



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 7, 2023

Ms. Heather Filonow, Administrator
Wake Robin-Linden Nursing Home
200 Wake Robin Drive
Shelburne, VT 05482-7569

Provider ID #: 475056

Dear Ms. Filonow:

The Division of Licensing and Protection completed a Life Safety Code survey at your facility on **September 29, 2023**. The purpose of the survey was to determine if your facility was in compliance with Federal participation requirements for nursing homes participating in the Medicare and Medicaid programs. This survey found that your facility was in substantial compliance with the participation requirements. However, there were three deficiencies that do not require a plan of correction but do require a commitment to correct. All references to regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations. Please **sign the enclosed CMS-2567 and return** the original to this office by **November 17, 2023**.

Informal Dispute Resolution

In accordance with §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to Suzanne Leavitt, RN, MS, Assistant Division Director, Division of Licensing and Protection. This request must be sent during the same ten days you have for returning the enclosed CMS-2567 statement of deficiencies. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Sincerely,

A handwritten signature in cursive script that reads "tammy wehmeyer".

Tammy Wehmeyer
Administrative Services Manager

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

PRINTED: 11/07/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475056	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 09/29/2023
NAME OF PROVIDER OR SUPPLIER WAKE ROBIN-LINDEN NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 200 WAKE ROBIN DRIVE SHELBURNE, VT 05482		
(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 9/29/23. While the facility was found to be in substantial compliance with applicable Life Safety Code Requirements, the following issues were identified that require a commitment to correct by the facility.	K 000	Wake Robin Linden Nursing Home commits to correct the deficiencies cited in this document.		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER/REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

[Signature] *Dir Health & Resident Svcs* *11/16/23*

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.

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 475056	MULTIPLE CONSTRUCTION A. BUILDING: 01 B. WING _____	DATE SURVEY COMPLETE: 9/29/2023
NAME OF PROVIDER OR SUPPLIER WAKE ROBIN-LINDEN NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 200 WAKE ROBIN DRIVE SHELBURNE, VT	
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES		
K 211	<p>Means of Egress - General CFR(s): NFPA 101</p> <p>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 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 9/29/23, the facility failed to ensure that doors are properly maintained. Findings include the following.</p> <p>Several rated doors have their rating labels partially painted over.</p>		
K 223	<p>Doors with Self-Closing Devices CFR(s): NFPA 101</p> <p>Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of:</p> <ul style="list-style-type: none"> * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. <p>18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This REQUIREMENT is not met as evidenced by: Per observation on 9/29/23, the facility failed to ensure that self-closing doors were kept in the closed position. Findings include the following.</p> <p>One leaf on the Cedar door did not latch.</p>		
K 353	<p>Sprinkler System - Maintenance and Testing CFR(s): NFPA 101</p> <p>Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA</p>		

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

The above isolated deficiencies pose no actual harm to the residents

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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES		
K 353	<p>Continued From Page 1</p> <p>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.</p> <p>a) Date sprinkler system last checked _____</p> <p>b) Who provided system test _____</p> <p>c) Water system supply source _____</p> <p>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</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Per observation on 9/29/23, the facility failed to ensure that automatic sprinkler systems are inspected, tested, and maintained. Findings include the following.</p> <p>1) Storage in the supply closets is closer than 18" to the sprinkler heads.</p> <p>2) Sprinkler escutcheons are missing in the salon.</p>		