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

August 24, 2022

Mr. David Beauregard, Administrator
Pine Heights At Brattleboro Center For Nursing & Rehab
187 Oak Grove Avenue
Brattleboro, VT 05301-6642

Provider #: 475023

Dear Mr. Beauregard:

Enclosed is a copy of your acceptable plans of correction for the Life Safety Code survey conducted on **July 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
Licensing Chief

Enclosure

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 475023 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **07/14/2022** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **PINE HEIGHTS AT BRATTLEBORO CENTER FOR NURSING & R** | **187 OAK GROVE AVENUE**<br>**BRATTLEBORO, VT 05301** |

| (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<br><br>The Division of Fire Safety completed an unannounced onsite Life Safety Code inspection on July 14, 2022. Entry and Exit interviews were conducted with the Administrator. The following violations were identified. | K 000 | Please see the following plan of correction. The filing of this plan does not constitute an admission that the deficiencies alleged did in fact exist. This plan of correction is filed and executed as evidence of the facility's desire to comply with the provisions of federal and state law and to continue to provide quality care and service. | |
| K 300 SS=D | Protection - Other<br>CFR(s): NFPA 101<br><br>Protection - Other<br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Per observation on July 14, 2022, the facility failed to ensure that all doors in the facility meet regulatory requirements. Findings include the following:<br><br>1. Per observation on July 14, 2022, and accompanied by the Maintenance Director and Administrator, inspection revealed that fire doors and frame's fire rating label has been removed or painted over. NFPA-80 sec 5.2.3.5.1-5.2.3.5.2.<br><br>2. Per observation on July 14, 2022, and accompanied by the Maintenance Director and Administrator, inspection revealed that the fourth-floor medication room door does not have a door closure. NFPA-101 7.2.1.8.1 | K 300 | K300 NFPA 101 Protection - Other<br>The facility ensures adherence to LSC Protection Requirements.<br>Fire door and frames with fire rating tags were cleaned of any paint or substance that may inhibit their interpretation.<br>Doors with missing tags will be evaluated by a Licensed Contractor to be re-certified and have new tags issued where applicable.<br>Environmental services staff were provided with in-service education related to the importance of not painting over or removing fire rating labels/tags.<br>The Environmental Services Director will complete random weekly audits to ensure that all applicable doors have the necessary fire rating labels/tags.<br>Audit findings will be reviewed monthly by the QAPI Committee unitl 3 months of 100% compliance is achieved.<br>The Administrator will review and monitor all findings.<br>Completion Date: 10/4/2022 | |

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 300 | Continued From page 1<br><br>3. Per observation on July 14, 2022, and accompanied by the Maintenance Director and Administrator, inspection revealed that the supply and linen storage room doors do not have self-closure and are left open throughout this facility. NFPA-101 7.2.1.8.1 | K 300 | Continued from Previous.<br>Nursing, Laundry, and Housekeeping staff were provided with in-service education regarding door closures and the importance of not propping doors open.<br>A door closure was added to the fourth floor medication room.<br>Door closures were added to supply and linen storage room doors.<br>The Environmental Services Director will complete random weekly audits to ensure that all applicable doors have the necessary door closures & are not propped open.<br>Audit findings will be reviewed monthly by the QAPI Committee until 3 months of 100% compliance is achieved.<br>The Administrator will review and monitor all findings.<br>Completion Date: 8/26/2022 and on-going<br><br>K300 accepted 8/23/22 S. Dumont/T.Wehmeyer | |
| K 311<br>SS=D | Vertical Openings - Enclosure<br>CFR(s): NFPA 101<br><br>Vertical Openings - Enclosure<br>2012 EXISTING<br>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<br>If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box.<br>This REQUIREMENT is not met as evidenced by:<br>Per observation on July 14, 2022, the facility failed to ensure that verticle openings have fire resistant rating of at least one hour. Findings include the following:<br><br>1. Per observation on July 14, 2022, and accompanied by the Maintenance Director and Administrator, inspection revealed that the fourth-floor linen and storage rooms have penetrations in the ceiling tiles.<br><br>2. Per observation on July 14, 2022, and accompanied by the Maintenance Director and Administrator, inspection revealed that the | K 311 | K311 NFPA 101 Vertical Openings - Enclosure<br>The facility ensures 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.<br>The penetrations to the: Fourth floor linen room, fourth floor storage room, and third floor utility room were repared. | |

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| K 311 | Continued From page 2<br>third-floor utility room has penetrations in the ceiling tile. | K 311 | Continued from Previous.<br>The Environmental Services Director or his designee will conduct random weekly audits throughout the building to inspect for penetrations in the ceiling tiles.<br>Audit findings will be reviewed monthly by the QAPI Committee until 3 months of 100% compliance is achieved.<br>The Administrator will review and monitor all findings.<br>Completion Date: 8/19/2022<br><br>K311 POC accepted 8/23/22 S. Dumont/T.Wehmeyer | |