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

October 12, 2018

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 **August 29, 2018**. 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

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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_____	**08/29/2018**

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

(X4) ID PREFIX TAB	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAB	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY)	(x5) COMPLETTION DATE
K 000	INITIAL COMMENTS An unannounced onsite Life Safety Code Inspection was completed by the Division of Fire Safety on 8/29/2018. The following regulatory violations were identified.	K 000	Allegation of Substantial Compliance Vernon Green Nursing Home has and continues to be in substantial compliance with NFPA 101 Life Safety Code Standard. Vernon Green Nursing Home has substantially corrected the alleged deficiency and achieved substantial compliance by the date specified herein. This Plan of Correction constitutes Vernon Green Nursing Home's allegation of substantial compliance such that the alleged deficiencies cited will be substantially corrected. The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiency herein. To continue to remain in substantial compliance with state and federal regulations, Vernon Green Nursing Home has taken or will take the actions set forth in this plan of correction.	
K347 SS=D	Smoke Detection CFR(s): NFPA 101 Smoke Detection 2012 EXISTING Smoke detection systems are provided in spaces open to corridors as required by 19.3.6.1. 19.3.4.5.2 This REQUIREMENT is not met as evidenced By: Based on observation, the facility failed to ensure one smoke detector in the building is installed correctly. Per observation on *8/29/18,* accompanied by the Hospitality Services Director, the smoke detector in room 103 was not installed correctly and is hanging by electrical wires. (continued on page 2)	K347	Vernon Green continues to insure smoke detection systems are properly installed. These systems include those required by NFPA 101 and the additional protection installed by Vernon Green in residents' rooms. **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** The smoke detector in room 103 was reinstalled immediately on the day of the survey. As was discussed with the Fire Marshall, the smoke detector is a battery powered unit and was hanging by its wall anchor, not wires. (continued on page 2)	8/29/18

LABORATORY DIRECTOR S OR PROVIDER/SUPPLIER REPRESENTATIVES SIGNATURE | TITLE *(X6)* | DATE

M Bradford Ellis | Executive Director | 10.11.18

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 inst ru ctions.) Except fo r nursing homes, the findings state::J above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above find ings 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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K347	(continued from page 1) Smoke Detection CFR(s): NFPA 101	K347	(continued from page 1) **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 alleged deficient practice. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;** A quarterly audit will be conducted by the maintenance department to assure that the smoke detectors in residents' rooms are securely attached to the ceiling. **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.** A smoke detector audit will be conducted quarterly and the results will be reviewed at QA meetings to ensure ongoing compliance until the QA committee has determined that 100% compliance has been achieved. K347 POC accepted 10/11/18 SDumont/RME	8/29/18 10/31/18 11/6/18

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K363 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 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 I window assemblies are allowed per 8.3. In sprinklered compartments there are no re strictions in area or fire resistance of glass or frames in window assemblies. (continued on page 4)	K363	Vernon Green insures fire doors are properly installed and function according to the requirements of NFPA 101. **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** Vernon Green consulted with the Fire Marshall and he determined that if the door latches on the shower rooms are roller latches, they are permissible under NFPA 101 since they are on utility doors to rooms that do not contain flammable materials Vernon Green will insure the handle-set hardware on the loading dock door latches. The B-wing (memory care) corridor fire doors outside of room 210 will have latching hardware installed if possible, if not, then these doors will be replaced with those that meet the code requirements. **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 alleged deficient practice. (continued on page 4)	10/05/2018 10/31/2018 02/28/2019 8/29/18

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K363 SS=D	(continued from page 3) 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: Based on observation, the facility failed to ensure three doors in the facility meet requirements regarding fire safety. Per observation on *8/29/18,* accompanied by the Hospitality Services Director, the shower room door has roller latches still in use. Also, the fire door located in the corridor leading to the loading dock did not lock and latch. Finally, the memory care unit fire doors in the main hallway did not lock and latch.	K363	(continued from page 3) **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;** The existing quarterly fire door audit will continue to be conducted by the maintenance department to assure that the loading dock door is closed and latched. **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 existing quarterly fire door audit will continue to be conducted and the results will be reviewed at QA meetings to ensure ongoing compliance until the QA committee has determined that 100% compliance has been achieved K363 POC accepted 10/11/18 SDumont/RN	10/31/18 11/6/18
K500 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: Based on observation, the facility failed to ensure electrical extension cords are not in use in 2 areas of the facility. (continued on page 5)	K500 SS=D	Vernon Green insures HVAC equipment is installed according to manufacturer's specifications. **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** Vernon Green's electrical contractor converted the nursing office air conditioner power supply from 208v to 115v. The extension cord was removed. The emergency light in the maintenance shop was removed from service	10/2/2018 8/29/18

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K500 SS=D	(continued from page 4) Per observation on 8/29/18 , accompanied by the Hospitality Services Director, there is an extension cord powering an air conditioner unit in the nurse's office located in the main hallway. Also, there was an extension cord powering an emergency light in the maintenance shop located near the boiler room.	K500	(continued from page 4) **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 alleged deficient practice. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;** Vernon Green's maintenance staff will conduct a quarterly audit of window mounted or through-the-wall air conditioners to insure none are using an extension cord as part of the power supply. Vernon Green's maintenance staff will insure no emergency lights are powered via extension cords during the routine monthly emergency light audit. **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 results of the quarterly audit of window mounted or through-the-wall air conditioners and the monthly emergency light audits will be reviewed at QA meetings to ensure ongoing compliance until the QA committee has determined that 100% compliance has been achieved. K500 POC accepted 10/11/18 SDumont/RME	8/29/18 10/31/18 10/31/18 11/6/18

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K521 SS=D	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 185.2.1. 19.5.2. 1, 9.2 This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to ensure that HVAC systems are properly installed. Per observation on *8129/18,* accompanied by the Hospitality Services Director, the Maintenance workshop, located near the boiler room, has a wall heater that does not vent to the outside.	K521	**What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** Vernon Green's maintenance garage heater (located in a separate building) will be disconnected and removed from service **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 alleged deficient practice. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;** No fuel burning unvented heating appliances will be installed at Vernon Green. **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 Hospitality Services director will insure all fuel burning heating appliances installed at Vernon Green in the future will be vented according to the Code in force at that time. K521 POC accepted 10/11/18 SDumont/mc	10/31/2018 8/29/18 10/31/18 10/31/18