VERMONT

AGENCY OF HUMAN SERVICES

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

March 28, 2014

Mr. Bruce Bodemer, Administrator
Helen Porter Healthcare & Rehab
30 Porter Drive
Middlebury, VT 05753-8422

Provider #: 475017

Dear Mr. Bodemer:

Enclosed is a copy of your acceptable plans of correction for the Life Safety Code survey conducted on **February 12, 2014**. 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

Fax 8022412348 Mar 17 2014 04:24pm P003/005

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

PRINTED: 03/17/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475017	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/12/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELEN PORTER HEALTHCARE & REHAB	30 PORTER DRIVE MIDDLEBURY, VT 05753

(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 2/12/14. The following are violations of Life Safety Code requirements.	K 000		
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation, the facility failed to assure all fire doors adequately resist the passage of smoke in one applicable area of the facility. Per observation on 2/12/14, accompanied by the Supervisor in charge of maintenance, the fire doors located near Room 109 do not close and	K 018	Replaced broken latch spring on door in question on 2/2/2014 and tested all door function, door closed and latched properly. Inspection of the corridor fire doors for latching functionality has been added to our morning environmental rounds. Continue current practice of preventative maintenance that includes monthly inspections and testing of all fire doors to meet compliance with NFPA 101 19.3.6.3.6 & 101 19.7.3 K018 POC accepted 3/27/14 JBenard / PMC	2/2/2014

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Bruce Gordon TITLE: Interim Administrator (X6) DATE: 3/27/14

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.

PMC

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

PRINTED: 03/17/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED
	475017		02/12/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELEN PORTER HEALTHCARE & REHAB	30 PORTER DRIVE MIDDLEBURY, VT 05753

(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 018	Continued From page 1 latch.	K 018		
K 054 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: Based on observation, the facility failed to ensure that smoke detectors are placed properly to ensure proper functioning in one applicable area of the facility. Per observation on 2/12/14, accompanied by the Supervisor in charge of maintenance, the corridor smoke detectors near the Memory Care hub area are less than 3 feet from the tips of ceiling fan blades.	K 054	The ceiling fan in question was removed on 3/17/2014 to meet compliance with NFPA 101 Standard 9.6.1.3 Checked all facility ceiling fans to ensure they are in compliance with this code. Inspection of ceiling fan locations relative to smoke detectors has been added to our monthly safety and environmental rounds check list. K054 POC accepted 3/27/14 JBenard / PMC	3/17/2014
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 ensure that all applicable Life Safety Code requirements are met regarding labeling of delayed egress doors in one area of the facility. Per observation on 2/12/14, accompanied by the Supervisor in charge of maintenance, the delayed egress locks on the exterior exit doors off the community room in the Memory Care Unit do not	K 130	To meet requirments stated in section 7.2.1.6.1 (4) of 2012 Life Safety Code Standard. Signage was placed on the Front enterance and Memory Care Unit doors that were in question. We have added inspection of signage to our existing preventative maintenance task for operational testing of our secure care doors. K130 POC accepted 3/27/14 JBenard / PMC	3/26/2014

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

PRINTED: 03/17/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED
	475017		02/12/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELEN PORTER HEALTHCARE & REHAB	30 PORTER DRIVE MIDDLEBURY, VT 05753

(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 130	Continued From page 2 meet the requirements of Section 7.2.1.6.1.1(4) of the 2012 Life Safety Code in regards to proper labeling. This also applies to the main entrance egress doors.	K 130		
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation, the facility failed to ensure that electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code 9.1.2. Per observation on 2/12/14, accompanied by the Supervisor in charge of maintenance, the circuit breaker #9 in panel LVC does not have a breaker lock provided. This circuit is for the sprinkler system air compressor. Also, circuit breaker #15 in panel LVCS does not have a breaker lock provided. This circuit is for the fire alarm system.	K 147	Added breaker locks on 2-14-2014 to circuit breaker #9 (sprinkler system air compressor) in the LVC panel, and circuit breaker #15 (Fire Alarm system) in the LVCS panel. Additionally both of these Life Safety panels are locked panels that are located in a controlled "Authorized Access Area" that is maintained as a secured (locked) space only accessible by authorized personnel. This space is validated as locked during morning rounds and prior to days end by qualified maintenace personnel. - K147 POC accepted 3/27/14 J Benard / pmc This plan of correction constitues our written allegation of compliance effective 03/10/14 for the deficiencies cited. However submission of this plan of correction is not an admission that any deficiences exist or were cited correctly. This plan of correction is submitted to meet requirments by state and federal law.	2/14/2014 3/27/14