rehab
160 Hospital Drive
Bennington, VT 05201-2279

Dear Ms. Anair:

Enclosed is a copy of your acceptable plans of correction for the Life Safety Survey conducted on October 22, 2019. Please post this document in a prominent place in your facility.

We may 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

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 _____	10/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTERS FOR LIVING AND REHAB	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 An unannounced onsite Life Safety Code inspection was completed by the Division of Fire Safety on 10/22/2019. The following violations were identified.	K 000	**K 211** *1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice?*	
K 211 SS=D	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 REQUIREMENT is not met as evidenced by: Per observation on 10/22/2019, the facility failed to ensure that all egresses aer free of obstructions. Findings include the following: Per observation on 10/22/2019, and accompanied by the Maintenance Director, inspection revealed that the lunch room has storage in path of egress exit door.	K 211	All items in the path of the egress exit door in the lunchroom have been removed. *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 egress doors have been inspected. Any items blocking the doors has been removed. *3. What measures will be put into place or what systematic changes will you make to ensure that the deficient practice does not reoccur?* Education was provided to all staff And policies were reviewed.	
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.	K 321	If additional items are found a Life Safety work order will be placed. *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)?*	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	11272019

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 321	Continued From page 1 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 Hazard - see K322) This REQUIREMENT is not met as evidenced by: Per observation on 10/22/2019, the facility failed to ensure that hazardous areas are being maintanied accordingto requirements. Findings include the following: 1. Per observation on 10/22/2019, and accompanied by the Maintenance Director, inspection revealed that trash bins exceeding 64 gallons are stored in the electrical room in the Stark Wing. 2. Per observation on 10/22/2019, and accompanied by the Maintenance Director, inspection revealed that trash bins exceeding 64 gallons are stored in the electrical room in the Frost Wing.	K 321	Audits will be conducted by the Director of Plant Operations and/or Designee weekly for 4 weeks, then monthly for 2 months. The results will be reviewed by the facility Safety-Quality Committee. *5. The dates corrective action will be completed.* November 21, 2019 K321 POC accepted 12/6/19 S. Dumont/TW **K321** *1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice?* All combustibles were removed from the Stark electrical room and the Frost electrical room. *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 other electrical rooms were inspected and any found combustibles were removed. *3. What measures will be put into place or what systematic changes will you make to ensure that the deficient practice does not reoccur?* The policy: "Combustible Items and Seasonal Decorations" was reviewed and updated as indicated.	

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K 362 K 362 SS=D	Continued From page 2 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 10/22/2019, the facility failed to ensure that requirements were being met to resit the transfer of smoke. Findings include the following: 1. Per observation on 10/22/2019, and accompanied by the Maintenance Director, inspection revealed in the Stark Wing next to Room 129 penetrations were found above the ceiling. 2. Per observation on 10/22/2019, and accompanied by the Maintenance Director,	K 362 K 362	Education has been provided to all staff. If additional items are found a Life Safety work order will be placed. *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)?* Audits will be conducted by the Director of Plant Operations and/or Designee weekly for 4 weeks, then monthly for 2 months. The results will be reviewed by the facility Safety-Quality Committee. *5. The dates corrective action will be completed.* November 21, 2019 K321 POC accepted 12-6-19 S. Dumont / TW K362 *1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice?* All areas noted in the 2567 were addressed in accordance to the NFPA regulations. *2. How will you identify other*	

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K 362	Continued From page 3 inspection revealed in the Stark Wing that there is a broken ceiling tile in teh main hallway next to teh soiled linen room. 3. Per observation on 10/22/2019, and accompanied by the Maintenance Director, inspection revealed in the Moses Wing next to Room 105 penetrations were found above the ceiling. 4. Per observation on 10/22/2019, and accompanied by the Maintenance Director, inspection revealed in the Laundrey Room penetrations were found above the ceiling. 5. Per observation on 10/22/2019, and accompanied by the Maintenance Director, inspection revealed in the Sprinkler Room that there are penetrations found around pipes and ceiling. 6. Per observation on 10/22/2019, and accompanied by the Maintenance Director, inspection revealed in the Kitchen a sprinkler head does not have a escutcheon ring and need to seal the hole around the sprinkler head. 7. Per observation on 10/22/2019, and accompanied by the Maintenance Director, inspection revealed in the main hallway next to the business offices four sprinkler heads do not have escutcheon rings and need to seal the hole around the sprinkler heads. 8. Per observation on 10/22/2019, and accompanied by the Maintenance Director, inspection revealed in the Rockwell Wing, the electrical room, has penetration inteh wall adn around the pipes next to Room 13.	K 362	*residents having the potential to be affected by the same deficient practice and what corrective action will be taken?* An inspection of the building occurred and any other areas noted were addressed. *3. What measures will be put into place or what systematic changes will you make to ensure that the deficient practice does not reoccur?* The policy: "Above Ceiling Access Permit Policy" has been reviewed and/or updated. Education has been provided to staff. If additional items are found a Life Safety work order will be placed. *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)?* Permits will be reviewed by the Director of Plant Operations and/or Designee weekly for 1 month, then monthly for 2 months. The results will be reviewed by the facility Safety-Quality Committee. *5. The dates corrective action will be completed.* November 21, 2019 K362 POC Accepted 12-6-19 S. Dumont / TW	

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K 362	Continued From page 4 9. Per observation on 10/22/2019, and accompanied by the Maintenance Director, inspection revealed in the Emergency Electrical Room has broken ceiling tiles.	K 362	K363 *1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice?* The door to room 135 was inspected, the door locks and latches. *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 resident doors were inspected to ensure that they lock and latch. *3. What measures will be put into place or what systematic changes will you make to ensure that the deficient practice does not reoccur?* All resident doors are on a monthly preventative maintenance review. Education has been provided to staff. If additional items are found a Life Safety work order will be placed. *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)?*	
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 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	K 363		

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K 363	Continued From page 5 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 10/22/2019, the facility failed to ensure that all doors lock and latch according to requirements. Findings include the following: Per observation on 10/22/2019, and accompanied by the Maintenance Director, inspection revealed that the door to Room 135, located in the Stark Wing, does not lock and latch.	K 363	All resident doors will be inspected by the Director of Plant Operations and/or Designee once a week for the next 4 weeks, then monthly going forward. The results will be reviewed by the facility Safety-Quality Committee. *5. The dates corrective action will be completed.* November 21, 2019 K363 POC Accepted 12-6-19 S. Dumont/TJO.	
K 500 SS=D	Building Services - Other CFR(s): NFPA 101 Building Services - Other List in the REMARKS section any LSC Section 18.5 and 19.5 Building Services 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 10/22/2019, the facility failed to ensure in Exposed Wiring - All parts of electric equipment shall be guarded against accidental contact by approved enclosures. All unused	K 500	<u>K 500</u> *1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice?* The fan and exposed wires in the boiler room were removed *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?* An inspection of the building was conducted, no other fans exist and no exposed wires were found. *3. What measures will be put into place or what systematic changes will you make to ensure that the deficient practice does not reoccur?*	

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K 500	Continued From page 6 openings shall be properly closed (NFPA 73 2.2.3, NFPA 70 110.27). Findings include the following: Per observation on 10/22/2019, and accompanied by the Maintenance Director, inspection revealed an oen electrical box in the ceiling & an old exhaust fan not in service that should be removed in the sprinkler room.	K 500	If additional items are found a Life Safety work order will be placed. *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)?* A building audit will be conducted by the Director of Plant Operations and/or Designee weekly for 4 weeks, then monthly for 2 months. The results will be reviewed by the facility Safety-Quality Committee. *5. The dates corrective action will be completed.* November 21, 2019 K 753 K500 POC accepted 12-6-19 S. Dumont/TW *1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice?* The combustible decorations in the North Stair Tower were removed immediately. *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?*	
K 753 SS=D	Combustible Decorations CFR(s): NFPA 101 Combustible Decorations Combustible decorations shall be prohibited unless one of the following is met: o Flame retardant or treated with approved fire-retardant coating that is listed and labeled for product. o Decorations meet NFPA 701. o Decorations exhibit heat release less than 100 kilowatts in accordance with NFPA 289. o Decorations, such as photographs, paintings and other art are attached to the walls, ceilings and non-fire-rated doors in accordance with 18.7.5.6(4) or 19.7.5.6(4). o The decorations in existing occupancies are in such limited quantities that a hazard of fire development or spread is not present. 19.7.5.6 This REQUIREMENT is not met as evidenced by: Per observation on 10/22/2019, the facility failed to ensure that combustible decorations met requirements. Findings include the following: Per observation on 10/22/2019, and accompanied by the Maintenance Director, inspection revealed in the North Stair Tower			

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K 753	Continued From page 7 combustible decorations were hung on the wall.	K 753	A building inspection was conducted and all combustible wall decorations were removed. *3. What measures will be put into place or what systematic changes will you make to ensure that the deficient practice does not reoccur?* The policy: "Combustible Items and Seasonal Decorations" were reviewed and updated as indicated. Education was provided to all staff And policies were reviewed. *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)?* Audits will be conducted by the Director of Plant Operations and/or Designee weekly for 4 weeks, then monthly for 2 months. The results will be reviewed by the facility Safety-Quality Committee. *5. The dates corrective action will be completed.* November 21, 2019 K753 POC accepted 12-6-19 S. Dumont / TD.	