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

May 10, 2019

Ms. Diana Lafountain, Administrator
Pines Rehab & Health Ctr
601 Red Village Road
Lyndonville, VT 05851-9068

Provider #: 475044

Dear Ms. Lafountain:

Enclosed is a copy of your acceptable plans of correction for the **Life Safety Code survey** conducted on **April 17, 2019**. 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
	475044	A. BUILDING 01 B. WING	04/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINES REHAB & HEALTH CTR	601 RED VILLAGE ROAD LYNDONVILLE, VT 05851

(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 4/17/2019. The following violations were identified.	K 000		
K 223 SS=D	Doors with Self-Closing Devices CFR(s): NFPA 101 Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to ensure doors with self-closing devices were working properly. Per observation on 4/17/2019, accompanied by the Administrator of the facility, the facility failed to ensure that the self-closing device on the door in the basement leaving the generator room was working properly creating the potential for smoke to spread in the event of a fire.	K 223	K 223 1. The identified self-closing device in the basement has been replaced and is functioning properly 2. All other self-closing devices have been reviewed to ensure proper operation 3. The Maintenance Director and Administrator have reviewed and are aware of the requirements for properly functioning self-closing devices 4. Weekly audits will be conducted by the Maintenance Director or designee to monitor effectiveness of the plan x4 weeks and monthly x3 months 5. The results of the audits will be reported to the QAA committee x3 months at which time the committee will determine further action 6. Corrective action will be completed by May 17, 2019 K223 POC accepted 5/9/19 PMclaughlin/pmc	
K 325 SS=D	Alcohol Based Hand Rub Dispenser (ABHR) CFR(s): NFPA 101	K 325		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Diana LaFountain, RN	Administrator	05.08.19

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 325	Continued From page 1 Alcohol Based Hand Rub Dispenser (ABHR) ABHRs are protected in accordance with 8.7.3.1, unless all conditions are met: * Corridor is at least 6 feet wide * Maximum individual dispenser capacity is 0.32 gallons (0.53 gallons in suites) of fluid and 18 ounces of Level 1 aerosols * Dispensers shall have a minimum of 4-foot horizontal spacing * Not more than an aggregate of 10 gallons of fluid or 135 ounces aerosol are used in a single smoke compartment outside a storage cabinet, excluding one individual dispenser per room * Storage in a single smoke compartment greater than 5 gallons complies with NFPA 30 * Dispensers are not installed within 1 inch of an ignition source * Dispensers over carpeted floors are in sprinklered smoke compartments * ABHR does not exceed 95 percent alcohol * Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11) * ABHR is protected against inappropriate access 18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485 This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to ensure that an alcohol based hand rub dispenser was properly placed. Per observation on 4/17/2019, accompanied by the Administrator of the facility, the facility failed to ensure that the Alcohol Based Hand Rub Dispenser outside of one room was placed properly as evidenced in that the dispenser was found directly above an outlet.	K 325	K 325 1. The identified Alcohol Based Hand Rub dispenser has been moved to an appropriate location 2. All other dispensers have been reviewed to ensure correct placement in appropriate locations 3. The Maintenance Director and Administrator have reviewed and understand the requirement for locations of Alcohol Based Hand Rub dispensers 4. Weekly audits will be done by the Maintenance Director or designee to monitor effectiveness of the plan x4 weeks and monthly x3 months. 5. The results of the audits will be reported to the QAA committee x3 months at which time the committee will determine further action 6. Corrective action will be completed by May 17, 2019 K325 POC accepted 5/9/19 PMclaughlin/PMC	
K 346	Fire Alarm System - Out of Service	K 346		

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K 346 Continued From page 2
SS=D CFR(s): NFPA 101

Fire Alarm - Out of Service
Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service.
9.6.1.6
This REQUIREMENT is not met as evidenced by:
Based on observation, the facility failed to ensure that all components of the fire alarm system were in operation.

Per observation on 4/17/2019, accompanied by the Administrator of the facility, the facility failed to ensure that the fire alarm system on the C-wing was operational. The Fire Alarm was noted to be in "Trouble" and once the issue had been resolved, the detectors had not been placed back into service.

K 346

K 346

1. The identified detectors were replaced
2. All other detectors were reviewed to ensure they were in place
3. The Maintenance Director and the Administrator have reviewed and understand the requirements for detectors to be properly placed and functional
4. Weekly audits will be conducted by the Maintenance Director or designee to monitor effectiveness of the plan x4 weeks and monthly x3 months
5. The results of the audits will be reported to the QAA committee x3 months at which time the committee will determine further action
6. Corrective action will be completed by May 17, 2019

K 351 Sprinkler System - Installation
SS=D CFR(s): NFPA 101

K 346 POC accepted 5/9/19 PMclaughlin/PMC

Spinkler 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.

K 351

K 351

1. The identified storage in front of the sprinkler control valves was removed
2. The sprinkler system was serviced by a contracted company and is fully functional

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K 351	Continued From page 3 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, the facility failed to ensure that all components of the sprinkler system were accessible. Per observation on 4/17/2019, accompanied by the Administrator of the facility, the facility failed to ensure that the sprinkler control valves were accessible as evidenced by storage of a desk and chairs in front of the sprinkler control valves, making them inaccessible. It was also noted that the tank for the sprinkler water was down from its full level approximately by one inch.	K 351	3. The Maintenance Director and Administrator have reviewed and understand the requirements for compliance with the sprinkler system 4. Weekly audits will be conducted by the Maintenance Director or designee to ensure there is no storage blocking the sprinkler control valves weekly x4 weeks and monthly x3 5. The sprinkler system is serviced quarterly by a contracted service and that service will continue on a quarterly basis 6. Results of the audits will be reported to the QAA committee x3 months at which time the committee will determine further action 7. Corrective action to be completed by May 17, 2019 K351 POC accepted 5/9/19 PMcLaughlin/PMC	
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms	K 920	K 920 1. The identified extension cord was removed 2. An initial audit was conducted throughout the building to ensure there were no other extension cords in use inappropriately 3. A letter has been given to residents and families to ensure they understand the requirements related to the use of extension cords in the facility. This letter has also been provided to staff	

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K 920	Continued From page 4 (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to ensure that an extension cord was used properly. Per observation on 4/17/2019, accompanied by the Administrator of the facility, in one room next to the dresser was located an extension cord being used to power the television. The extension cord was being used inappropriately as fixed wiring.	K 920	4. The Maintenance Director and the Administrator have reviewed and are aware of the requirements for appropriate use of extension cords 5. Weekly audits will be conducted by the Maintenance Director or designee to monitor effectiveness of the plan x4 weeks and monthly x3 6. The results of the audits will be reported to the QAA committee x3 months at which time the committee will determine further action 7. Corrective action will be completed by May 17, 2019 K920 POC accepted 5/9/19 PMclaughlin / PMC	
K 922 SS=D	Gas Equipment - Other CFR(s): NFPA 101 Gas Equipment - Other List in the REMARKS section any NFPA 99 Chapter 11 Gas Equipment 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. Chapter 11 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to ensure appropriate signage for oxygen usage in a resident room.	K 922	K 922 1. The identified room has had signage placed to indicate the use of oxygen 2. All other rooms with oxygen in use have been identified and appropriate signage is in place 3. In-servicing will be done with staff to ensure they understand the requirement for signage when oxygen is in use.	

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K 922	Continued From page 5 Per observation on 4/17/2019, accompanied by the Administrator of the facility, the facility failed to post signage on either the door or the wall indicating that oxygen cylinders were in use in one resident room. (NFPA 99: 11.5.3.2.2)	K 922	4. Weekly audits will be conducted by the Maintenance Director or designee to monitor effectiveness of the plan x4 weeks and monthly x3 months 5. The results of the audits will be reported to the QAA committee x3 months at which time the committee will determine further action. 6. Corrective action to be completed by May 17, 2019 K922 POC accepted 5/9/19 PMclaughlin/PRN	