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

March 2, 2023

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

Provider #: 475021

Dear Ms. Jennings:

Enclosed is a copy of your acceptable plans of correction for the Life Safety Code survey conducted on **October 25, 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

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** B. WING _____	**10/25/2022**

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 The Division of Fire Safety complted an unannounced onsite Life Safety Code inspection on October 25, 2022. While the facility was found to be in substantial compliance with applicable Life Safety Code Requirements, the following issues were identified that require correction by the facility.	K 000		
K 251 SS=C	Dead-End Corridors and Common Path of Travel CFR(s): NFPA 101 Dead-End Corridors and Common Path of Travel 2012 EXISTING Dead-end corridors shall not exceed 30 feet. Existing dead-end corridors greater than 30 feet shall be permitted to be continued to be used if it is impractical and unfeasible to alter them. 19.2.5.2 This REQUIREMENT is not met as evidenced by: At the time of survey, 10/25/2022 at 10:00am, inspection activities with the Facilities Director determined the following: A basement storagem area was in use a a staff training room, with a dead end and non-compliant egress provided more than 45 feet from the exit access door. This deficiency was reviewed on 11/15/2022 with the Facilties Manager and photo evidence of correction and disuse was received.	K 251	Please see attached	
K 311 SS=B	Vertical Openings - Enclosure CFR(s): NFPA 101 Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction	K 311	Please see attached	

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

11/16/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475021	A. BUILDING **01** B. WING _____	**10/25/2022**

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 311	Continued From page 1 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 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box. This REQUIREMENT is not met as evidenced by: At the time of survey, 10/25/2022 at 10:00am, inspection activities with the Facilities Director determined the following: The dumbwaiter remains out of service. It must be closed while it is out of service, or the openings temporarily coverd with 5/8 TYPE-X Gypsum board and sealed. This deficiency was reviewed with Facilities Director on 11/15/2022 and photographic evidence of correction was received.	K 311		

K311

The filing of this plan of correction does not constitute an admission of the allegations set forth in the statement of deficiencies. The plan of correction is prepared and executed as evidence of the facility's continued compliance with applicable law.

There were no untoward effects related to the dumbwaiter not being properly sealed.

The dumbwaiter has been offline for multiple years and given its location does not present as a potential hazard to any residents.

The dumbwaiter was sealed properly on 10/25/2022 day of survey.

The maintenance staff were educated regarding K311 regarding Enclosure of Vertical Openings.

Random audits of the center involving vertical openings will occur weekly x 4, and then monthly times 2 or until substantial compliance has been achieved. Results will be reported to QAPI.

The Maintenance Director will be responsible to ensure compliance.

Date of compliance: 11/15/2022

K311 accepted 1/19/2023 M.Steele/TW

K251

There were no untoward effects related to the room in the basement being utilized as a training room.

The training room has been moved to the first floor effective 10/25/2022.

The staff have been educated on K251 in regards to egress being greater than 30 feet from the exit door.

Random audit of utilized space/rooms in relation to dead-end-corridors not Exceeding 30 feet will be conducted monthly x 4 and reviewed in QAPI for Compliance.

The Maintenance Director and/or his designee will be responsible to Ensure compliance.

Date of compliance: 11/15/2022

K251 accepted 1/19/2023 M. Steele/TW