

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

May 1, 2012

Ms. Melissa Jackson, Administrator
Vermont Veterans Home
325 North Street
Bennington, VT 05201-5014

Provider #: 475032

Dear Ms. Jackson:

Enclosed is a copy of your acceptable plans of correction for the Life Safety Code survey conducted on **March 26, 2012**. 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, MS
Licensing Chief

PC:ne

Enclosure



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

PRINTED: 04/06/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475032	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 03/26/2012
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NAME OF PROVIDER OR SUPPLIER VERMONT VETERANS HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 325 NORTH STREET BENNINGTON, VT 05201
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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
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K 000	INITIAL COMMENTS An unannounced on-site Life Safety Code inspection was completed by the Division of Fire Safety on 3/26/12. The following are Life Safety Code violations.	K 000	Please note that the filing of this plan of correction does not constitute any admission as to any of the alleged violations set forth in this Statement of Deficiency. The POC is being filed as evidence of the Facility's continued compliance with all applicable laws.	
K 027 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 This STANDARD is not met as evidenced by: Based on observation, the facility failed to ensure smoke barrier doors properly close in 2 areas of the facility. Findings include: Per observation on 3/26/12, accompanied by the Maintenance Supervisor, the smoke/fire doors in openings in the North Corridor and opening into the main dining room do not close tightly to prevent the passage of smoke.	K 027	K 027 <u>Corrective Action:</u> The smoke/fire doors in the openings of the northing corridor and opening into the main dining room have been repairs and now close tightly to prevent the passage of smoke. <u>Other Residents:</u> All Residents are at risk. <u>Systemic Changes:</u> Maintenance staff will be educated on the proper smoke/fire door maintenance to ensure the doors closely tightly and prevent the passage of smoke. <u>Monitoring:</u> The Maintenance Supervisors or designee will conduct 7 weekly audits x 90 days on random smoke/fire doors to ensure they close tightly and prevent the passage of smoke. Audit results will be reviewed at the bimonthly QA meeting (Attachment B)	
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system	K 029	<u>Compliance Date:</u> April 22, 2012	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Melissa A Jackson, BSW, RNHA* TITLE *Administrative* (X6) DATE *4/17/12*

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

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K 029	Continued From page 1 option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation, the facility failed to ensure areas are separated from other spaces by smoke resisting partitions and doors. Findings include: Per observation on 3/26/12, accompanied by the Maintenance Supervisor, there was a large quantity of materials stored by the elevator in an uncontained area that will not prevent the passage of smoke to other areas. This area is more than 50 square feet.	K 029	K 029 <u>Corrective Action:</u> The items stored by the elevator in an uncontained area have been removed <u>Other Residents:</u> All Residents are at risk. <u>Systemic Changes:</u> This area will be checked twice weekly to ensure large quantities of materials are not stored by elevator.	
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 NFPA (National Fire Protection Agency) codes are met. Findings include: 1. Per observation on 3/26/12, accompanied by the Maintenance Supervisor, there was an unsecured oxygen tank found in the North unit utility room. All oxygen tanks must be secured per NFPA 99 Section 5.3.13.2.2(11).	K 130	<u>Completion Date:</u> April 22, 2012	

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K 130	Continued From page 2 2. Per observation on 3/26/12, accompanied by the Maintenance Supervisor, there was an extension cord being used in a guest bathroom. Extension cords cannot be used as a replacement for permanent wiring per NFPA 70 (National Electric Code) section 400.8(1).	K 130	<p>K130 <u>Corrective Action:</u> All utility rooms used for oxygen storage now have 2 oxygen storage racks. One rack is for full tanks and the other for empty tanks.</p> <p><u>Other Residents:</u> All Residents are at risk.</p> <p><u>Systemic Changes:</u> Staff have been educated on the two storage cart system for all oxygen tanks. (Attachment D)</p> <p><u>Monitoring:</u> The Director of Environmental Services or designee will conduct 2 weekly random audits x 90 days of Oxygen storage areas within the facility to ensure oxygen storage carts are being used. Audit findings will be reviewed at bimonthly Quality Assurance Meetings. (Attachment E)</p> <p><u>Compliance Date:</u> April 22, 2012</p> <p><i>K027, K029, K130 POC's accepted 4/30/12 F. Croff / AmcetaRN</i></p>	
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