

Division of Licensing and Protection

HC 2 South, 280 State Drive

Waterbury, VT 05671-2060

<http://www.dail.vermont.gov>

Survey and Certification Voice/TTY (802) 241-0480

Survey and Certification Fax (802) 241-0343

Survey and Certification Reporting Line: (888) 700-5330

To Report Adult Abuse: (800) 564-1612

October 6, 2016

Ms. Alecia Dimario, Administrator  
Kindred Transitional Care & Rehab Birchwood Ter  
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 **June 14, 2016**. 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: 06/24/2016  
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  R 06/14/2016
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  An unannounced on-site follow-up visit, for the survey of 04/27/16, was conducted on 06/14/16 by the Division of Licensing and Protection. While the facility was found to be in substantial compliance, the following repeat issues were identified that require correction.	{F 000}	<i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the alleged facts or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of federal and state law require it.</i>	
{F 253} SS=B	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES  The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.  This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to provide housekeeping and maintenance services to maintain a sanitary, orderly and comfortable interior in resident rooms and bathing areas on Unit A. The findings include the following:  1. Five Resident rooms with built in closets and bureaus were found to have bent or broken knobs, rough edges and chipped and peeling paint. Walls are noted to have missing or peeling paint as well as cove bases sloughing from the walls in nine resident rooms. The bathroom/shower was noted to have chipped tiles and grout missing from around the lower portion of the shower.  During interview at 11:15 AM the Administrator stated that a CBR [capital budget request] was made and work is starting on Unit B. The CBR states that 24 rooms on Unit B, which has approximately 30 beds, were going to be	{F 253}	F 253  The Director of Maintenance and ED/ or Designee will work with the Corporate Office to develop a systematic plan for refurbishment and repairs in patient rooms and shower rooms. First resident room on A wing started 6/20/16. Resident rooms (wall protection, replacement of cove base, paint and hardware replacement) should be completed by August 2016.  Shower room tiles/cracks will be repaired or replaced.  Maintenance and ED/ or Designee will complete monthly rounds and identify any areas of needed repair. Work orders will be established so that repairs can be tracked for completion.  The results of rounds and repairs will be reviewed with the QAPI committee monthly x 3 months to ensure compliance.  The ED is responsible for overall compliance.  <i>F253 POC accepted 10/6/16 Semmons/ML</i>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Heena D. Mahajan* TITLE *Executive Director* (X6) DATE *6/30/16*

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 253}	Continued From page 1	{F 253}	F514		
{F 514} SS=B	<p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to assure the clinical record is completed according to accepted professional standards to identify the services provided for 1 of 4 residents reviewed. (Resident #77)</p> <p>Per record review, Resident #77 had missing signatures, which signify that care and services were provided, on the TAR [treatment administration record]. This occurred mostly on the evening shift of 06/10/16 and the morning shift of 06/11/16. The treatments included monitoring an access site, applying dressings and/or ointments and checking equipment. The DNS [Director of Nursing Services] at 1:57</p>	{F 514}	<p>Resident # 77 missing signature on TAR was corrected by nurses involved. Nurses involved in missing documentation were re-educated on policy to document treatments in the TAR.</p> <p>A house audit of resident's TAR's has been completed to ensure no other residents are affected by this practice.</p> <p>The DNS has re-educated licensed nurses on the policy to document treatments in the TAR.</p> <p>The DNS/designee will complete random audits of documentation in the TAR to monitor for gaps. Results of these audits will be reviewed at the monthly QAPI committee x 3 months to ensure compliance.</p> <p>The DNS is responsible for overall compliance.</p> <p><i>FS14 POC accepted 10/6/16 Semmons RN/pml</i></p>		

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{F 514}	Continued From page 2 PM confirmed that the TAR had missing signatures and the clinical record was not complete.	{F 514}			
{F9999}	FINAL OBSERVATIONS	{F9999}			