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

July 31, 2018

Mr. Timothy Urich, Administrator
The Pines At Rutland Center For Nursing And Rehabitation
99 Allen Street
Rutland, VT 05701-4501

Provider #: 475018

Dear Mr. Urich:

Enclosed is a copy of your acceptable plans of correction for the Life Safety Code survey conducted on **June 27, 2018**. 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
	475018	A. BUILDING 01 - BUILDING 01 B. WING _____	06/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PINES AT RUTLAND CENTER FOR NURSING AND REHABI	99 ALLEN STREET RUTLAND, VT 05701

(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 6/27/18. The following violations were identified.	K 000		
K 100 SS=D	General Requirements - Other CFR(s): NFPA 101 General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General 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: Based on observation, the facility failed to ensure that all applicable codes and standards are met in one area of the facility, regarding storage in the sprinkler room. Per observation on 6/27/18, accompanied by the Maintenance Director, in the sprinkler room the path to the sprinkler riser was blocked completely by items.	K 100	Corrective Action: The items in the sprinkler room have been removed and the path to the sprinkler riser is now clear. Identify Other: The facility has just one sprinkler room. Systemic Changes: All staff having access to the secured sprinkler room will receive education in regards to no items being stored in the area. Monitoring: The sprinkler room will be audited 3 times per week for 12 weeks to ensure no items are being stored in this area. The results of the audits will be submitted to the QA Committee monthly. Completion Date: 8/25/18 Responsible Party: Maintenance Director K100 POC accepted 7/26/18 DGreen/PMW	
K 232 SS=D	Aisle, Corridor, or Ramp Width CFR(s): NFPA 101 Aisle, Corridor or Ramp Width 2012 EXISTING The width of aisles or corridors (clear or unobstructed) serving as exit access shall be at least 4 feet and maintained to provide the convenient removal of nonambulatory patients on stretchers, except as modified by 19.2.3.4, exceptions 1-5. 19.2.3.4, 19.2.3.5	K 232	Corrective Action: (1) All items identified have been removed from the corridors on 3rd and 4th floor. (2) The corridor wall was immediately readjusted to the required 48 inches. Identify Others: All facility corridors could be affected by this same practice. Therefore, an inital audit of all facility corridors will be conducted to ensure compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Administrator 7/25/18

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.

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

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K 232	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to ensure that all aisles or corridors serving as exit access are at least 4 feet wide for 2 of 3 units. Per observation on 6/27/18, accompanied by the Maintenance Director, the corridors on the 3rd and 4th floor were used to store items such as wheeled carts, medical carts, and wheelchairs. The presence of these items reduced the width of the corridor down to 2 feet. Also, on the 3rd floor, a temporary corridor wall reduced the width of the corridor to 44 inches in the north side length of the corridor.	K 232	Systemic Changes: All staff will be reeducated in regards to the Life Safety Code and items not permitted to be stored in corridors. Monitoring: All facility corridors will be audited five times per week at random times to ensure compliance. Completion Date: 8/25/18 Responsible Parly: Maintenance Director K232 POC accepted 7/26/18 DGreen/PMC	
K 293 SS=D	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to ensure that all exit signs are maintained in working order in one area of the building. Per observation on 6/27/18, accompanied by the Maintenance Director, the first floor south tower stair landing's exit sign is not properly	K 293	Corrective Action: The identfied sign located in the first floor south tower's stair landing has been replaced and is now functioning properly. Identify Others: All illuminated signage within the facility has the potential to be affected by the same. Therefore, an initial audit of all illuminated signage with be completed. Systemic Change: The facility will ensure that illuminated signage is placed on the facility's monthly Preventative Maintenance Schedule and audited monthly. Monitoring: An audit of all illuminated signage will be completed weekly for 12 weeks to ensure compliance. The results of these audits will be submitted to the QA Committee for review. Completion Date: 8/25/18 Repsonsible Parly: Maintenance Director	

K293 POC accepted 7/26/18 DGreen/PMC

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K 293	Continued From page 2 illuminated.	K 293		
K 345 SS=D	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to ensure the fire alarm system is maintained in accordance with standards. Per observation on 6/27/18, accompanied by the Maintenance Director, on the first floor, a duct smoke detector showed it was activated and/or in trouble.	K 345	Corrective Action: The facility will have its Fire Protection System contractor inspect/evaluate the identified duct smoke detector and make appropriate repairs/adjustments. Identify Others: All facility duct smoke detectors have the potential to be affected by the same practice. Systemic Change: The maintenance staff will be re-educated on the importance of monitoring the facility's smoke detectors and responding to any issues immediately. Monitoring: All duct smoke detectors will be audited weekly for 12 weeks to ensure compliance. The results of the audits will be report to the QA Committee for review. K345 POC accepted 7/26/18 DGreen/PMC	
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	K 363	Corrective Action: The identified doors on the 2nd and 4th floors have been adjusted and both now close tightly to resist the passage of smoke. Identify Others: All smoke doors within the facility can be affected by this same practice: Systemic Change: The facility will ensure that all smoke doors are placed on a Monthly Preventative Maintenance Schedule. The Maintenance Director will complete education with appropriate staff on the requirement of these doors to close tightly to resist the passage of smoke.	

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K 363	Continued From page 3 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 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: Based on observation, the facility failed to ensure smoke doors resist the passage of smoke in 2 areas of the facility. Per observation on 6/27/18, accompanied by the Maintenance Director, the 4th floor dining room smoke door is not closing tightly as required to resist the passage of smoke. Also, the 2nd floor north corridor smoke door is not closing tightly as required to resist the passage of smoke.	K 363	Monitoring: All smoke doors will be audited monthly to ensure compliance. The results of the audits will be submitted to the QA Committee monthly for review. Completion Date: 8/25/18 Responsible Party: Maintenance Director K363 POC accepted 7/26/18 DEGreen/RMA	

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K 923 SS=D	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather.	K 923	Corrective Action: All identified oxygen tanks that were unsecured have been placed in appropriate storage racks. Additionally, the gasoline has been removed from the area and stored in an appropriate location. Identify Others: All storage areas at the facility containing oxidizing gases have the potential to be affected by the same practice. Systemic Change: All staff having access to the outside secured storage areas containing oxidizing gases will be educated on the requirement that they are not to be stored with flammables or combustibles. Monitoring: All outside storage areas containing oxidizing gases will be audited 3 times per week for 12 weeks to ensure compliance. The results of the audits will be submitted to the QA Committee monthly for review. Completion Date: 8/25/18 Responsible Party: Maintenance Director K923 POC accepted 7/26/18 DGreen/RNE	

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K 923	Continued From page 5 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to ensure the proper storage of oxygen, in one storage building located behind the facility. Per observation on 6/27/18, accompanied by the Maintenance Director, there were oxygen tanks being stored in a small storage building behind the facility. The storage building did not ensure proper securing of the tanks, and there was also gasoline being stored in the same building, less than 25 feet away from the oxygen.	K 923		