

Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury VT 05671-2306
<http://www.dail.vermont.gov>
Voice/TTY (802) 241-2345
To Report Adult Abuse: (800) 564-1612
Fax (802) 241-2358

June 27, 2011

Daniel Daly, Administrator
Birchwood Terrace Healthcare
43 Starr Farm Rd
Burlington, VT 05401

Provider ID #:475003

Dear Mr. Daly:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **May 24, 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 SERVICES

RECEIVED
Division of
PRINTED: 06/02/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475003	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	JUN 20 11 Licensing and Protection	(X3) DATE SURVEY COMPLETED C 05/24/2011
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NAME OF PROVIDER OR SUPPLIER BIRCHWOOD TERRACE HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 43 STARR FARM RD 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
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F 000	INITIAL COMMENTS The Division of Licensing and Protection conducted an annual recertification survey, including 3 complaint investigations from 5/23/11 - 5/24/11. Regulatory deficiencies were cited as a result.	F 000	<i>This Plan of Correction is the center's credible allegation of compliance.</i>	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's	F 157	F 157 Resident #1 daughter was notified 5/18/11 of transfer to the hospital. All residents with significant changes have potential to be affected by this deficient practice. Staff involved have been counseled and re-educated regarding this practice on an individual basis. The DNS or her designee will in-service licensed nursing staff on the facility policy to notify responsible parties on significant change of status. The DNS or her designee will audit weekly through record review and the 24 hour report to ensure compliance. Results of these audits will be brought to the PI committee monthly for review and recommendations. The DNS is responsible for overall compliance.	June 24, 2011

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* TITLE *Administrator* (X6) DATE *6/9/11*

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.

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F 157 Continued From page 1
legal representative or interested family member.

This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to notify 1 of 17 sampled resident's (Resident #1) family of a change in condition. Findings include:

Per record review on 5/24/11 at 8:00 AM, Resident #1 had a change in condition necessitating transfer to a hospital on 5/17/11. There was no evidence in the clinical record that the family was notified. During a 5/24/11, 2:15 PM interview with the Director of Nursing Services (DNS), the DNS confirmed that the family was not notified of Resident #1's transfer to a hospital.

F 278 483.20(g) - (j) ASSESSMENT
SS=D ACCURACY/COORDINATION/CERTIFIED

The assessment must accurately reflect the resident's status.

A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.

A registered nurse must sign and certify that the assessment is completed.

Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.

Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is

F 157

This Plan of Correction is the center's credible allegation of compliance.

Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.

F 278

The MDS for Resident # 30 has been corrected. A Bosnian interpreter has been used in insure accuracy. MDS transmitted

F 278 The IDT will review the MDS of residents with English as a second language to assess for accuracy and correct any information deemed to be inaccurate.

The MDS Coordinator or her designee will in-service the IDT on the need for accuracy of the information coded on each MDS. The IDT will verify the accuracy of the MDS by using interpreters as necessary prior to affixing their signatures.

The MDS Coordinator or her designee will monitor through observation and record review accuracy of MDS with use of interpreter. Results of audit will be brought to monthly PI meeting until 100 % compliance achieved.
The Administrator is responsible for overall compliance.

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F278 POC Accepted 6/27/11 Amaturen

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F 278	<p>Continued From page 2</p> <p>subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to accurately assess and address all care needs of 1 of 17 applicable residents in the stage 2 sample.(Resident #30) Findings include:</p> <p>1. Per record review on 5/23/11 at 11:00 AM Resident #30's Minimum Data Set (MDS) dated 04/20/11, which contains core set of screening, clinical and functional status elements, contained incorrect information. In section A1100-language Part A was coded as '0' - doesn't need an interpreter; however, Part B listed preferred language as Bosnian. Per further review of the MDS, section B 700 & 800 were coded as usually understands or makes self understood, but section C 0100 - Brief Interview for Mental Status (BIMS) was coded as '0'- rarely/never understood. Per the staff assessment of Mental Status (section C1000), it lists cognitive skills for daily decision making as moderately impaired.</p> <p>Per interview with staff at 11:30 AM, staff indicated that Resident #30 "doesn't speak English" and "has a language barrier" and "we</p>	F 278			

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F 278	Continued From page 3 used to have a communication board" but indicated that the resident has a routine and makes his/her own decisions. Per interview on 5/23/11 at 12:00 PM, the Social Services Director stated that the physician in November of 2010 requested an interpreter and on 11/15/10 with the help of the interpreter was able to answer questions appropriately that would be found on the BIMS, however, did not complete this portion on the MDS as she "felt the meeting was informal". Per interview on 5/23/11 at 1:00 PM, the MDS Nurse stated that the 04/20/11 MDS was incomplete due to "there was no interpreter or family available at the time of the MDS review, so I used staff information" and did not use any other method to communicate regarding her language barrier. S/he confirmed the MDS not is accurate.	F 278	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed	F 280	F 280 Resident # 56 care plan was updated 5/24/11 to reflect no male caregivers. The DNS, or her designee will review the comprehensive care plans of all residents that wish to have no male caregivers to assure that these residents needs are met. The DNS or her designee will in-service the IDT on development of care plans with emphasis on resident's specific wishes for care. The DNS or her designee will monitor through record review, at least monthly for three months, that the needs of residents wishing no male care-givers be addressed on the care plan. The DNS is responsible for overall compliance.	June 24, 2011

F 280 PDC Accepted 6/27/11 JMCotern

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F 280	Continued From page 4 and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to revise the care plan for 1 of 17 residents in the stage 2 sample (Resident #56). Findings include: 1. Per interview with the DNS on 5/24/11 at 9:47 AM, Resident #56 has a new plan for no male caregivers. Per review of the Care Plan in the medical chart and the LNA (Licensed Nursing Assistant) care plan located in the resident's room, neither had updated information regarding no male caregivers. Per interview on 5/24/11 at 10:50 AM, the Unit Manager stated there was a sticky note taped at the nursing station but confirmed that the care plans were not revised.	F 280	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to obtain a physicians order as required by facility policy, regarding self-administration of medications for 1 applicable resident in the stage 2 sample (Resident #1). Findings include:	F 281	Nurse involved was counseled and in-serviced on the need to obtain MD order that resident may self-administer medication. All residents that self-administer medications have potential to be affected by the same deficient practice. RN and LPN were educated by the DNS on the procedure to obtain an MD order for residents to be able to self administer medications. The DNS or her designee will monitor for compliance through record review. Results of these audits will be brought to the monthly PI committee until 100 % compliance achieved. The DNS is responsible for over all compliance.	June 24, 2011

F281 POC Accepted 6/27/11 JMcstARN

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F 281	Continued From page 5 Per record review on 5/24/11 at 2:15 PM, Resident #1 was assessed for self-administration of medications without a physician's order (which is required by facility policy). During a 2:15 PM interview with the Director of Nursing Services (DNS) and the Unit Manager (UM), both the DNS and the UM confirmed that the physicians order was not obtained prior to allowing Resident #1 to self-administer medications. The facility policy regarding self-administration of medications as well as the assessment form clearly stated that a physician order was needed prior to allowing the self-administration of medications.	F 281	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329	F 329 Resident #148 has a dx of dementia w/psychosis associated with rapid decline. Was seen by MD on 6/1/11. DISCUS was done 4/8/11 and 5/24/11 with negative findings. Resident #108 was seen by psychiatrist 5/26/11 given dx of vascular dementia w/psychosis. Resident's seroquel was increased for identified target behaviors of delusions, hallucinations and aggressive behaviors (kicking, hitting,yelling) Residents receiving antipsychotic medications have the potential to be affected by the deficient practice. Their records will be reviewed to assure that they have appropriate dx, target behaviors, baseline DISCUS with adequate monitoring identified in interdisciplinary care plan. The DNS and SDC will provide in-service education to nursing staff to assure adequate monitoring of residents. Target behaviors will be identified in the MAR. LNA monitoring will be with use of flow sheets The DNS or her designee will audit through record review and 24 hour report appropriate monitoring of residents on antipsychotic	June 24, 2011	

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F 329	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure 2 of 10 applicable stage 2 residents (Residents #108, 148) were free from unnecessary medications. Findings include: 1. Per record review on 5/24/11 at 1:00 PM, Resident #148 had no diagnosis in the clinical record for Seroquel, a prescribed antipsychotic medication. Additionally, the facility failed to obtain a baseline assessment (DISCUS) when the resident started the antipsychotic medication. In a 5/24/11, 1:58 PM interview with the Unit Manager (UM), the UM confirmed there was no diagnosis for the Seroquel and also confirmed that baseline DISCUS was not done per policy for Seroquel. Refer also to F428. 2. Per record review on 5/24/11 at 12:00 PM, Resident #108 did not have adequate indications for use of an antipsychotic nor did staff follow the recommendation of the physician. Resident #148 was admitted with diagnoses of depression with aggressive behaviors, delusions, anxiety and CVA with right hemiparesis. Per review of the care plan dated 4/2/11, it states Seroquel for delusions, hallucinations, combative refusal of care. Per review of the LNA behavior sheets as well as the Nursing behavior monitoring log dating back to November 2010 there was no documentation of delusions or hallucinations. Per	F 329	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i> medications. The Pharmacist through record review will assure appropriate diagnosis to support use of antipsychotic medications. Results of these audits will be brought to the monthly PI committee meeting until 100% compliance achieved. The Administrator is responsible for overall compliance. <i>F329 POC Accepted 6/27/11 Amotarn</i>		

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F 329	Continued From page 7 the LNA behavior sheet there were 7 days during the 6 month period of incidents of resisting care. Per the nursing behavior monitoring log during the 6 month period approximately 42 incidents of resisting care, however no corresponding nursing notes addressing the incidents except on 01/02/11, "refused all meds x 2 increase behaviors of yelling all around, resident attempting to hit people, res needed redirection". Per review of the MDS assessment dated 04/21/11, "resident has no behaviors coded per Mar/Apr daily care records". In addition, Section E [psychosis] was coded as not having delusion or hallucinations. Per a physician order dated 01/19/11 "returned call [from MD] nursing order for psych consult". There is no indication that the resident was seen for a psychiatric consultation. Per interview on 05/24/11 at 1:30 PM the UM confirmed that the order for a psychiatric consult was not written until 05/20/11, the resident was not seen by a psychiatrist for 5 months, and there is a lack of adequate indications for the use of Seroquel.	F 329	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>	
F 412 SS=D	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist.	F 412	F 412 Resident # 108 was seen by dentist 5/31/11. Arrangements are pending for 2 teeth extractions. Unit managers will assess residents for the need of dental services. Residents and or responsible parties will be notified re: need for external dental services. The SDC or her designee will educate nursing staff on appropriate oral hygiene based on resident needs. Random audits of residents will be done monthly to ensure that any resident in need of dental services has follow-up. Results of these audits will be brought to the monthly PI committee meeting. Changes will be made as necessary. The DNS is responsible for overall compliance.	June 24, 2011

F412 POC Accepted 6/27/11 Amotuen

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F 412	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based upon interview and record review, the facility failed to provide dental services to meet the needs of 1 of 3 residents in the applicable Stage 2 sample (Resident #108). Findings include: 1. During an interview on 05/23/11 at 10:38 AM, Resident #108 stated that his/her front teeth hurt and was observed with food debris between the teeth. S/he also stated that "I don't have a toothbrush". Per observation of the resident's personal care items, there was a toothbrush in a carrying case which was covered with body powder, as well as sponge 'toothettes'. Per review of the dental care plan, it directs staff to assist with oral hygiene/dental care am/hs (in the morning and at hour of sleep) as well as to monitor for signs and symptoms or complaints of facial pain, etc. Per interview on 05/24/11 at 2:00 PM, the LNA stated that the resident did not brush his/her teeth and hasn't used a toothbrush lately but uses a toothette because "[the resident's] teeth have been hurting." The Unit Manager was present for the interview and confirmed that the dental needs were not being met for this resident.	F 412	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>	
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of	F 428	Resident # 148 was seen by MD 6/6/11 and has diagnosis of Dementia with psychosis with rapid decline. Residents receiving antipsychotic medication have the potential to be affected by this deficient practice. Their records will be reviewed to assure that they have an appropriate diagnosis. RN and LPN will be in-service to assure response to Pharmacist's recommendation. Emphasis will be placed on appropriate use of antipsychotic medications. The DNS or Pharmacist through record review will audit for appropriate follow-up to pharmacy recommendations. Results of these audits will be brought to the monthly PI meeting until 100% compliance achieved. The Administrator is responsible for overall compliance.	June 24, 2011

F428 POC Accepted 6/27/11 Pharmacist

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475003	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/24/2011
NAME OF PROVIDER OR SUPPLIER BIRCHWOOD TERRACE HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 43 STARR FARM RD BURLINGTON, VT 05401		
(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	
F 428	Continued From page 9 nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to act on an irregularity reported by the consultant pharmacist for 1 of 10 residents in the applicable sample (Resident # 148). Findings include: Per record review on 5/24/11 at 1:00 PM, the facility did not act on the consulting pharmacist's 4/19/11 request for a diagnosis for Seroquel, an antipsychotic medication for Resident #148. In a 5/24/11, 1:58 PM interview with the Unit Manager (UM), the UM confirmed that the pharmacy consultant requested a diagnosis for Seroquel on 4/19/11 and that the physician did not respond to that request. Refer also to F329, example #1.	F 428			