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

January 27, 2022

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 **October 29, 2021**. 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 B. WING _____	10/29/2021

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 The Division of Fire Safety completed an unannounced onsite Life Safety Code inspection on October 29, 2021. Entry and exit interviews were conducted with the Director of Environmental Services. The following violations were identified.	K 000		
K 362 SS=D	Corridors - Construction of Walls CFR(s): NFPA 101 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 October 29, 2021, the facility failed to ensure the facility is free of penetrations allowing for the passage of smoke. Findings include the following:	K 362	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 01.13.2022. **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 01.13.2022. **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. K362 POC accepted 1/26/22 *S.Dumont* T Wehmeyer	1.13.22 1.13.22 2.4.22

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

M. Bradford Ellis | Executive Director | January 14, 2022

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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	475008	A. BUILDING **01** B. WING _____	**10/29/2021**

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

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K 362	Continued From page 1 1. Per observation on October 29, 2021, and accompanied by the Director of Environmental Services, inspection revealed there is a penetration in the wall in the B-Wing Housekeeping closet. 2. Per observation on October 29, 2021, and accompanied by the Director of Environmental Services, inspection revealed that the B-Wing Med room has a penetration in the ceiling next to the light. 3. Per observation on October 29, 2021, and accompanied by the Director of Environmental Services, inspection revealed that the B-Wing Air Handler room ceiling has penetration around pipes. 4. Per observation on October 29, 2021, and accompanied by the Director of Environmental Services, inspection revealed that the A-Wing IT room has penetrations around electrical receptacles. 5. Per observation on October 29, 2021, and accompanied by the Director of Environmental Services, inspection revealed that the A-Wing Old Handler room has penetrations in the ceiling and walls. 6. Per observation on October 29, 2021, and accompanied by the Director of Environmental Services, inspection revealed in the A-Wing Hallway to the loading dock there are penetrations in the walls. 7. Per observation on October 29, 2021, and accompanied by the Director of Environmental Services, inspection revealed that the acoustical	K 362		

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K 362	Continued From page 2 ceiling tile is broken in the A-Wing Old Smoke room. 8. Per observation on October 29, 2021, and accompanied by the Director of Environmental Services, inspection revealed in the A-Wing Locker room has penetration in the wall and around pipes.	K 362		
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 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	K 363	**K363** **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 1/13/22. The rehab doors will have magnetic door holders installed that will be controlled by the fire alarm system by 1/20/22. **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 1/13/22. **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.	1.13.22 1.13.22 2.4.22

K363 POC Accepted 1/26/22 *S.Dumont*

T Wehmeyer

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K 363	Continued From page 3 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. This REQUIREMENT is not met as evidenced by: Per observation on October 29, 2021, the facility failed to ensure no impediment when closing doors. Findings include the following: 1. Per observation on October 29, 2021, and accompanied by the Director of Environmental Services, inspection revealed the door to Room 205 in the B-Wing does not lock and latch. 2. Per observation on October 29, 2021, and accompanied by the Director of Environmental Services, inspection revealed the Clean Serviceroom in the A-Wing does not lock and latch. 3. Per observation on October 29, 2021, and accompanied by the Director of Environmental Services, inspection revealed the door to the Rehabilitation room in the A-Wing was held open by a doorstop.	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	K 500	Beginning on page 5	

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K 500	Continued From page 4 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 October 29, 2021, the facility failed to ensure that electrical equipment was guarded against accidental contact. Findings include the following: 1. Per observation on October 29, 2021, and accompanied by the Director of Environmental Services, inspection revealed that in the Maintenance Shop, there is an open electrical box in the ceiling. Exposed Wiring: All parts of electric equipment shall be guarded against accidental contact by approved enclosures. All unused openings shall be properly closed. (NFPA 73 2.2.3, NFPA 70 110.27)	K 500	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. **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 1/13/22. **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 1/26/22 *S. Dumont* *T Wehmeyer*	**1.7.22** **1.13.22** **2.4.22**