

1.28.11 JH

Division of Licensing and Protection
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January 28, 2011

Charlene Bedor, Administrator
Redstone Villa
7 Forest Hill Drive
St Albans, VT 05478

Provider ID #:475055

Dear Ms.. Bedor:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on
January 5, 2011.

Follow-up may occur to verify that substantial compliance has been achieved and maintained.

Sincerely,



Pamela M. Cota, RN
Licensing Chief

PC:jl

Enclosure



DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICESAH
"A" FORM

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNF'S AND NFR'S	PROVIDER # 475055	MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING 01 B. WING _____	DATE SURVEY COMPLETE: 1/5/2011
NAME OF PROVIDER OR SUPPLIER REDSTONE VILLA	STREET ADDRESS, CITY, STATE, ZIP CODE 7 FOREST HILL DRIVE ST ALBANS, VT		
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES		
K 046	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Emergency lighting of at least 1 1/2 hour duration is provided in accordance with 7.9. 19.2.9.1.</p> <p>This STANDARD is not met as evidenced by: Based on inspection on 1/5/11, the emergency light in the remote emergency generator building did not work when tested on battery back-up.</p> <p><i>See next page for POC →</i></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

The above isolated deficiencies pose no actual harm to the residents

	K 046	<p>Redstone Villa, (the "Provider") submits this plan of correction, (POC), in accordance with specific regulatory requirements. It shall not be construed as an admission of any alleged deficiency cited.</p> <p>The Provider submits this POC with the intention that it be inadmissible by any third party any civil or criminal action against the Provider or any employee, agent, officer, director or shareholder of the Provider. The Provider hereby reserves the right to challenge the findings, that are relied upon to adversely influence or serve as a basis, in any way, for the selection and / or imposition of future remedies, or for any increase in future remedies, whether any such remedies are imposed by the Centers for Medicare and Medicaid Services ("CMS"), the State of Vermont or any other entity.</p> <p>Any changes to Provider Policy or Procedure should be considered to be subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and should be inadmissible in any proceedings on that basis.</p> <p>1. How will corrective action be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Emergency light in remote generator building has been replaced.</p> <p>2. How will the facility identify other residents having the potential to be affected by the same deficient practice?</p> <p>No residents were adversely affected. Residents have no access to the area where this light is located.</p> <p>3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?</p> <p>The light will be tested monthly by maintenance director or designee.</p> <p>4. How will the facility monitor its corrective actions to ensure that the deficient practice will not recur?</p> <p>The monthly testing will be recorded on the maintenance department preventative maintenance log.</p> <p>5. Include dates when a corrective action will be completed.</p> <p>The light was replaced on 1/5/11.</p>	1/5/11
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K046 POC accepted 1/27/11
 J. Benard / PMS/ARN

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

PRINTED: 01/19/2011
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 - BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 01/05/2011
NAME OF PROVIDER OR SUPPLIER REDSTONE VILLA			STREET ADDRESS, CITY, STATE, ZIP CODE 7 FOREST HILL DRIVE ST ALBANS, VT 05478	
(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)	(X6) COMPLETION DATE
K 000	INITIAL COMMENTS	K 000		
K 130 SS=D	<p>A Life Safety Code survey was conducted on 1/5/11.</p> <p>NFPA 101 MISCELLANEOUS</p> <p>OTHER LSC DEFICIENCY NOT ON 2786</p> <p>This STANDARD is not met as evidenced by: Based on observation on 1/5/11, the stairway chairlift has not been inspected by a certified inspector for this field in accordance with the 2008 Vermont Elevator Safety Rules, Chapter 142 and 152.</p>	K 130	<p>1. How will corrective action be accomplished for those residents found to have been affected by the deficient practice?</p> <p>A Vermont Elevator inspector was contacted to come and inspect the chairlift.</p> <p>2. How will the facility identify other residents having the potential to be affected by the same deficient practice?</p> <p>All residents that use the chairlift have the potential to be affected.</p> <p>3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?</p> <p>The Vermont Elevator inspection is scheduled on the preventative maintenance log to come annually and inspect the chairlift.</p> <p>4. How will the facility monitor its corrective actions to ensure that the deficient practice will not recur?</p> <p>The facility has added an annual inspection with a Vermont Elevator inspector on the preventative maintenance log.</p> <p>5. Include dates when a corrective action will be completed.</p> <p>The chairlift was inspected by a Vermont Elevator inspector on 1/26/11 and was certified to be in proper working order.</p> <p>K130 POC Accepted 1/27/11 J. Benard / JMCoturn</p>	1/26/11

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

TITLE

(X6) DATE

Charlene Bede

Administrator 1-27-11

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.