

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

August 7, 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 **July 13, 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: 07/27/2015  
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 07/13/2015
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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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F 000 INITIAL COMMENTS

An unannounced onsite complaint investigation was conducted by the Division of Licensing and Protection on 7/13/2015. The following regulatory violations were identified:

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 2 of 3 residents with medical risk factors (Resident #1 & Resident #2). Findings include:  
1. Per medical record review, Resident #1 was admitted to the facility with diagnoses that

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F 279 F279 483.20(d), 483.20(k)(1)

1. Resident #1 and #2 had no negative effect as a result of this alleged deficient practice
2. Residents with medical risk factors have the potential to be affected by this alleged deficient practice
3. Education to be provided to licensed nurses regarding the requirement for care plan development to address medical risk factors
4. Random weekly audits will be conducted by the DNS or designee to monitor effectiveness of the plan
5. Results of the audit will be presented to the QAA committee x3 months at which time frequency of further audits will be determined
6. Corrective action will be completed by August 13, 2015

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Executive Director

8/4/15

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.

F279 POC accepted 8/6/15 SDENISRN/PML

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F 279	<p>Continued From page 1</p> <p>included a personal history of falls, aftercare for a healing traumatic fracture of the upper arm, difficulty walking and other chronic medical problems. Per review, a 6/26/15 nursing progress note documented that the "...resident attempted to self-transfer from toilet to w/c lost balance and fell to floor landing on buttocks. Both feet extended in from of [him/her], facing the bathtub. Noted to be bleeding from the left neck and left FA skin tears. Areas cleansed and [dressings] applied." Following the fall, a fall risk assessment on 6/26/15 identified the resident as at "high risk" for falls.</p> <p>On 7/13/15 at approximately 11:43 AM, the nursing Unit Manager (UM) confirmed the above information and that a care plan had not yet been developed for Resident #1 to address his/her specific fall risks and identify strategies to reduce the risk for further falls.</p> <p>2. Per 7/13/15 record review, Resident #2 was admitted to the facility with a past diagnosis of clostridium difficile, a bacterial infection that can cause symptoms ranging from diarrhea to life threatening inflammation of the colon [bowel]. Per review of labs, on 6/1/15 Resident #2 tested positive for clostridium difficile.</p> <p>Per review, the facility Clinical Policies and Procedures for Clostridium Difficile, address that preventative measures will be taken to prevent the occurrence of Clostridium Difficile infections among residents and precautions will be taken while caring for residents with C. difficile (to prevent transmission of C. difficile to others).</p> <p>On 7/13/15 at 2:45 PM, the UM confirmed that there was no evidence that a care plan for Clostridium Difficile infection was developed for Resident #2 after the infection was identified on 6/1/15 until the day of the survey on 7/13/15,</p>	F 279	

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F 279 Continued From page 2  
approximately 6 weeks from the time of identification.

F 280 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP  
SS=D

The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.

A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.

This REQUIREMENT is not met as evidenced by:  
Based on Interview and record review, the facility failed to revise the care plan for 1 of 3 residents to reflect their current medical care needs (Resident #1). Findings Include:  
Per medical record review, Resident #1 was admitted to the facility on 5/1/15 and readmitted on 8/25/15 following a brief hospital stay. Per review, the resident had a care plan initiated on

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F 280 F 280 483.20(d)(3), 483.10(k)(2)

1. Resident #1 had no negative effect from the alleged deficient practice
2. Residents requiring revisions to the plan of care to reflect current medical care needs have the potential to be affected by the alleged deficient practice
3. Education will be provided to licensed nurses regarding the requirement to update and revise resident care plans to reflect current medical care needs
4. Random weekly audits will be conducted by the DNS or designee to monitor effectiveness of the plan
5. The results of the audits will be reported to the QAA committee x3 months at which time the QAA committee will determine further frequency of the audits.
6. Corrective action will be completed by August 13, 2015

F280 POC accepted 8/6/15 SDennis RN/pmc

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F 280 Continued From page 3

5/5/15 for an "indwelling catheter related to urinary retention." Per record review, the catheter was discontinued and removed on 6/17/15. Following the resident's readmission on 8/25/15, there was no revision made to the care plan to indicate that the catheter had been removed or whether there was a need for continued bladder function monitoring for retention. The resident also had a care plan for "mixed bladder incontinence related to weakness, medications, decreased tone" initiated on 5/5/15, the same date and time frame that the resident was care planned for having a catheter. Additionally, Resident #1 had a care plan initiated on 5/5/15 for being on "Anticoagulant therapy related to Post surgical." Per 7/13/15 medical record review, there was no evidence in the medical record that the resident was taking an anticoagulant medication.

On 7/13/15 at 11:43, the Unit Manager (UM) confirmed the above information and that the resident no longer had a urinary catheter and that the care plan was not revised following its removal. When the resident was readmitted to the facility on 6/26/15 the 5/5/15 care plans continued to be part of the resident's current care plan without revision. The UM further confirmed that there was no evidence that Resident #1 was on an anticoagulant at the time of the 7/13/15 survey and that the care plan was not revised to reflect the resident's current medical condition and care needs.

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