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

February 28, 2020

Ms. Lauren White, Administrator
Saint Albans Healthcare And Rehabilitation Center
596 Sheldon Road
Saint Albans, VT 05478-8011

Provider #: 475021

Dear Ms. White:

Enclosed is a copy of your acceptable plans of correction for the **Life Safety Code** survey conducted on **January 30, 2020**. 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
	475021	A. BUILDING 01 - 01 BUILDING B. WING _____	01/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT ALBANS HEALTHCARE AND REHABILITATION CENTER	596 SHELDON ROAD SAINT ALBANS, VT 05478

(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 January 30, 2020. The following violations were identified.	K 000	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, **Saint Albans Health & Rehabilitation Center** does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."	
K 200 SS=B	Means of Egress Requirements - Other CFR(s): NFPA 101 Means of Egress Requirements - Other List in the REMARKS section any LSC Section 18.2 and 19.2 Means of Egress 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. 18.2, 19.2 This REQUIREMENT is not met as evidenced by: Per observation on January 30, 2020, the facility failed to ensure that egress requirements are being met. Findings include the following: Per observation on January 30, 2020, and accompanied by the Director of Facility Maintenance, inspection revealed that the stair guard leading to the basement does not meet the requirements of NFPA 101 Chapter 7.	K 200	K200 *Corrective Action* Stair guard being installed by Maintenance Director. Stair guard will be secured. Corrective action will be completed by 2/21/2020. No residents were affected by the alleged deficient practice. *Systematic Changes* Maintenance Director educated regarding regulations pertaining to means of egress. *Monitoring* The Center Executive Director and or designee will ensure the stair guard is in place 4x weekly and then 3x monthly. The results will be reviewed at QAPI.	
K 211 SS=B	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is	K 211	K200 POC Accepted 02282020 J. Directe/TD	

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

Administrator 2/21/2020

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 211 Continued From page 1

continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11.
18.2.1, 19.2.1, 7.1.10.1
This REQUIREMENT is not met as evidenced by:
Per observation on January 30, 2020, the facility failed to ensure that all Egress requirements are met. Findings include the following:

Per observation on January 30, 2020, and accompanied by the Director of Facility Maintenance, inspection revealed a build up of ice near the ambulance entrance door. The violation was corrected at the time of inspection.

K 225 SS=B Stairways and Smokeproof Enclosures
CFR(s): NFPA 101

Stairways and Smokeproof Enclosures
Stairways and Smokeproof enclosures used as exits are in accordance with 7.2.
18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2

This REQUIREMENT is not met as evidenced by:
Per observation on January 30, 2020, the facility failed to ensure stairway used as exits meet regulatory requirements. Findings include the following:

Per observation on January 30, 2020, and accompanied by the Director of Facility Maintenance, inspection revealed that storage was found in the basement stair enclosure near the old generator room.

K211

K 211 *Corrective Action*
While the issue was corrected immediately, maintenance or designee will continue to clear means of egress of snow and ice during each storm.
Corrective action was completed at time of inspection 1/30/2019.
No residents were affected by the alleged deficient practice.

Systematic Changes
Maintenance Director will be educated on maintaining a regular schedule to clear means of egress.

Monitoring
Center Executive Director and or designee will audit the snow and ice removal at means of egress for the next 4 snow storms to ensure snow and ice is removed appropriately.
Results of the audit will be present to QAPI.

K211 POC Accepted 02-28-2020 J. Dobrecki/RN

K225 *Corrective Action*
Materials have been removed from the area and properly stored. Corrective action was complete on 2/17/2020.
No residents were affected by the deficient practice.

Systematic Changes
Maintenance Director educated on proper storage of materials.

Monitoring
Add to TELS system for maintenance to regularly check designated means of egress for clutter to ensure proper location for storage items. Results will be review at QAPI.

K225 POC Accepted 02-28-2020
J. Dobrecki/RN

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K 353 Sprinkler System - Maintenance and Testing
SS=B CFR(s): NFPA 101

Sprinkler System - Maintenance and Testing
Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.
a) Date sprinkler system last checked

b) Who provided system test

c) Water system supply source

Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.
9.7.5, 9.7.7, 9.7.8, and NFPA 25
This REQUIREMENT is not met as evidenced by:
Per observation on January 30, 2020, the facility failed to ensure that sprinkler systems meet regulatory requirements. Findings include the following:

Per observation on January 30, 2020, and accompanied by the Director of Facility Maintenance, inspection revealed storage (1 cardboard box) in the records room in the basement was found to be closer than 18" to a sprinkler head.

K 353

K353
Corrective Action
The one box in violation was moved immediately. Corrective action was completed on 1/30/2019.
No residents were affected by this deficient practice.

Systematic Changes
Maintenance Director and supply coordinators were educated on proper storage protocols. A visual aid will be utilized to assist in assessing proper distance from the sprinkler heads. Corrective action will be complete by 2/24/2020.
No residents were affected by the alleged deficient practice.

Monitoring
Center Executive Director and or designee will perform audits, 4x weekly and 3x monthly to ensure that storage is within appropriate limits of the sprinkler heads. Results will be reviewed at QAPI.

K353 POC Accepted 02-28-2020
J Dobiecki ITW

K 511 Utilities - Gas and Electric
SS=B CFR(s): NFPA 101

Utilities - Gas and Electric
Equipment using gas or related gas piping

K 511

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K 511	Continued From page 3 complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: Per observation on January 30, 2020, the facility failed to ensure all gas and electric utilites meet regulatory requirements. Findings include the following: 1. Per observation on January 30, 2020, and accompanied by the Director of Facility Maintenance, inspection revealed an improperly used extension cord to be powering a defrosting device in the freezer nearest the exit door in the kitchen. 2. Per observation on January 30, 2020, and accompanied by the Director of Facility Maintenance, inspection revealed an electrical panel in the boiler room near the entrance to be lacking a panel schedule.	K 511	K511 *Corrective Action* In example 1 the extension cord will be removed and electrical will be wired appropriately within the freezer. The corrective action will be complete on 2/24/2020. Example 2 the panel schedule was located a returned to the proper location in the boiler room electrical panel. The corrective action was complete on 1/30/2019. No residents were affected by the alleged deficient practice. *Systematic Change* Maintenance Director educated on use of extension cords and importance of educating third party contractors of regulations while providing a service for the building, i.e. regarding electrical panel labeling and use of additional materials (such as extension cords). *Monitoring* Input a regular check of the electrical panels in the TELS system as a means of ensuring appropriate labels remain in place. Monitor weekly x4 and monthly x3. Ensure electrical work is completed appropriately and completely within the freezer. Results will be reviewed at QAPI. K511 Poc accepted 2-28-2020 J. Dabrecki RN	