

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

November 14, 2012

Ms. Ursula Margazano, Administrator
Burlington Health & Rehab
300 Pearl Street
Burlington, VT 05401

Dear Ms. Margazano:

Enclosed is a copy of your amended acceptable plans of correction for the survey conducted on **October 17, 2012**. 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



PRINTED: 10/29/2012
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475014	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/17/2012
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NAME OF PROVIDER OR SUPPLIER BURLINGTON HEALTH & REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 300 PEARL STREET BURLINGTON, VT 05401
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F 000	INITIAL COMMENTS An unannounced onsite recertification survey was completed by the Division of Licensing and Protection from 10/15/12 through 10/17/12. Based on information gathered, regulatory violations were cited as follows. F 279 483.20(d), 483.20(k)(1) DEVELOP SS=D COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to develop a comprehensive care plan for one of three residents in the applicable stage two sample (resident #184). Findings include:	F 000 F 279 F279	The following constitutes the facility's response to the findings of the Department of Licensing and Protection and does not constitute an admission of guilt or agreement of the facts alleged or conclusions set forth on the summary statement of deficiencies. The facility maintains that it develops a comprehensive care plan for residents with urinary incontinence. How the corrective action(s) will be accomplished for those residents found to be affected by the alleged deficient practice? : Resident #184 suffered no negative outcome, resident recovered and discharged home. How will the facility identify other residents having the potential to be affected by the same deficient practice? : All residents with urinary incontinence are potentially affected by this alleged deficient practice	10/17/2012 On-going
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE Administrator DATE 11/7/12

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 patient. (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 279	Continued From page 1 1. Per record review on 10/17/12 at 8:45 AM, there was no care plan in place to address needs pertaining to urinary incontinence for Resident #184. Resident #184 was admitted on April 24, 2012 and discharged on August 15, 2012. Per assessment data from the MDS (Minimum Data Sets) completed in May and June of 2012, Resident #184 was assessed as frequently incontinent of urine. Per interview with the Director of Nursing (DNS) on 10/17/12 at 12:05 PM, the DNS confirmed that there was no care plan to address the needs of Resident #184 related to urinary incontinence and that there should have been a care plan in place.	F 279	What measures will be put into place or systematic changes made to ensure that the deficient practice will not recur? : All nurses will be re-educated re: the development of comprehensive care plans will include urinary incontinence when applicable. DNS, ADNS, SDC, UM, &/or designee	11/10/2012
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to implement the care plan that directed staff to attempt alternative approaches prior to the use of psychoactive medications for 1 of 10 residents in the sample (Resident #155). Findings include: Per record review on 10/16/2012 at 1:28 PM, Resident #155 was administered an anti-anxiety medication on 4 occasions during October 2012 without the nurse assessing the need for the medication or attempting non-pharmacological		How will the facility monitor its corrective actions to ensure that the deficient practice will not recur? : Initial audit of all residents to determine urinary incontinence. Initial audit of all incontinent residents' care-plans to insure a care-plan has been developed for urinary incontinence. Audit of all new admissions x4 weeks to insure urinary incontinence care-plan has been developed when applicable, continued random auditing. Results reported at Action Team and QA Meetings with changes made as appropriate. DNS, ADNS, SCD, UM &/or designee <i>F279 POC accepted 11/9/12 JHS/merrill/PMC</i>	11/14/2012 & on-going

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F 282	Continued From page 2 interventions prior to its use. Neither the behavior flow sheet nor the nurses' notes for 10/11/2012 or 10/12/2012 indicated the reason the medication was used or that any alternative approaches were first attempted. The medical record further does not indicate that the resident was monitored after the medication was administered to determine the effectiveness of the medication administration. Unit staff confirmed on 10/17/2012 at 11:35 AM that there was no documentation justifying the administration of an anti-anxiety medication or that redirection or one-to-one was first attempted as directed by the care plan dated 07/19/2012. This was further confirmed during an interview with the Director of Nursing on 10/17/2012 at 1:05 PM.	F 282	The facility maintains that all residents receive the appropriate treatment and services as per care plan by appropriate qualified staff. How the corrective action(s) will be accomplished for those residents found to be affected by the alleged deficient practice? : Resident #155 was not negatively affected by this alleged deficient practice. Care plan reviewed and revised. Direct care nurses educated to attempt alternative approaches before administering psychotropic medication as per care-plan using supported documentation. DNS, ADNS, SDC, UJ & Jor designee	
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		How will the facility identify other residents having the potential to be affected by the same deficient practice? : All residents receiving psychotropic medication are potentially affected.	11/10/2012 On-going

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F 329

Continued From page 3
record; and residents who use antipsychotic drugs receive gradual dose reductions; and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.

This REQUIREMENT is not met as evidenced by:
Based on staff interview and record review, the facility failed to ensure that 2 of 10 applicable residents in the stage 2 sample were free from unnecessary drugs (Residents #77 and #155). Findings include:

1. Per record review on 10/16/12 at 2:10 P.M., Resident # 77 was administered an anti-anxiety medication 18 times in September and October of 2012 without attempting non-pharmacological interventions and without adequate monitoring of behaviors. Per review of the plan of care, there were no non-pharmacological interventions in place. During interview on 10/16/12 at 2:50 P.M., the Unit Manager (UM) stated that there should be non-pharmacological interventions on the plan of care as well as a behavioral monitoring form in the treatment record. The UM also stated that it is his/her expectation that nursing staff attempt non-pharmacological interventions prior to administering as needed psychotropic medications and that behaviors are monitored. The UM confirmed that there were no non-pharmacological interventions in the Resident's plan of care and that there was no behavioral monitoring form in the treatment

F282
cont

What measures will be put into place or systematic changes made to ensure that the deficient practice will not recur? :

All nurses will be educated re: alternative approaches will be used before administering psychotropic medication as per care-plan with supported documentation.

DNS, ADNS, SDC &/or designee

11/10/2012

How will the facility monitor its corrective actions to ensure that the deficient practice will not recur? :

Initial audit of all residents on psychotropic medication to review and/or revise alternative approaches on psychotropic medication care-plan. 5 random audits per week per unit x 4 weeks of residents receiving psychotropic medication, to insure alternative approaches, as per care-plan, were attempted before administering the medication with supported documentation. Continued random auditing. Results reported at Action Team and QA Meetings with changes made as appropriate.

DNS, ADNS, SDC, UM &/or designee

11/14/2012 & on-going

F282 POC accepted 11/14/12 JH.../PME

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F 329	Continued From page 4 record. 2. Per record review on 10/16/2012 at 1:28 PM, Resident #155 was administered an anti-anxiety medication on 4 occasions during October 2012 without the nurse assessing the need for the medication or attempting non-pharmacological interventions prior to its use. Neither the behavior flow sheet nor the nurses' notes for 10/11/2012 or 10/12/2012 indicated the reason the medication was used or that any alternative approaches were first attempted. The medical record further did not indicate that the resident was monitored after the medication was administered to determine the effectiveness of the medication. Unit staff confirmed on 10/17/2012 at 11:35 am that there was no documentation justifying the administration of an anti-anxiety medication or that redirection or one-to-one was first attempted, as directed by the care plan dated 07/19/2012. This was further confirmed during interview with the DNS (Director of Nursing) on 10/17/2012 at 1:05 PM.	F 329	The facility maintains that all psychotropic medications given to residents are necessary. How the corrective action(s) will be accomplished for those residents found to be affected by the alleged deficient practice? : Resident # 77 & # 155 were not negatively affected by this alleged practice. Care-plans for both residents reviewed and revised. Direct care nurses for both residents were educated re: behavior monitoring and alternative, non-pharmacologic interventions to be used before administering psychotropic medication, monitoring to continue after med. administration/Interventions to evaluate effectiveness, supported documentation. DNS, ADNS,SDC, UM &/or designee How will the facility identify other residents having the potential to be affected by the same deficient practice? : All residents receiving psychotropic medication are potentially affected by this alleged deficient practice.	11/10/2012
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local			On-going

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F 371	<p>Continued From page 5 authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations and interview(s) the facility failed to store and prepare food under sanitary conditions. Findings include:</p> <p>During the initial tour of the kitchen on 10/15/12 at 10 A.M. and the follow-up tour on 10/15/12 at 3:00 P.M., the following observations were made in the kitchen:</p> <ol style="list-style-type: none"> 1. The outside of the ice machine had visible dirt stains. 2. In the walk-in refrigerator where resident food is stored, there were (staff) beverages on the shelf including soda and an energy drink. 3. The refrigerator held cake in a pan which was stored on the bottom shelf and was not covered or dated. 4. In the storage room there were 4 large, white plastic containers holding oatmeal, panko bread crumbs, flour and brown sugar. All four containers were visibly soiled on the outside with food residue and debris. 5. There were 2 fans located on the wall in the kitchen that were blowing toward the dishwasher 	F328 <i>cont.</i>	<p>What measures will be put into place or systematic changes made to ensure that the deficient practice will not recur? :</p> <p>All nurses will be educated re: behavior monitoring and alternative, non-pharmacologic interventions, as per care-plan, to be used before administering psychotropic medication, monitoring to continue after medication administration/interventions to evaluate effectiveness, and supportive documentation. DNS, ADNS, SDC &/or designee</p> <p>How will the facility monitor its corrective actions to ensure that the deficient practice will not recur? :</p> <p>Initial audit of all residents on psychotropic medication reviewed and/or revised with alternative, non-pharmacologic approaches on psychotropic medication care-plan. 5 random audits per week per unit x 4 weeks of residents receiving psychotropic medication, to insure behavior monitoring and alternative approaches were attempted, per care-plan, before administering psychotropic medication and continued monitoring for effectiveness of medication/interventions, with supportive documentation. Results reported at Action Team and QA Meetings with changes made as appropriate. DNS, ADNS, SDC, UM, &/or designee</p>	11/10/2012
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F328 POC accepted 11/14/12
JHosmer RN / Pmc

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F 371	Continued From page 6 rack where both dirty and clean dishes are stacked/washed/cleaned. Both fans were heavily coated with dirt/debris. On 10/15/12 at 10:15 A.M. and at 10/15/12 at 3:15 P.M. the kitchen account manager (food service supervisor) confirmed the above observations.	F 371	<p>The facility maintains that it stores, prepares, distributes and serves food under sanitary conditions</p> <p>How the corrective action(s) will be accomplished for those residents found to be affected by the alleged deficient practice? :</p> <ol style="list-style-type: none"> 1. Outside of ice machine was wiped down with disinfectant. Ice was emptied and internally cleaned. 10-15-12 2. The 2 sealed can/bottled beverages that were staff's were removed from refrigerator 10-15-12 3. Uncovered cake was thrown away 10-15-12 4. Bins were wiped down, lids and/or wrap was placed on top to seal contents 10-15-12 5. 2 new bins purchased to replace above ingredient bins + 2 additional bins with extra lids ordered for stock 11-7-12 6. Fans were removed 10-16-12 <p style="text-align: right;">Dietary Director, Cook &/or designee</p>	
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FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: Y6UT11 Facility ID: 476014

How will the facility identify other residents having the potential to be affected by the same deficient practice? :
All residents are potentially affected. On-going

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	<p>What measures will be put into place or systematic changes made to ensure that the deficient practice will not recur? : Dietary will be re-educated re: sanitary / cleaning standards to include surface areas and covering/dating unsealed prepared food products. Director of Dietary Services, &/or designee</p> <p>How will the facility monitor its corrective actions to ensure that the deficient practice will not recur? : 5 random audits per week Xs 4 weeks of general main kitchen environment and main kitchen refrigerators checked to cleanliness and covered/dated food product with results reported at morning meeting and QA Meetings with changes made as appropriate. Director of Dietary Services, &/or designee</p> <p>F371 POC accepted 11/9/12 JHshmeckert Pmc noted correction accepted 11/10/12 Pmc</p>	<p>11-10-12</p> <p>11-8-12 on-going</p>
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error and corrected date
 11/12/12
 an