



AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

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 24, 2024

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 complaint investigation conducted on **June 24, 2024**. 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,

A handwritten signature in cursive script that reads "Pamela M. Cota, RN".

Pamela M. Cota, RN
Licensing Chief

Enclosure

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

PRINTED: 07/24/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475003	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/24/2024
NAME OF PROVIDER OR SUPPLIER BIRCHWOOD TERRACE REHAB & HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
F 000	INITIAL COMMENTS The Division of Licensing and Protection conducted an onsite, unannounced investigation of a facility reported incident (ACTS #22987) and 4 complaints (ACTS #23014, #22741, #23013, and #23053) on 6/10/24 and 6/14/24, with additional offsite interviews and record review through 6/24/24, to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. The following regulatory deficiency was identified:	F 000	<i>This Plan of Correction is the center's credible allegation of compliance.</i>		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable	F 623	Resident #1 no longer is at the facility. All residents with facility-initiated discharges related to the following: the safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; or the health of individuals in the facility would otherwise be endangered, have the potential to be affected. All residents with facility initiated discharges will be issued a notice of transfer in writing, explaining the reason for transfer and a statement of the resident's right to appeal. The Executive Director or their designee will complete random audits to assure compliance. Results of these audits will be brought to the monthly Performance Improvement meeting to assure 100% compliance for 3 consecutive months. Executive Director or designee is responsible for overall compliance.	July 31, 2024	

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

Alicia J. Mars, ED

TITLE

7/24/24

(X6) DATE

07/08/2024

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.

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

PRINTED: 07/24/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475003	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/24/2024
NAME OF PROVIDER OR SUPPLIER BIRCHWOOD TERRACE REHAB & HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
F 623	Continued From page 1 before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with	F 623	Tag F 623 POC accepted on 7/16/2024 by S. Stem/P. Cota		

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

PRINTED: 07/24/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475003	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/24/2024	
NAME OF PROVIDER OR SUPPLIER BIRCHWOOD TERRACE REHAB & HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 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
F 623	<p>Continued From page 2</p> <p>developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.</p> <p>§483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.</p> <p>§483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on interviews and record review, the facility failed to notify the resident in writing of a transfer/discharge for one applicable resident (Resident #1). Findings include: Record review reveals that Resident #1 was admitted to the facility for rehabilitation on 3/8/24 following a hospital stay related to a fall. S/He has</p>	F 623		

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

PRINTED: 07/24/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475003	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/24/2024
NAME OF PROVIDER OR SUPPLIER BIRCHWOOD TERRACE REHAB & HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 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
F 623	<p>Continued From page 3</p> <p>diagnoses that include Down syndrome, anxiety, mild intellectual disabilities, and obsessive-compulsive behavior. While Resident #1's medical record profile lists Resident #1 as having a financial guardian, Resident #1 is listed as his/her own self, indicating that s/he is his own guardian. On 6/14/24 at 11:25 AM, a Social Service Specialist confirmed that while Resident #1 was at the facility, s/he was his own person. On 3/13/24, Resident #1 has a BIMS of 13 (brief interview for mental status; a cognitive assessment score indicating cognitive intactness).</p> <p>Per a 5 day investigation summary of a facility reported resident to resident incident sent to the State Agency on 5/10/24, the facility implemented an involuntary discharge for Resident #1 on 5/2/23. The summary reveals that Resident #1's family member was informed of the involuntary discharge by phone that day and by email on 5/3/2024 but does not indicate that the facility ever informed Resident #1 of a notice of discharge or their right to appeal.</p> <p>Per review of Resident #1's electronic medical record and paper chart, there is no evidence that Resident #1 was given a notice of discharge. There is a transfer discharge notice that reveals it was provided to Resident #1's family member by phone on 5/2/24 and by email on 5/3/24.</p> <p>Per interview on 6/10/24 at 4:51 PM, the Administrator confirmed that the only notice of discharge was given to Resident #1's family member by phone on 5/2/24 and by email on 5/3/24.</p> <p>Per interview on 6/19/24 at 10:09 AM, Resident</p>	F 623		

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

PRINTED: 07/24/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475003	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/24/2024
NAME OF PROVIDER OR SUPPLIER BIRCHWOOD TERRACE REHAB & HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
F 623	Continued From page 4 #1 indicated that s/he was not notified of the facility's decision to discharge him/her on 5/2/24. S/He stated that s/he was confused as to why he was going to the hospital. S/He did not receive a discharge notice in writing and was not informed of his/her right to appeal the discharge. Resident #1 stated that s/he "would have done anything" to go back to the facility. S/He explained that while s/he has a financial guardian, s/he makes all other decisions because s/he is his/her own self. Resident #1 stated that s/he is still residing at the hospital while they find a long term placement.	F 623			