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) 564-1612December 21, 2022

January 12, 2023

Mr. Isaac Spilman, Administrator
Elderwood At Burlington
98 Starr Farm Rd
Burlington, VT 05408-1396

Provider #: 475030

Dear Mr. Spilman:

Enclosed is a copy of your acceptable plans of correction for the Life Safety Code survey conducted on **December 6, 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
	475030	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/06/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELDERWOOD AT BURLINGTON	**98 STARR FARM RD** **BURLINGTON, VT 05408**

(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 December 6, 2022. Entry and exit interviews were conducted with the Administrator and Facilities Maintenance Director. While the facility was in substantial compliance with applicable Life Safety Code requirements, the following issues were identified that require correction by the facility.	K 000	The facility wishes to have this plan of correction stand as its written plan of compliance. Preparation and/or execution of this does not constitute an admission or agreement with the existence of or scope of severity of the cited deficiencies. This plan is prepared and/or executed to ensure compliance with regulatory requirements.	
K 761 SS=C	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: This standard was not met, as evidenced by the walk-through of the facility on December 6, 2022. Inspection revealed the following: Smoke barrier doors to the kitchen area & dining area are provided with fire closer hinges that no longer function as designed. An egress hall is subject to smoke from a high hazardous area.	K 761	No residents were directly impacted by this potential deficient practice. The hinges on the smoke barrier doors to the kitchen were replaced on 12/22/22 to correct the deficient practice All residents have the potential to be affected. An audit of all doors will be initiated to inspect them for safety and to ensure that no other hinges are out of compliance. The Administrator will educate the Maintenance Department on asset tagging the doors, & the policy on TELS tasks for fire door inspections to identify and prevent breaches in the smoke barrier doors. The Director of Maintenance will auditdoor hinges to ensure that door hinges & smoke barrier doors are checked monthly for 3 months to	

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 761	Continued From page 1 This deficiency was reviewed with the Facilities Manager and Administrator at the time of the survey.	K 761	ensure compliance with door hinges and smoke barrier doors. The Maintenance Director will be responsible for this plan of correction. Substantial compliance will be achieved by Feb 6th, 2023. K761 approved 1/11/2023 M.Steele/TW	