

Division of Licensing and Protection
103 South Main Street
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

December 1, 2015

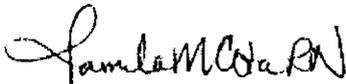
Ms. Alecia Dimario, Administrator
Kindred Transitional Care & Rehab Birchwood Terrace
43 Starr Farm Rd
Burlington, VT 05408-1321

Dear Ms. Dimario:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **October 28, 2015**. Please post this document in a prominent place in your facility.

We may 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



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

PRINTED: 11/12/2015
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 _____	(X3) DATE SURVEY COMPLETED C 10/28/2015
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE & REHAB BIRCHWOOD TER			STREET ADDRESS, CITY, STATE, ZIP CODE 43 STARR FARM RD BURLINGTON, VT 05408	
(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 000	INITIAL COMMENTS	F 000	<i>This Plan of Correction is the center's credible allegation of compliance.</i>	
F 282 SS=D	<p>An unannounced onsite investigation of two complaints regarding care and services was completed by the Division of Licensing and Protection on 10/28/15. The following regulatory issues were identified:</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide care and services in accordance with the plan of care for 1 of 3 residents in the sample (Residents #2). Findings include: Per 10/28/15 record review and observation, the care plan related to the set up and cleaning of nebulizer equipment by nursing staff was not followed. Per observation in the room of Resident #2 on 10/28/15 at 3:45 PM, the resident's nebulizer mask was positioned on a bed stand with no protective covering and in contact with multiple dried liquid stains, dust and small dark debris that were on the surface of the stand. Positioned on the same stand as the nebulizer mask was a urinal with 750 ml of urine, 2 filled coffee cups, and 8 used Duoneb vials (Duoneb = a medication that is inhaled thru the nebulizer mask to enhance breathing). Per review of the medical record, Resident #2 has diagnoses of</p>	F 282	<p><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></p> <p>F 282 Resident #2 bedside stand, nebulizer equipment cleaned and dried per care plan.</p> <p>All residents that have nebulizer treatment have the potential to be affected.</p> <p>Nursing staff have been re- educated on the procedure for care and maintenance of nebulizer equipment. Emphasis was placed on environmental cleanliness and appropriate infection control practices.</p> <p>The DNS/designee will audit compliance through observation and record review. Results of these audits will be brought to the monthly Performance Improvement Committee until 100% compliance achieved. The DNS is responsible for overall compliance.</p> <p><i>F282 POC accepted 11/25/15 SDennis RN/pmc</i></p>	November 27, 2015

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Celia Malone* TITLE *Executive Director* (X6) DATE *11/17/15*

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 282	Continued From page 1 emphysema and a past history of acute and chronic respiratory failure that required a Medical Intensive Care Unit stay in August 2015. S/he was admitted to the hospice program on October 8, 2015 related to his/her declining respiratory status and has physician orders for Duoneb nebulizer treatments 1 vial five times/day and oxygen at 3 Liters/minute. Per review of Resident #2's care plan for the self-administration of nebulizer treatments: the resident is able to hold the mask for the duration of the treatment and turn off the nebulizer machine. The nurse is to "set up [the] Rx" (Rx= Duoneb nebulizer medication) "and clean/dry equipment when done each shift." On 10/28/15 at 4:50 PM, the Nurse Unit Manager (UM) confirmed that the nursing staff had not followed the care plan related to ensuring that the nebulizer equipment was cleaned and used Duoneb vials were properly discarded after use. (Refer F441)	F 282	<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 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation and staff and resident interview, the facility failed to ensure that the	F 323	Residents #1 and #3 have been discharged from the facility. All residents that have a history of recent smoking have the potential to be affected. Residents will be informed on admission that the facility is a tobacco-free center. The tobacco free environment policy will be given to residents on admission. Patients will be asked to immediately comply. Patients will be assessed for any distress. Any tobacco products or lighting materials found in the facility will be confiscated and returned upon discharge from the facility per policy. Residents with recent history of smoking will be assessed for need of continued smoking cessation intervention. Care plans will reflect interventions. Grandfathered residents still choosing to smoke after the center has chosen to become tobacco-free will be allowed to use tobacco products while on premises in designated areas. These residents are required to have a smoking assessment completed quarterly to determine the level of supervision to be provided and interventions to mitigate the risk of injury. Care plans of grandfathered	November 27, 2015	

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F 323	Continued From page 2 resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision to prevent accidents for 2 of 3 residents who smoked while residing in the facility (Resident #1 and Resident #3). Findings include: 1. Per 10/27/15 telephone interview with Resident #1, s/he reported smoking in outdoor public areas while a resident in the facility. Per 10/28/15 record review, Resident #1's 9/22/15 admission MDS (Minimum Data Set), identified that Resident #1 scored a 9 on a BIMS assessment (BIMS = Brief Interview for Mental Status; scores in the 8-12 range suggest a moderate impairment in cognitive function); the resident was also listed as having physical and verbal behaviors directed at others on 1-3 days in the evaluation period. Per medical record review, there was no evidence that a smoking safety assessment had been completed or care plan developed related to measures to address smoking safety or rules or education around safety. Per interview with the Nurse Unit Manager (UM) on the B wing, s/he reported that the facility was now a non-smoking facility; there is no policy for smoking as the facility is "non-smoking." The UM confirmed that no smoking safety assessment was completed for Resident #1 and that there was no care plan for smoking or smoking safety as Resident #1 was an independent smoker who smoked off the facility property; the resident was "doing it on [his/her] own and taking it on themselves." 2. On 10/27/15 at approximately 2:05 PM, the UM on the C-wing reported that there might be one resident on the unit who smokes as s/he had seen Resident #3 leave the unit frequently and thought [s/he] might be going out to smoke. Per	F 323	<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> residents choosing to smoke will address secured storage of smoking paraphernalia and any safety interventions identified through smoking assessment. Residents wishing to leave the facility grounds must have a physician's order for "may have pass." Residents leaving facility on pass will be required to sign in and out. Facility staff have been educated regarding Tobacco-Free Environment and resident sign out, sign in process. Grandfathered residents choosing to smoke will be monitored for compliance by a licensed nurse each shift. Results of these audits will be brought to monthly Performance Improvement meeting. Failure to comply with care plan interventions of grandfathered smokers will be addressed by the Executive Director/and or Director of Nursing. <i>F323 POC accepted 11/25/15 SDEANUSRN/PWC</i>		

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F 323	Continued From page 3 medical record review, the 10/2/15 14 day MDS indicated that although no BIMS assessment was done, Resident #3's short and long term memory was OK. When Resident #3 was approached with the UM, a cigarette package was visible in his/her breast pocket and s/he reported smoking 1 1/2 packs of cigarettes per day having restarted smoking since residing in the facility after being offered a cigarette by another resident smoker. At approximately 2:30 PM, the UM confirmed that no smoking safety assessment was completed and no care plan developed for Resident #3 around smoking. The UM further confirmed that Resident #3 had not signed out in the green sign out book that [s/he] was leaving the facility grounds to smoke as per policy. At 2:45 PM, the resident was observed to have 3 packs of cigarettes and a lighter fully visible on top of his/her bedside table. S/he reported that s/he did not have a lock box or drawer with a lock to keep them in. The resident reported s/he started smoking during the first or second week of his/her almost 6 week stay at the facility. On 10/28/15 at approximately 4:30 PM, the Director of Nursing (DNS) reported that the facility had transitioned to nonsmoking and there is no smoking policy. If residents have a pass to go off the property, the facility is not going to ensure that patients who smoke off property are safe. When asked how it was safe for a resident to keep a lighter in his/her room without a safety assessment, s/he reported being unaware that Resident #3 was a smoker and had a lighter and cigarettes in his/her room until brought to his/her attention during the survey.	F 323			
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441			

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F 441	Continued From page 4 The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as Isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441	<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 441 Resident #2 bedside stand, nebulizer equipment cleaned and dried per care plan. All residents that have nebulizer treatment have the potential to be affected. Nursing staff have been re- educated on the procedure for care and maintenance of nebulizer equipment. Emphasis was placed on environmental cleanliness and appropriate infection control practices. The DNS/designee will audit compliance through observation and record review. Results of these audits will be brought to the monthly Performance Improvement Committee until 100% compliance achieved. The DNS is responsible for overall compliance. F441 POC accepted 11/25/15 SDennis RHP/ML	November 27, 2015

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F 441	<p>Continued From page 5</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, facility staff failed to provide a safe and sanitary environment to help prevent the development and transmission of infection regarding the use and storage of nebulizer equipment for 1 applicable resident in the sample (Resident #2). Findings include:</p> <p>Per observation in the room of Resident #2 on 10/28/15 at 3:45 PM, the resident's nebulizer mask was positioned on a bed stand with no protective covering and in contact with multiple dried liquid stains, dust and small dark debris that were on the surface of the stand. Positioned on the same stand as the nebulizer mask was a urinal with 750 ml of urine, 2 filled coffee cups, and 8 used Duoneb vials (Duoneb = a medication that is inhaled thru the nebulizer mask to enhance breathing). Also in the room, the surface of an oxygen concentrator machine used by Resident #2 was heavily soiled with dust. Per review of the medical record, Resident #2 has diagnoses of emphysema and a history of acute and chronic respiratory failure that required a Medical Intensive Care Unit stay in August 2015. S/he was admitted to the hospice program on October 8, 2015 related to his/her declining respiratory status and has physician orders for Duoneb nebulizer treatments 1 vial five times/day and oxygen at 3 Liters/minute.</p> <p>The observations as described above were confirmed by the Nurse Unit Manager (UM) at the time of the observation and s/he confirmed that the storage of the nebulizer mask and dusty oxygen concentrator were infection control issues.</p>	F 441			

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F 441	Continued From page 8 (Refer F282)	F 441			