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

November 5, 2019

Mr. Bradford Ellis, Administrator
Vernon Green Nursing Home
61 Greenway Drive
Vernon, VT 05354-9474

Provider #: 475008

Dear Mr. Ellis:

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

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
	475008	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VERNON GREEN NURSING HOME	61 GREENWAY DRIVE VERNON, VT 05354

(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 Life Safety Code survey was conducted on September 17, 2019 by the Division of Fire Safety. The following violations were identified.	K 000		
K 300 SS=D	Protection - Other CFR(s): NFPA 101 Protection - Other List in the REMARKS section any LSC Section 18.3 and 19.3 Protection 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: Per observation on 9/17/2019, the facility failed to ensure there are no Obstructions to Sprinkler Discharge Pattern Development for Standard Upright or Pendent Spray Sprinklers. According to NFPA 13 Figure A.8.5.5.1 storage within 18 inches of the sprinkler head will reduce the distribution of the water and hinder the effectiveness of the automatic sprinkler system. The findings include the following: Per observation 9/17/2019, and accompanied by the Assistant Maintenance Director, inspection revealed that in teh Maintenance Shop that a sprinkler pipe was being used as a tool hanger and obstructing the sprinkler head.	K 300	**What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** The tools were removed immediately after the survey from the sprinkler pipe in the maintenance shop. 09/17/19 **How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** All residents have the potential to be affected by this finding. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur.** The maintenance department will perform an inspection of these sprinkler pipes twice per year to insure no obstructions exist. The first inspection will be completed by 11/30/19. 11/30/19 **How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.** The quarterly audits will be reviewed at the Quality Assurance team meetings for compliance beginning in November 2019. 11/12/19 K300 POC Accepted 10/25/19 S. Dumont/RN.	
K 362 SS=D	Corridors - Construction of Walls CFR(s): NFPA 101	K 362	Plan of correction begins on next page	

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

M. Bradford Allen | Executive Director | 10.22.19

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 362	Continued From page 1 Corridors - Construction of Walls 2012 EXISTING Corridors are separated from use areas by walls constructed with at least 1/2-hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the transfer of smoke. In nonsprinklered buildings, walls extend to the underside of the floor or roof deck above the ceiling. Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Fixed fire window assemblies in corridor walls are in accordance with Section 8.3, but in sprinklered compartments there are no restrictions in area or fire resistance of glass or frames. If the walls have a fire resistance rating, give the rating _____ if the walls terminate at the underside of the ceiling, give brief description in REMARKS, describing the ceiling throughout the floor area. 19.3.6.2, 19.3.6.2.7 This REQUIREMENT is not met as evidenced by: Per observation on 9/17/2019, the facility failed to assure that walls in the corridors have at least 1/2-hour fire resistance rating. The findings include the following: 1. Per observation on 9/17/2019, and accompanied by the Assistant Maintenance Director, inspection revealed that housekeeping closet in B-Wing has penetration in the wall. 2. Per observation on 9/17/2019, and accompanied by the Assistant Maintenance Director, inspection revealed that the Med Room in B-Wing has penetration in teh ceiling next to light.	K 362	**What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** The identified wall and ceiling penetrations have been repaired with fire-rated materials as of 10/17/19. **How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** All residents have the potential to be affected by this finding. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur.** The maintenance department will inspect every room in the facility twice per year and repairs made to any discovered penetrations with a fire-rated material. The first inspection will be completed by 11/30/19 **How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.** The inspection results will be reviewed at the Quality Assurance team meetings for compliance. **End of K362 Plan of Correction** K362 POC Accepted 10/25/19 S. Dumont / tw	10/17/19 11/30/19 11/30/19

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K 362	Continued From page 2 3. Per observation on 9/17/2019, and accompanied by the Assistant Maintenance Director, inspection revealed that the air handler room in B-Wing has a penetration in the ceiling around the pipes. 4. Per observation on 9/17/2019, and accompanied by the Assistant Maintenance Director, inspection revealed that the IT room in A-Wing has penetration around electrical receptacles. 5. Per observation on 9/17/2019, and accompanied by the Assistant Maintenance Director, inspection revealed that the old air handler room in A-Wing has penetration in the walls and ceiling. 6. Per observation on 9/17/2019, and accompanied by the Assistant Maintenance Director, inspection revealed that the hallway to the loading dock in A-Wing has penetration in the walls. 7. Per observation on 9/17/2019, and accompanied by the Assistant Maintenance Director, inspection revealed that the old smoke room in A-Wing has an acoustical ceiling tile that is broken. 8. Per observation on 9/17/2019, and accompanied by the Assistant Maintenance Director, inspection revealed that the locker room in A-Wing has penetration in the wall and around the pipes.	K 362		
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101	K 363	Plan of Correction starts on next page	

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K 363	Continued From page 3 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 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.	K 363	**What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** The non-latching doors for room 205 and the A-wing clean service room were corrected by 9/18/19. The rehab doors will have magnetic door holders installed that will be controlled by the fire alarm system by 12/31/2019. **How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** All residents have the potential to be affected by this finding. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur.** The maintenance department performs door inspections twice per year now and these will be increased to quarterly inspections. The inspection criteria will now include door stop observations. The first inspection will be completed by 11/30/2019. **How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.** The inspection results will be reviewed at the Quality Assurance team meetings for compliance. K363 POC accepted 10/25/19 S Dumont/TW	12/31/19 11/30/19 11/30/19

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K 363	Continued From page 4 This REQUIREMENT is not met as evidenced by: Per observation on 9/17/2019, the facility failed to ensure door protecting corridor openings can resist the passage of smoke. The findings include the following: 1. Per observation on 9/17/2019, and accompanied by the Assistant Maintenance Director, inspection revealed that Room 205 door in B-Wing does not lock and latch. 2. Per observation on 9/17/2019, accompanied by the Assistant Maintenance Director, inspection revealed that the rehabilitation room door in A-Wing was being held open by a door stop. 3. Per observation on 9/17/2019, accompanied by the Assistant Maintenance Director, inspection revealed that door to the clean service room in A-Wing does not lock and latch.	K 363		
K 500 SS=D	Building Services - Other CFR(s): NFPA 101 Building Services - Other List in the REMARKS section any LSC Section 18.5 and 19.5 Building Services 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: Per observation on 9/17/2019, the facility failed	K 500	**What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** A cover was installed on the open electrical box on 9/18/19. **How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** All residents have the potential to affected by this practice. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur.** The maintenance department will conduct inspections twice per year throughout the facility to insure there are no open electrical boxes. The first inspection will be completed by 11/30/2019. **continued on next page**	09/18/19 11/30/19

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K 500	Continued From page 5 to ensure that all parts of electric equipment shall be guarded against accidental contact by approved enclosures. All unused opening shall be properly closed according to NFPA 73 2.2.3, NFPA 70 110.27 The findings include the following: Per observation 9/17/2019, and accompanied by the Assistant Maintenance Director, inspection revealed an open electrical box in teh ceiling of the Maintenance Shop.	K 500	**How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.** The inspection results will be reviewed at the Quality Assurance team meetings for compliance. K500 POC Accepted 10/25/19 SDumont/TW	11/30/19