Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

July 21, 2021

Ms. Alecia Dimario, Administrator
Birchwood Terrace Rehab & Healthcare
43 Starr Farm Rd
Burlington, VT 05408-1321

Dear Ms. Dimario:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **June 24, 2021.** 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475003	A. BUILDING _____ B. WING _____	C 06/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD TERRACE REHAB & HEALTHCARE	43 STARR FARM RD BURLINGTON, VT 05408

(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
E 000	Initial Comments An emergency preparedness review was conducted by the Division of Licensing & Protection during the recertification survey on 6/20-6/24//2021. There were no regulatory deficiencies identified as a result of the emergency preparedness review.	E 000		
F 000	INITIAL COMMENTS An unannounced onsite recertification survey was conducted by the Division of Licensing and Protection on 6/20-6/24/2021. The following regulatory deficiencies were identified as the result of the survey:	F 000	*Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the alleged facts or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of federal and state law require it.*	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) 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 §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized	F 656	Resident #24's care plan was immediately reviewed and updated as indicated. House audits have been completed on residents with pressure related wounds to ensure that care plans have be developed. The SDC/designee completed re-education on the facility's policy and procedure for developing Comprehensive Care Plans. The DNS/designee will complete random weekly audits of care plans for six (6) consecutive weeks to ensure that comprehensive care plans are developed for residents. The results of these audits will be reviewed at the monthly QAPI meetings until such time consistent substantial compliance has been achieved. The DNS will be responsible for overall compliance.	7/23/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Alicia DiMaso	Executive Director	7/14/21

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.

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F 656	Continued From page 1 rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to develop a person-centered care plan for 1 of 27 residents in the survey sample. (Resident #24) Per review of Resident #24's medical record, it was revealed that the resident developed a Stage 1 pressure ulcer on her/his left outer ankle that was discovered on 5/4/21, a Stage 2 pressure ulcer on her/his left heel that was discovered on 5/4/21, and a Stage 2 pressure ulcer on her/his right great toe extending down over the toe joint that was discovered on 5/4/21. Per review of Resident #24's care plan, there had been no care plan created specific to the resident's pressure ulcers.	F 656	**Tag F 656 POC Approved on 7/15/21 L. Lovell/P.Cota**	

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F 656	Continued From page 2 Interview with the Unit Manager on the B wing on 6/24/21 at approximately 1:30 PM, she/he confirmed that a care plan related to Resident #24's pressure ulcers had not been developed.	F 656		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based observation and staff interview, the facility failed to ensure that drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles on one	F 761	The insulin pen and vial was immediately removed and replaced with properly labeled medications. The facility has determined all residents have the potential to be affected. The SDC/designee will educate all Licensed Nurses on the facility's policies on proper storage and labeling of medications. Unit Managers will inspect/audit medication carts and cabinets (3) times a week for two (2) weeks then, weekly for three (3) months, to ensure proper labeling of medication. The results of these audits will be reviewed at the monthly QAPI meetings until such time consistent substantial compliance has been achieved. The DNS will be responsible for overall compliance.	7/23/21

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F 761	Continued From page 3 unit. 1. Per observation of insulin pens contained in medication cart 1 on Unit B at approximately 12:30 PM on 6/21/2021, a multi-dose, short-acting insulin pen prescribed for one resident was not labeled with the resident's full name. The pen cap had only the resident's initials written on it and the writing was largely faded. This was confirmed per interview with the LPN (Licensed Practical Nurse) who was assigned to the medication cart at approximately 12:45 PM the same day. 2. Per observation of insulin vials contained in medication cart 1 on Unit B at approximately 12:30 PM on 6/21/2021, a multi-dose insulin vial prescribed for one resident was not labeled with the resident's name anywhere on the vial. This was confirmed per interview with the LPN who was assigned to the medication cart at approximately 12:45 PM the same day. Medication labels at a minimum must include the medication name, prescribed dose, strength, the expiration date when applicable, the resident's name, and route of administration. For medications designed for multiple administrations, the label must identify the specific resident for whom it was prescribed.	F 761	**Tag F 761 POC Approved on 7/15/21 L. Lovell/P.Cota**	