

DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING
Division of Licensing and Protection

103 South Main Street, Ladd Hall

Waterbury VT 05671-2306

<http://www.dail.vermont.gov>

Voice/TTY (802) 871-3317

To Report Adult Abuse: (800) 564-1612

Fax (802) 871-3318

January 14, 2014

Ms. Meagan Buckley, Administrator
Burlington Health & Rehab
300 Pearl Street
Burlington, VT 05401

Provider #: 475014

Dear Ms. Buckley:

Enclosed is a copy of your acceptable plans of correction for the Life Safety Code survey conducted on **December 19, 2013**. 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

PC:jl

Enclosure

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

PRINTED: 12/27/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475014	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - 01 BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 12/19/2013
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NAME OF PROVIDER OR SUPPLIER BURLINGTON HEALTH & REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 300 PEARL STREET BURLINGTON, VT 05401
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(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 onsite Life Safety Code inspection was completed by the Division of Fire Safety on 12/19/13. The following are Life Safety Code violations.		The following constitutes the facility's response to the findings of the Department of Licensing and Protection and does not constitute an admission of guilt or agreement of the facts alleged or conclusions set forth on the summary statement of deficiencies.	
K 130 SS=D	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: Based on observation, the facility failed to assure all other applicable NFPA codes are met in 2 isolated areas of the building. Per observation on 12/19/13, accompanied by facility staff: 1. Inspection revealed that the rear (north) exit door near the first floor laundry room was hard to open due to ice build up. Section 7.1.10.1, 2000 Edition of NFPA. 2. Inspection revealed that the doors to the laundry room with the dryers would not close and latch due to a negative pressure condition that is caused by lack of combustion air for the gas dryers. Section 5.3, NFPA 1999 Edition.	K130	How the corrective action(s) will be accomplished for those residents found to be affected by the alleged deficient practice? : No resident was affected by this alleged deficient practice. How will the facility identify other residents having the potential to be affected by the same deficient practice? : All residents are potentially affected by this alleged deficient practice. What measures will be put into place or systematic changes made to ensure that the deficient practice will not recur? : #1 - Heater installed near the rear (North) exit door. #2 - Installation of air intake fans in the laundry room.	On-going 1/18/2014 1/18/2014

REGULATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *[Signature]* TITLE: Executive Director DATE: 1/10/2014

A deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that 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 following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued team participation.

[Handwritten initials]

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	<p>How will the facility monitor its corrective actions to ensure that the deficient practice will not recur? :</p> <p>#1 - Random weekly auditing to insure the exit door opens freely</p> <p>#2 - Random weekly inspection of laundry room doors</p>	<p>1/18/2014 & on-going</p> <p>1/18/2014 & on-going</p>
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K130 POC accepted 1/10/14 JBernard, JMC

REGULATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* TITLE **Executive Director** (X6) DATE **1/10/2014**

A deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that 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 following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued sam participation.