

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

June 3, 2013

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

Dear Ms. Margazano:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **May 10, 2013**. 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

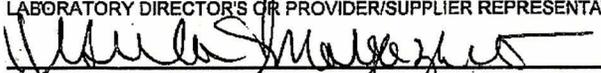
PRINTED: 05/15/2013
FORM APPROVED
OMB NO. 0938-0391

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 C 05/10/2013
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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 investigation of a facility self-report was conducted on 5/7/2013 by the Division of Licensing and Protection and concluded on 5/10/2013. There were regulatory deficiencies identified during this investigation. Findings include:	F 000	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.	
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on staff interviews and review of documentation the facility failed to assure that one resident (Resident #4) was free from any physical restraint not required to treat the resident's medical symptoms. Findings include: Per record review Resident #4 has a history of agitation with combative behavior and resistance to care. On 5/1/2013 Resident #4 refused to allow morning care when approached by staff. The LNA (LNA#1) assigned to his/her care left and attempted to reapproach later. LNA#1's written statement says that s/he returned several times to attempt and offer care, all of which the resident refused. The resident had also been incontinent and remained in clothing wet with urine. At approximately 2 PM on 5/1/13 LNA#2 arrived at work and received report. During report s/he learned that Resident #4 was wet and had	F 221	The facility maintains that it's residents have the right to live free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. How the corrective action(s) will be accomplished for those residents found to be affected by the alleged deficient practice? : Intervention had been put in place and modified as needed depending on residents' outcome/response. Resident #4 had no negative outcome/injury DON, Unit Mng, SDC, &/or designee How will the facility identify other residents having the potential to be affected by the same deficient practice? : All residents that are resistant with care are potentially affected by this alleged deficient practice.	5-6-13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE *Executive Director* (X6) DATE *5/24/13*
 Administrator

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.

AM

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F 221	<p>Continued From page 1</p> <p>refused care all day. At that point LNA's #1&2 reapproached the resident to attempt care. During this time the resident became agitated and began yelling at the two LNAs and attempted to strike out at them. LNA#1 left the room to obtain clean bed linens leaving LNA#2 alone in the room with the resident.</p> <p>At this time LNA#3 was nearby outside the room completing his/her daily charting. As LNA#1 re-entered the room LNA#3 asked how it was going and went into the room after LNA#1. Upon entering the room it was noted that the resident was on the bed with his/her hands tied together with his/her shirt sleeves. LNA#3 reportedly stated "you can't do that" and untied the resident's hands. He/she attempted to soothe the resident as the resident became more agitated again.</p> <p>The LPN (Licensed Practical Nurse) was making walking rounds and was near the resident's room. When LNA#1 came out of the room and explained that the resident was very agitated the LPN told him/her not to go back in and went and told the other two LNAs to leave the room to allow the resident to calm. At that point the resident was not tied. The LPN was not made aware that the resident had been tied by any of the three LNAs.</p> <p>In an interview on 5/7/2013 at 12:07 PM, LNA#2 confirmed that he/she had tied the wrists of Resident #4 with his/her shirt sleeves fearing that the resident would harm him/her. These facts are also confirmed in LNA#2's written statement, as well as in interviews of LNA#3 at 11:30 AM and LNA#1 at 1:15 PM on 5/7/2013 and the written</p>	F 221	<p>What measures will be put into place or systematic changes made to ensure that the deficient practice will not recur? : Re-education to all Unit 5 direct care nursing staff re: restraint use/abuse protocol, behavioral triggers, symptoms, interventions specific to resident #4. DON, SDC, &/or designee</p> <p>Re-education to all nursing staff re: recognition of abuse/restraint protocol, including reporting timelines DON, SDC, &/or designee</p> <p>How will the facility monitor its corrective actions to ensure that the deficient practice will not recur? : 3 audits/week of Resident #4 intervention outcomes X 4 weeks through clinical stand-up meeting (concurrent review) to insure effectiveness of interventions. Results reported at Action Team and QA meetings with changes made as appropriate. DON, Unit Mngr, Social Svc, &/or designee</p> <p><i>POC ACCEPTED M. J. [Signature]</i></p>	<p>5-6-13</p> <p>5-31-13</p> <p>5-31-13</p>

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F 223	<p>Continued From page 3</p> <p>began yelling at the two LNAs and attempted to strike out at them. LNA#1 left the room to obtain clean bed linens leaving LNA#2 alone in the room with the resident.</p> <p>At this time LNA#3 was nearby outside the room completing his/her daily charting. As LNA#1 re-entered the room LNA#3 asked how it was going and went into the room after LNA#1. Upon entering the room it was noted that the resident was on the bed with his/her hands tied together with his/her shirt sleeves. LNA#3 reportedly stated "you can't do that" and untied the resident's hands. He/she attempted to soothe the resident as the resident became more agitated again.</p> <p>The LPN (Licensed Practical Nurse) was making walking rounds and was near the resident's room. When LNA#1 came out of the room and explained that the resident was very agitated the LPN told him/her not to go back in and went and told the other two LNAs to leave the room to allow the resident to calm. At that point the resident was not tied. The LPN was not made aware that the resident had been tied by any of the three LNAs.</p> <p>In an interview on 5/7/2013 at 12:07 PM, LNA#2 confirmed that he/she had tied the wrists of Resident #4 with his/her shirt sleeves fearing that the resident would harm him/her. These facts are also confirmed in LNA#2's written statement, as well as in interviews of LNA#3 at 11:30 AM and LNA#1 at 1:15 PM on 5/7/2013 and the written statements of LNAs #1&3.</p>	F 223	<p>How will the facility monitor its corrective actions to ensure that the deficient practice will not recur? :</p> <p>100% of all new orientis will be educated re: Resident Rights and Abuse protocol. All staff will minimally attend re-education re: Resident Rights and Abuse protocol annually. Results reported at Action Team and QA meetings with changes made as appropriate. DON, Unit Mngr, Social Svc, &/or designee</p>	5-31-13
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT	F 225		

*POC ACCEPTED
M. H. [Signature]*

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F 225	<p>Continued From page 4 ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p>	F 225	<p>The facility maintains that it reports all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source in accordance with State law.</p> <p>How the corrective action(s) will be accomplished for those residents found to be affected by the alleged deficient practice? : Incident involving resident # 4 was investigated and reported upon confirmation of allegation. DON, Unit Mng, SDC, &/or designee</p> <p>How will the facility identify other residents having the potential to be affected by the same deficient practice? : All residents are potentially affected by this alleged deficient practice.</p> <p>What measures will be put into place or systematic changes made to ensure that the deficient practice will not recur? : Re-education for all staff re: Resident rights and Abuse protocol. DON, SDC, &/or designee</p>	<p>5-6-13</p> <p>5-31-12</p>

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F 225	<p>Continued From page 5</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interviews and record reviews the facility failed to report an incident of alleged abuse immediately to the State Survey Agency within the required time frames. Findings include:</p> <p>The facility first became aware of an alleged staff to resident abuse incident on 5/4/2013. On 5/4/2013 the Director of Nurses (DNS) was approached by an LNA who stated that a second LNA had told some staff about a resident (Resident #4) being "tied up". The DNS began an immediate investigation and later that afternoon, when the LNA arrived for a shift, suspended that LNA pending the results of an internal investigation.</p> <p>The incident was reported to the State Agency on the afternoon of 5/6/2013. In an interview at 8 AM on 5/7/2013 the DNS confirmed that s/he had reported the incident to the State Agency on the afternoon of 5/8/2013.</p> <p>See also F223.</p>	F 225	<p>How will the facility monitor its corrective actions to ensure that the deficient practice will not recur? : 100% of all new orients will be educated re: Resident Rights and Abuse protocol. All staff will minimally attend re-education re: Resident Rights and Abuse protocol annually. Results reported at Action Team and QA meetings with changes made as appropriate DON, Unit Mngr, Social Svc, &/or designee</p> <p><i>POC ACCEPTED m 7/8/2013</i></p>	5-31-13
F 226 SS=D	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the</p>	F 226		

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F 250 SS=D	<p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to provide medically-related social services to maintain the highest practicable well-being of one resident (Resident #4). Findings include:</p> <p>Per record review, the resident record for Resident #4 reflects that the Social Services department has been involved in Care Plan meetings in January 2013 and April of 2013. There are no notes reflecting Social Worker visits regarding the resident's agitation and combative behaviors. The resident was reportedly extremely resistive to care and combative for several days prior to an incident of restraint/abuse by staff on May 1, 2013. There are no follow-up notes by the Social Services department regarding this recent behavior or multiple prior resident to staff incidents reported in the investigative documentation related to the most recent event. There is one Social Services note related to the current incident dated 5/7/2013 at 14:44 PM.</p> <p>In an interview on 5/7/2013 at 3:20 PM the Social Worker who covers this unit stated that if there isn't documentation regarding an incident in the record it would be in a "soft file". When asked to</p>	<p>F226 cont</p> <p>F250</p>	<p>How will the facility monitor its corrective actions to ensure that the deficient practice will not recur? : 100% of all new orients will be educated re: Resident Rights and Abuse protocol. All staff will minimally attend re-education re: Resident Rights and Abuse protocol annually. Results reported at Action Team and QA meetings with changes made as appropriate DON, Unit Mngr, Social Svc, &/or designee</p> <p>The facility maintains that it provides medically-related social services to attain or maintain the highest practicable well-being of the residents.</p> <p>How the corrective action(s) will be accomplished for those residents found to be affected by the alleged deficient practice? : Social Service intervention has been put in place and modified as needed depending on residents' outcome/response. DON, Unit Mng, SDC, &/or designee</p> <p>How will the facility identify other residents having the potential to be affected by the same deficient practice? : All residents are potentially affected by this alleged deficient practice.</p>	<p>5-31-13</p> <p>5-31-13</p>

