

Division of Licensing and Protection
103 South Main Street
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 2, 2015

Ms. Meagan Buckley, Administrator
Burlington Health & Rehab
300 Pearl Street
Burlington, VT 05401-8531

Dear Ms. Buckley:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **March 11, 2015**. 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: 03/19/2015
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 03/11/2015
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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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(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	<p>INITIAL COMMENTS</p> <p>An unannounced on-site investigation of 2 entity self-reports and 1 complaints concerning resident rights and quality of care was conducted by the Division of Licensing and Protection on 3/10-3/11/15. The following regulatory violation was identified:</p> <p>F 353 SS=E 483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS</p> <p>The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.</p> <p>The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:</p> <p>Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.</p> <p>Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and interviews the facility failed to assure sufficient nursing staff to provide nursing and related</p>	F 000	<p>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 in the summary statement of deficiencies.</p> <p>F 353</p> <ol style="list-style-type: none"> No residents were negatively affected by this alleged deficit practice. All residents on Unit 4 are potentially at risk of this alleged deficit practice. Re-educate staff on proper grooming care and call bell answering process. Random observations and interviews will be completed with residents, staff and families weekly by Director of Nursing or designee to determine continued compliance with plan. Director of Nursing shall report out to QAA committee monthly x3 at this time frequency of further surveillance shall be determined by committee. Corrective actions shall be complete by 4/1/2015 <p><i>F353 FCC accepted 3/31/15 SDennisR/pml</i></p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Executive Director	(X6) DATE 3/30/15
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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 their 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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Continued From page 1
services to attain or maintain the highest emotional, physical, and psychosocial well-being of residents. This has the potential to effect all residents residing on the 4th floor unit (37 Residents). *This is a repeat citation, previously cited on 12/18/13 and 7/29/14* Findings include:

A family member, who requested to be anonymous, reported that a relative who resides in the facility is frequently not out of bed and dressed by 11 or 11:30 AM. In one instance, the family member reported that s/he requested help to assist the resident to the bathroom; no one came to assist and when leaving stopped again at the nurse's station to request help and was told to "go back to your room and push the button for the nurse."

Over the course of the 3/10-3/11/15 survey, 4 residents, each of whom requested confidentiality, reported concerns of short staffing. Resident #1 reported that sometimes it takes up to an hour for LNAs (Licensed Nursing Assistants) to respond to a call light. S/he reported preferring to get up after breakfast but often had to wait until 10 or 11 to get up. The resident reported that the facility is short staffed, not enough LNAs. Resident #2 reported concerns that there are not enough LNA staff and must wait a long time for call lights to be answered. S/he expressed concern that if a resident who wanders came into his/her room [on a day that staffing was short], staff might be slow to respond to the call light for help which causes him/her continued worry and stress. Resident #3 reported that sometimes wait 30-35 minutes for a call light to be answered. Staff are busy during meal times delivering trays or feeding residents so aren't able to answer call lights timely; s/he

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F 353	<p>Continued From page 2</p> <p>reported not using his/her call light to request an alternative meal choice or a missed food item on his/her tray during this time as s/he knows the response will be slow, so don't call as do not want to wait. S/he reported, on other days, there are staff call outs and not enough staff to respond to lights. S/he wondered if staff sometime feel overwhelmed with care. On 3/11/15 at 1:08 PM, Resident #4 was observed with hair uncombed and face unshaved in the Unit 4 dining room. The resident stated that the facility is short staffed almost daily and s/he reported that sometimes feels "residents are in the way of staff getting their work done." S/he reported that s/he is not shaved regularly and sometimes needs to complain to get care ...some days are better than others.</p> <p>Per 3/11/15 at 11:42 AM interview with the 4th floor Unit Manager (UM), s/he reported that there are currently 37 residents on the unit which provides long term care. 13 of the residents require the use of a Hoyer lift. On days, there are 2 nurses, the UM and 3-4 LNAs. S/he reported that nurses are expected to assist the LNAs with Hoyer lifts and care. When there are LNA call outs, staff are floated to other units to equalize resident assignments and the scheduler tries to call to find fill in staff.</p> <p>Per interviews with LNA staff, on 3/10-3/11/15 LNA #1 reported that the facility could use more LNA staff, it's especially difficult when there are call outs. Feels able to meet care needs when there are 4 LNAs on the unit, but more difficult when there are 3 LNAs. Half of his/her assigned residents require the use of a Hoyer lift [a mechanical lift that requires 2 staff to operate to transfer residents from bed to chair or toilet] S/he reported that during meals, staff are expected to</p>	F 353		

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F 353	<p>Continued From page 3</p> <p>pass out trays, feed residents and answer call lights at the same time and if a resident needs to be toileted, it's hard to do it all, someone needs to wait. Sometimes nurses help. LNA #2 reported that the facility has been short staffed and LNAs try to get as much done as they can but residents have to wait longer some days. It burns staff out. LNAs are expected to get residents up, toileted, washed and dressed; serve meals, check weights and vital signs, help with scheduled baths, and assist [other LNAs] with Hoyer lifts. Sometimes the nurses help, but they are busy with medications and their jobs; residents have complained about the wait time for assistance ...try to reassure them we are doing the best we can. LNA #3 reported that short staffing makes it hard to provide care and sometimes residents have to wait a little longer to get care. LNA #4 reported that sometimes staffing is "horrible." If another unit is short and this unit is fully staffed, one LNA might be sent to another unit to provide care. When there are 2-3 LNAs on the unit, it's hard to answer call lights and see that resident's get the care they need. Sometimes, can't get to showers and ask the evening shift to see if they can get them done or try to do the next day. Staff also need to monitor residents that wander ...take turns doing this between resident care. S/he reported that staff have complained to the scheduler and nurses who say they are trying to call to find replacements for staff who call out.</p>	F 353		