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

February 28, 2022

Ms. Amy Walker, Administrator
Rutland Healthcare & Rehabilitation Center
46 Nichols Street
Rutland, VT 05701-3275

Provider #: 475039

Dear Ms. Walker:

Enclosed is a copy of your acceptable plans of correction for the **Life Safety Code survey** conducted on **February 8, 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
	475039	A. BUILDING 01 B. WING _____	02/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RUTLAND HEALTHCARE & REHABILITATION CENTER	46 NICHOLS 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 The Division of Fire Safety completed an announced onsite Life Safety code inspection on February 8, 2022. Entry and exit interviews were conducted with the Facility Administrator and Facilities Maintenance Director. The following violations were identified.	K 000		
K 222 SS=B	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location	K 222	The Rutland Health and Rehabilitation Center provides this plan of correction without admitting or denying the validity or existence of the alleged deficiencies. The plan of correction is prepared and executed solely because it is required by federal and state law. 1. All residents/patients that reside at the center, staff and visitors have the potential to be affected by the alleged deficient practice. 2. The latch lock was immediately removed from the storage door in the third floor break room. 3. Audit of other center locks/latches was completed. 4.Results of the audit will be reported to the QAPI committee. Compliance date of 2/10/2022. K222 accepted 2/25/2022 by *M. Steele/ T Wehmeyer*	

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

Administrator 2/25/22

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475039	A. BUILDING 01 B. WING _____	02/08/2022

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K 222	Continued From page 1 within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Per observation on February 8, 2022, the facility failed to ensure that doores in a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key. Findings include the following: Per observation on February 8, 2022, and accompanied by the Facility Administrator and the	K 222		

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	475039	A. BUILDING 01 B. WING	02/08/2022

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K 222	Continued From page 2 Facilities Maintenance Director, inspection revealed that the primary egress door for the Staff Lounge located on the third floor (Dementia Unit) Kitchenette is equipped with a hasp and latch.	K 222	The Rutland Health and Rehabilitation Center provides this plan of correction without admitting or denying the validity or existence of the alleged deficiencies. The plan of correction is prepared and executed solely because it is required by federal and state law. 1. All residents/patients that reside at the center, staff and visitors have the potential to be affected by the alleged deficient practice. 2. The second floor smoke barrier/fire barrier door was found and is being replaced. Center is working with a contracted vendor for proper installation and compliance. 3. Audit of other center doors and passageways completed. 4.Results of the audit will be reported to the QAPI committee. Compliance date of 3/4/2022. Pending contractor availability and availability of parts. K223 accepted 2/25/2022 by M.Steele/T Wehmeyer	
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: Per observation on February 8, 2022, the facility failed to ensure that doors in an exit passageway or horizontal exit, smoke barrier, are self closing and kept in teh closed position unless held open by a release device complying with 7.2.1.8.2. Findings include the following: Per observation on February 8, 2022, and accompanied by the Facility Administrator and the Facilities Maintenance Director, inspection revealed that on Floor 2 teh smoke barrier/fire barrier door for teh main coordior to the South Wing has been removed.	K 223		
K 325	Alcohol Based Hand Rub Dispenser (ABHR)	K 325		

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K 325 SS=B	Continued From page 3 CFR(s): NFPA 101 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: Per observation on February 8, 2022, the facility failed to ensure that Alcohol-Based Hand Rub (ABHR) Dispensers meet all regulatory requirements. Findings include the following: Per observation on February 8, 2022, and accompanied by the Facility Administrator and the Facilities Maintenance Director, inspection revealed that ABHR dispensers are provided in every patient room where the exit access hallway	K 325	The Rutland Health and Rehabilitation Center provides this plan of correction without admitting or denying the validity or existence of the alleged deficiencies. The plan of correction is prepared and executed solely because it is required by federal and state law. 1. All residents/patients that reside at the center, staff and visitors have the potential to be affected by the alleged deficient practice. 2. The center is in compliance with 9 of the 10 conditions described in the regulation. Placement of the sanitizers are compliant with the center's infection control guidance during the pandemic and we are working with The Division of Fire Safety for a long-term plan for adequate placement of the sanitizer dispensers. 3.Results of the audit will be reported to the QAPI committee. K325 accepted 2/25/22 by *M. Steele/T Wehmeyer*	

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K 325	Continued From page 4 is less than six feet wide.	K 325		
K 912 SS=B	Electrical Systems - Receptacles CFR(s): NFPA 101 Electrical Systems - Receptacles Power receptacles have at least one, separate, highly dependable grounding pole capable of maintaining low-contact resistance with its mating plug. In pediatric locations, receptacles in patient rooms, bathrooms, play rooms, and activity rooms, other than nurseries, are listed tamper-resistant or employ a listed cover. If used in patient care room, ground-fault circuit interrupters (GFCI) are listed. 6.3.2.2.6.2 (F), 6.3.2.2.4.2 (NFPA 99) This REQUIREMENT is not met as evidenced by: Per record observation on February 8, 2022, the facility failed to ensure all power receptacles met regulatory requirements. Findings include the following: Per observation on February 8, 2022, and accompanied by the Facility Administrator and the Facilities Maintenance Director, inspection revealed power receptacles throughout the facility have at least one highly dependable grounding pole capable of maintaining resistance with its mating plug (two-prong units not permitted).	K 912	The Rutland Health and Rehabilitation Center provides this plan of correction without admitting or denying the validity or existence of the alleged deficiencies. The plan of correction is prepared and executed solely because it is required by federal and state law. 1. All residents/patients that reside at the center, staff and visitors have the potential to be affected by the alleged deficient practice. 2. All 2 prong power receptacles were upgraded to meet requirements of regulation. 3. Audit of other receptacles completed. 4. Results of the audit will be reported to the QAPI committee. Compliance date of 2/14/2022. K912 accepted 2/25/22 by *M.Steele/ T Wehmeyer*	

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 475039	MULTIPLE CONSTRUCTION A. BUILDING: 01 B. WING	DATE SURVEY COMPLETE: 2/8/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RUTLAND HEALTHCARE & REHABILITATION CENTER	46 NICHOLS STREET RUTLAND, VT

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
K 331	Interior Wall and Ceiling Finish CFR(s): NFPA 101 Interior Wall and Ceiling Finish 2012 EXISTING Interior wall and ceiling finishes, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and have a flame spread rating of Class A or Class B. The reduction in class of interior finish for a sprinkler system as prescribed in 10.2.8.1 is permitted. 10.2, 19.3.3.1, 19.3.3.2 Indicate flame spread rating(s). _____ This REQUIREMENT is not met as evidenced by: Per record review on February 8, 2022, the facility failed to ensure that existing walls have an appropriate flame spread rating. Findings include the following: Per record review on February 8, 2022, and accompanied by the Facility Administrator and the Facilities Maintenance Director, inspection revealed no documentation of flame spread rating of Class C wall finish in a sprinklered building available at the time of survey for the thrid floor North Utility Room. (Homosote, which is painted).

K331	The Rutland Health and Rehabilitation Center provides this plan of correction without admitting or denying the validity or existence of the alleged deficiencies. The plan of correction is prepared and executed solely because it is required by federal and state law. 1. All residents/patients that reside at the center, staff and visitors have the potential to be affected by the alleged deficient practice. 2. Homosote was removed, scraped and repainted according to regulations. 3.Results of the audit will be reported to the QAPI committee. Compliance date of 3/4/2022. K331 accepted 2/25/22 by *M.Steele/T Wehmeyer*

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The above isolated deficiencies pose no actual harm to the residents