

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

April 14, 2014

Mr. Daniel Daly, Administrator
Kindred Transitional Care & Rehab Birchwood Ter
43 Starr Farm Rd
Burlington, VT 05408-1321

Dear Mr. Daly:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **March 20, 2014**. 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

PC:jl

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475003	(X2) MULTIPLE CORRECTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/20/2014
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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE & REHAB BIRCHWOOD TER	STREET ADDRESS, CITY, STATE, ZIP CODE 43 STARR FARM RD BURLINGTON, VT 05408
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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 An unannounced on-site complaint investigation was conducted by the Division of Licensing and Protection from 3/19/14 to 3/20/14. There were regulatory deficiencies identified. A determination of Immediate Jeopardy to the health and safety of residents was made on 3/20/14, which also constituted Substandard Quality of Care. Prior to the end of the survey, on 3/20/14, the facility successfully removed the Immediate Jeopardy, however deficient practice remains	F 000	<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-J	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, record review, and staff interview, the facility failed to ensure that adequate supervision of residents and staff training were implemented to provide a safe environment and avoid serious injury for one of three residents sampled (Resident #1). Findings include 1. Per record review on 3/19-3/20/14, Resident #1 was admitted to the facility on 9/20/10. The resident had diagnoses that included Dementia, Osteoporosis, Paralysis Agitans, Abnormal Posture, Kidney Disease, Hypertension, Anxiety,	F 323	Birchwood POC—3/20/14 F3231 Resident #1 no longer resides at center. Residents #2 and #3, who were utilizing the Invacare HTR 5500 Tilt / Recline wheelchair prior to 3/19/2014, were assessed by Rehab and alternative, appropriate wheelchair seating has been implemented for both residents #2 and #3. All (3) Invacare HTR 5500 Tilt / Recline wheelchairs were permanently removed from service on 3/19/14. Rehab staff has reassessed current residents seated in "non-hydraulic" assisted tilt - in - space wheelchairs. Rehab staff will place a picture of residents seated in "non-hydraulic" assisted tilt - in - Space wheelchairs in plastic sleeve with general operational guidelines and place in LNA / ADL books. LNAs and Licensed nurses will be educated related to general guidelines for use of "non-hydraulic" assisted tilt - in- space wheelchairs. Education will include a return demonstration. The Rehab staff will coordinate any future	04/10/2014

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 4/9/14
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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 323

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and Anemia. The resident weighed under 100 lbs. and was considered physically frail. According to documentation and staff statements, Resident #1 was sometimes very resistant to care, and would be very agitated during provision of bathing or dressing. Resident #1 had a condition of Spinal Kyphosis which left her posture in a forward-bent state continuously. Physical Therapy assessed Resident #1 for comfort and positioning and determined that the resident would benefit from a tilted reclining wheelchair that would allow the resident to be seated in a more comfortable position, adjusting for the forward leaning posture of the spine. A specialized tilt/recline wheelchair was ordered for Resident #1 and was issued to them on 2/12/14, with specific measurements of Resident #1 for proper fit done several months prior to the actual issue date.

On the evening of 2/24/14 at 8:00 PM, two LNAs (Licensed Nursing Assistants) were in the room of Resident #1 preparing the resident for bed. According to the written statements of both LNAs done on the evening of the incident, Resident #1 was seated in the HTR Tilt/Recline chair, and they were preparing for a transfer from the wheelchair to the bed. LNA #1 was positioned in the back of the chair, and LNA #2 was positioned in the front of the chair, standing next to the bed. They had completed washing the upper body of the resident and changed him/her. To complete the care, the LNAs had removed a neck pillow from behind the resident's head which provided comfortable positioning in the chair, and placed it at the head of the bed. According to the written statement from 2/24/14 at 8:20 PM, LNA #2 stated that the resident was very agitated and combative during the bathing and changing task, and was demanding to have the neck pillow back.

F 323.

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.

training related to new resident positioning wheelchairs with the Staff Development Coordinator, or DNS / ADNS in the Staff Development Coordinator's absence. The Staff Development Coordinator, DNS or ADNS will be responsible for scheduling new equipment specific training for the LNAs and Licensed nurses prior to the LNAs and Licensed nurses being allowed to work. The Staff Development Coordinator will be responsible for maintaining formalized education logs with the attendance records to validate the education with return demonstration was completed.

Unit Managers and Charge nurses will monitor LNA compliance with appropriate use of "non-hydraulic" wheelchairs during routine unit rounds twice per shift x (3) months. Findings will be reported to the DNS and discussed at monthly Performance Improvement Committee meetings and monthly Safety Committee meetings x (3) months.

Completion date 4/10/14

F323 PDC accepted 4/10/14
KCampCSRN IPME

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F 323	<p>Continued From page 2</p> <p>LNA#2 turned away from the resident to reach for the neck pillow, as LNA #1 changed the position of the tilt/recline chair to the upright position, the resident fell forward out of the chair onto the floor.</p> <p>Resident #1 was transported to the hospital by Emergency Medical Services, where s/he was diagnosed with fractures of the spine at Cervical Vertebrae C1 and C2, as well as a laceration to the right forehead that required sutures. The resident was put in a Miami J collar neck brace, and sent back to the facility at 0400 on 2/25/14. Resident #1 had a decline in appetite and general condition for the next two weeks, and on 3/10/14 the nurse's note stated that Resident #1 was on "comfort care". On about 3/10/14, the resident stopped eating and drinking, was unable to swallow crushed medications, and proceeded to decline until his/her death on 3/12/14.</p> <p>The HTR Tilt/Recline 5500 Model has two gas cylinders that assist in the ease of operation when tilting and/or reclining the chair, as well as making the return to an upright position easier for staff to perform. Per observation on 3/19/14 at 11:10 AM, while operating the chair, this surveyor noted that the return to the upright position had some force provided by the gas cylinders that gave it an abrupt movement into the upright position. Per review of the manufacturer's manual for the chair, there were multiple cautions to be aware of that were listed to ensure safe operation. On page 2: "WARNING/CAUTION notices as used in this manual apply to hazards or unsafe practices which could result in personal injury or property damage." Also on Page 2: "AS REGARDS TO RESTRAINTS-SEAT POSITIONING STRAPS- IT IS THE OBLIGATION OF THE DME DEALER, THERAPISTS, AND OTHER HEALTH</p>	F 323		
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PROFESSIONALS TO DETERMINE IF A SEATING POSITIONING STRAP IS REQUIRED TO ENSURE THE SAFE OPERATION OF THIS EQUIPMENT BY THE USER. SERIOUS INJURY CAN OCCUR IN THE EVENT OF A FALL FROM THE HTR." Again on Page 2: "Make sure the occupant of the chair is properly positioned." On Page 4 of the manual: "To determine and establish your particular safety limits, practice bending, reaching and transferring activities in several combinations in the presence of a qualified healthcare professional BEFORE attempting active use of the HTR." Also on Page 4: "Do not attempt to reach objects if you have to move forward in the seat." Again on Page 4: ALWAYS wear your positioning seat strap. Inasmuch as the SEAT POSITIONING STRAP is an option on the HTR (You may order with or without the seat positioning strap), Invacare strongly recommends ordering the seat positioning straps as an additional safeguard for the HTR user." In other areas of the manual, it clearly cautions on the importance of properly being positioned in the chair so that one's center of gravity is not too far forward, due to the possibility of the chair tipping forward.

Per interview on 3/19/14 at 11:45 AM and again at 3:40 PM, the Director of the Therapy Dept stated that the primary LNAs and Nurses on the day shift on B wing where Resident #1 resided were instructed in the use of the chair, and shown the various functions of it's use. The lever on the left back of the chair was labeled "Do Not Use", as it was the recline function lever of the chair and was not needed to properly position the resident in the reclining position. The right sided lever operated the tilt back and forward function of the chair. The nursing staff who worked the

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F 323	<p>Continued From page 4</p> <p>evening shift were instructed to show the LNAs on those shifts how to properly use the HTR chair. Although the Physical Therapist and Occupational Therapist documented teaching the LNAs on the therapy notes, the Dept. head confirmed that there was no log of who was specifically trained in the proper use of the HTR chair and what exactly was reviewed/performed in the training.</p> <p>Per interview on 3/19/14 at 1:55 PM, the Staff Development Coordinator (SDC) presented documentation of training for the LNAs on the use of the chair that was conducted in a mandatory inservice at different times of day on three dates. 3/3, 3/4, and 3/6/14 in order to accommodate all LNA staff to attend. This was conducted a week after the accident involving Resident #1. The SDC also confirmed at this time that there was no formalized education logs with attendance records to show who had been inserviced in February when the chair was issued to the resident.</p> <p>Per interview on 3/20/14 at 1:40 PM, LNA #1 who was at the rear of the HTR chair when Resident #1 fell, stated that they had been shown the function of the chair prior to using it. The in-person interview details were not consistent with the written account of the incident on the evening of Resident #1's fall, as LNA #1 did not state that the chair was moved purposefully into the upright position immediately before the resident fell, but that the resident had moved forward in the chair and fell due to moving too far forward in the chair (indicating lack of supervision), not due to the action of moving it into the upright position.</p>	F 323		
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F 323	<p>Continued From page 6</p> <p>Per interview on 3/19/14 at 2:45 PM, LNA #2 recalled that the resident was calling out for the neck pillow which had been placed on the bed. As LNA #2 was turned away from facing Resident #1, the chair moved into an upright position and the resident fell forward. LNA#2 did not see if the lever was intentionally squeezed or it happened unintentionally. Both LNAs stated that they attempted to catch the resident to prevent the fall however it happened too quickly. In the interview, LNA #2 stated that they had not transferred Resident #1 before that evening, and was not inserviced on the function of the HTR chair until the inservices conducted a week later.</p> <p>Interviews with staff were conducted on 3/19/14 on the two units where this type of chair is used for 2 other residents as of 3/19/14. On "A wing" unit, which is a locked unit specializing in residents with dementia, Resident #2 had a similar type of chair that had been in use for more than a year. Per interview at 4:30 PM, the primary LNA for that afternoon, working with Resident #2 said that they had not been specifically instructed on it's use, that it was "common sense", and that they did need to ease the chair into the upright position for a gentle transition to sitting upright. This LNA stated that s/he had also worked on B Wing with Resident #1 and operated the newer HTC chair, and had noticed that the action of the chair was more forceful and moved to sitting position very quickly compared to the older type of tilt/recline chairs. The LNA confirmed they had not received specific training on the newer chair before being expected to operate it.</p> <p>Interviews were conducted on 3/19/14 on "B Wing" at 5:05 PM. Of the four LNAs working on the unit that evening, only one of them had been</p>	F 323		
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F 323	Continued From page 6 shown the proper use of the HTR chair prior to the 2/24/14 incident when Resident #1 fell. All of the LNAs interviewed on 3/19/14 attended the inservice after the accident when they were held the first week of March. One LNA expressed concern regarding the similar chair used by Resident #3 as of 3/19/14, due to the fact that it had a forceful motion when put into the upright position from the tilt position, and that s/he had to be careful when doing this that the resident did not pitch forward out of the chair. On 3/19/14 at 5:15 PM, the evening charge nurse confirmed that they had not been instructed to train the evening or night staff in the proper use of this type of chair.	F 323			