

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

August 8, 2013

Ms. Meagan Buckley, Administrator  
Burlington Health & Rehab  
300 Pearl Street  
Burlington, VT 05401

Dear Ms. Buckley:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **July 2, 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>475014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/02/2013</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>BURLINGTON HEALTH &amp; REHAB</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>300 PEARL STREET BURLINGTON, VT 05401</b>
--	---

(X4) ID PREFIX TAG  <b>F 000</b>	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG  <b>F 000</b>	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--	--	-----------------------------------	---	----------------------

<b>F 000</b>	<b>INITIAL COMMENTS</b>	<b>F 000</b>	<b>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.</b>	
<b>F 204 SS=D</b>	<b>483.12(b)(7) PREPARATION FOR SAFE/ORDERLY TRANSFER/DISCHRG</b>	<b>F 204</b>	<b>The facility maintains that it provides sufficient preparation and orientation to residents to ensure a safe and orderly discharge.</b>	<b>7/31/13 &amp; On-going</b>
	A facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.		<b>How the corrective action(s) will be accomplished for those residents found to be affected by the alleged deficient practice? : There were no negative outcomes to resident #1.</b>	<b>7/31/13</b>
	This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews, the facility failed to assure a safe orderly discharge for one resident sampled (Resident #1). Findings include:		<b>How will the facility identify other residents having the potential to be affected by the same deficient practice? : All discharging residents are potentially affected by this alleged deficient practice</b>	<b>7/31/13 &amp; On-going</b>
	Per record review on 7/2/13, Resident #1 was admitted to the facility on 9/20/12 from a hospital after having a total knee replacement. The rehab admission was complicated by a wound infection and slow progress in strengthening the leg. The resident was finally ready for discharge in March 2013 after receiving extensive therapy, being evaluated and fitted with a new walker, and setting up services to follow the resident once they were discharged to home. Resident #1 has insulin dependant diabetes and at the time of discharge was receiving a long acting insulin (Levemir 70 Units SC at bedtime) and coverage with Novolog regular insulin per a sliding scale depending on glucose reading three times a day with mbals.		<b>What measures will be put into place or systematic changes made to ensure that the deficient practice will not recur? The careplan team will be educated on the discharge procedure, including discharge instructions and education. DNS,SDC, &amp;/or designee</b>  <b>How will the facility monitor its corrective actions to ensure that the deficient practice will not recur? : All discharged residents will be audited X 4 weeks, then randomly. Results reported during 24hr stand up, Action Team and QA Meetings with changes made as appropriate. DNS, SDC &amp;/or designee</b>	<b>7/31/13 &amp; On-going</b>  <b>8/2/13 &amp; On-going</b>

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *[Signature]* TITLE: *Executive Director* (X6) DATE: *7/29/13*

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.

*me*

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

FORM APPROVED  
OMB NO. 0938-0392 Licensing and  
Protection

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 07/02/2013
NAME OF PROVIDER OR SUPPLIER  BURLINGTON HEALTH & REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 300 PEARL STREET BURLINGTON, VT 05401		
(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 204	Continued From page 1  The resident was discharged on Saturday 3/30/13 with a bag of medications and the walker that was fitted and evaluated by Physical Therapy. S/he also stated that no education had been provided as to the use of insulin pens. Upon arriving at home, Resident #1 discovered that the only insulin in the bag was the short acting Novolog and the Levemir was not in the bag. The resident went through the weekend without taking the long acting insulin, until s/he was able to call their primary MD's office on Monday 4/1/13 to get a prescription for Levemir. Per review of the telephone orders in the medical record, the 3/21/13 order to discontinue sliding scale Novolog, and have Social Services check to see if Levemir and Novolog Insulin pens had been called in. There was no documentation in the record to reflect that this was done, and a telephone physician order on 3/25/13 signed by the Nurse Practitioner stated "Please order Novolog Pen and give AC dose as ordered by pen. Please order Levemir Pen and give HS dose as ordered by pen. Educate family on use of Insulin pens and fingersticks."  Per interview on 7/2/13 at 1:15 PM, the Director of Nursing stated that the insulin pens had not arrived at the facility by the date of discharge, an RN had prepared a bag of the resident's medication to be taken home, and a note for the next shift that it was "all set" to be given to the resident. The LPN who gave the bag of medications told the DNS that they did not check the contents of the bag to assure all the medications were there, and that the insulin pens had not arrived at the facility in time to educate the resident on the proper use of them.	F 204			