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

January 29, 2024

Caitlin Sears, Manager
Burke Family Women's Rehabilitation Program
Po Box 536
Wallingford, VT 05773

Dear Ms. Sears:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **November 13, 2023.** 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.

If you have any questions, please feel free to contact me at (802) 585-0995.

Sincerely,

Carolyn Scott, LMHC, MS
State Long Term Care Manager
Division of Licensing & Protection

To: Vermont.gov 802-241-0343
From: Kevin Burke 802-446-3780

Division of Licensing and Protection

PRINTED: 11/28/2023
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0674	A. BUILDING: ______ B. WING ______	11/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BURKE FAMILY WOMEN'S REHABILITATION PROGR/	PO BOX 536 WALLINGFORD, VT 05773

(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) COMPLETE DATE
R100	Initial Comments: On 11/13/23 the Division of Licensing and Protection conducted an unannounced on-site re-licensure survey. The following regulatory deficiencies were identified:	R100		
R135 SS=B	V. RESIDENT CARE AND HOME SERVICES 5.5 Assessment 5.7.b If a resident requires nursing overview or nursing care, the resident shall be assessed by a licensed nurse within fourteen days of admission to the home or the commencement of nursing services, using an assessment instrument provided by the licensing agency. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview there was a failure to complete an admission assessment within 14 days of admission for two applicable residents (Residents #1 and #2). Findings include: Per record review Resident #1 was admitted to the home on 5/16/21. The admission assessment on file for Resident #1 was signed as completed by the Registered Nurse (RN) on 0/28/2020. At 2:25 PM on 11/13/23 the Manager confirmed an admission assessment was not completed for Resident #1 within 14 days of admission; and confirmed the admission assessment on file for Resident #1's was from a previous admission to another home managed by the same organization. Resident #2 was admitted to the home on	R135	Plans of Correction for all individual tags accepted by Jo A Evans RN 1/27/24 Please see the attached document to review the accepted Plans of Correction for individual tags.	

Division of Licensing and Protection

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [signature] TITLE Licensee (X6) DATE 1/8/24

STATE FORM 6899 56R511 If continuation sheet 1 of 10

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R135	Continued From page 1 12/22/22. The admission assessment on file for Resident #2 was signed by the RN as completed on 12/8/22, 14 days before s/he was admitted. On the afternoon of 11/13/23 the Manager confirmed Resident #2's admission assessment was not completed within 14 days following admission.	R135		
R145 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.9.c (2) Oversee development of a written plan of care for each resident that is based on abilities and needs as identified in the resident assessment. A plan of care must describe the care and services necessary to assist the resident to maintain independence and well-being; This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to develop written plans of care to address the nursing and medical needs of 2 out of 3 sampled residents (Residents #2 and #3). Findings include: Per record review Resident #2 was admitted to the home with diagnoses including Congestive Heart Failure, Mitral Valve Stenosis, Hypertension (high blood pressure), and Chronic Obstructive Pulmonary Disease. S/he has a history of a Cerebral Vascular Accident (stroke) and is prescribed the anticoagulant medication Warfarin (blood thinner). The plan of care on file for Resident #2 fails to address care needs related to	R145		

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R145	Continued From page 2 the administration of anticoagulant medication, and his/her risk for a cardiac event. Per record review Resident #3 was admitted to the home on 8/4/23 with diagnoses including Parkinson's Disease, Type 2 Diabetes Mellitus, Osteoporosis, and Memory Loss following a Subarachnoid Hemorrhage (brain bleed). S/he has a history of falls with fractures, traumatic brain injury, and urinary tract infections. The Plan of Care on file for Resident #3 is dated 5/3/23, three months before his/her admission to the home, and identifies the facility name as another facility owned by the organization that manages the home. The Plan of Care fails to address care needs related to Diabetes Mellitus; and fails to identify risks for falls, injury, and urinary tract infection. On the afternoon of 11/13/23 the Manager confirmed the written Plans of Care for Residents #2 and #3 failed to address care and services required to maintain the residents's independence and well-being.	R145		
R162 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.c. Staff will not assist with or administer any medication, prescription or over-the-counter medications for which there is not a physician's written, signed order and supporting diagnosis or problem statement in the resident's record. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there	R162		

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R162	Continued From page 3 was a failure to ensure signed physician's orders for medications administered to 3 out of 3 sampled residents (Residents #1, #2, and #3). Findings include: 1. Per record review Resident #1's November 2023 Medication Administration Record (MAR) listed the following medication orders for which the Manager confirmed there were no signed physician's orders on file and available for review: a. "Levothyroxine 50 mg (Synthroid) tablet one tab by mouth daily". Levothyroxine is dosed in micrograms(mcg) not milligrams (mg) b. "Lactobacillus Acidophilus /Pectin take 1 tab by mouth daily" c. "Gabapentin 600 mg cap ascend labs take 1 tab by mouth 2x a day" d. "Buprenorphine 2 mg take 3 tab dissolved under tongue daily" e. "Dextroamphet Amphetamine 20 mg tab take 2 tab by mouth daily" Additionally, supporting diagnoses for all medications listed on Resident #1 November 2023 MAR were not on file and available for review. At 3:02 PM on 11/13/23 the Manager confirmed these findings. 2. On the afternoon of 11/13/23 the Manager was requested to provide signed orders and supporting diagnoses for the medications listed on the November 2023 MAR for Residents #2 and #3 for review. At approximately 4:10 PM on 11/13/23 the Manager confirmed signed physician's orders for Residents #2 and #3 were not on file and available for review. Additionally, supporting diagnoses were not on file and available for review for all medications administered to Resident #2 with the exception of	R162		

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R162	Continued From page 4 Benzonatate for cough; and for all medications administered to Resident #3 with the exception of Carbidopa/Levodopa for Parkinson's Disease. This finding was confirmed by the Manager on the afternoon of 11/13/23.	R162		
R179 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.11 Staff Services 5.11.b The home must ensure that staff demonstrate competency in the skills and techniques they are expected to perform before providing any direct care to residents. There shall be at least twelve (12) hours of training each year for each staff person providing direct care to residents. The training must include, but is not limited to, the following: (1) Resident rights; (2) Fire safety and emergency evacuation; (3) Resident emergency response procedures, such as the Heimlich maneuver, accidents, police or ambulance contact and first aid; (4) Policies and procedures regarding mandatory reports of abuse, neglect and exploitation; (5) Respectful and effective interaction with residents; (6) Infection control measures, including but not limited to, handwashing, handling of linens, maintaining clean environments, blood borne pathogens and universal precautions; and (7) General supervision and care of residents. This REQUIREMENT is not met as evidenced by:	R179		

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R179	Continued From page 5 Based on staff interview and record review there was a failure to ensure completion of the required yearly trainings for 5 out of 5 sampled staff, Findings include: Per review of staff training records for a sample of 5 staff, 5 out of 5 staff did not complete the required yearly trainings. This was confirmed by the Manager of the home 12:39 PM on 11/13/23.	R179		
R188 SS=A	V. RESIDENT CARE AND HOME SERVICES 5.12.b.(2) A record for each resident which includes: resident's name; emergency notification numbers; name, address and telephone number of any legal representative or, if there is none, the next of kin; physician's name, address and telephone number; instructions in case of resident's death; the resident's assessment(s); progress notes regarding any accident or incident and subsequent follow-up; list of allergies; a signed admission agreement; a recent photograph of the resident, unless the resident objects; a copy of the resident's advance directives, if any completed; and a copy of the document giving legal authority to another, if any. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to ensure one applicable resident's record contained the resident's photo or documentation of a photo refusal (Resident #2). Findings include:	R188		

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R188	Continued From page 6 Per record review a photo was not on file in Resident #2's record. On the afternoon of 11/13/23 the Manager confirmed Resident #2's record did not contain a resident photo or documentation of a photo refusal.	R188		
R190 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.12.b.(4) The results of the criminal record and adult abuse registry checks for all staff. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to complete the required yearly criminal record and adult abuse registry checks as required for 2 out of 5 residents. Findings include: Per review of the criminal record and abuse registry checks for a sample of 5 staff, the criminal record and abuse registry checks for 2 out of 5 staff were not completed on hire as required. This finding was confirmed by the Manager of the home at 1:12 PM on 1:12 PM on 11/13/23.	R190		
R266 SS=F	IX. PHYSICAL PLANT 9.1 Environment 9.1.a The home must provide and maintain a safe, functional, sanitary, homelike and comfortable environment.	R266		

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R266	Continued From page 7	R266		

This REQUIREMENT is not met as evidenced by:
Based on observation and staff interview there was a failure to ensure care in a safe, functional, sanitary, and homelike environment. Findings include:

During the tour of the home commencing at 11:30 AM on 11/13/23 the following environmental concerns were observed:

1. During a tour of the kitchen the canned goods in the kitchen pantry were observed to be covered with what appeared to be rodent feces and urine. These droppings were also observed inside an open cracker box stored on a shelf in the pantry. The Manager of the home stated rodent droppings had previously been observed in the home; however a plan for routine pest control measures had not been implemented. The Manager took immediate actions to sanitize the pantry and discard items that could not be sanitized; and stated an exterminator was contacted to address any rodent infestation.

2. Chemicals and hazardous substances including bleach, hardwood cleaner, carpet and upholstery cleaners, disinfectant liquids and sprays, insecticides, toilet bowl cleaner, antibacterial and deodorizing sprays, Rustoleum, and isopropyl alcohol were observed to be stored in unlocked cabinets and accessible to residents under the kitchen sink, and in an unlocked cabinet near the top of the stairs on the second floor of the home. Additionally isopropyl alcohol was observed in Resident #1's room and hydrogen peroxide was observed in the first floor bathroom.

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R266	Continued From page 8	R266		

3. Stair tread rugs on the indoor staircase to from the first to second floor of the home were observed to be poorly secured to the stairs with the corners of the carpeting on several individual stairs curled upwards. This is a trip hazard, and a risk for falls and injury.

4. In Resident #2's room a bed rail utilized as a stand assist was observed to be unstable. The device was not secured to the bed and the mattress was observed to lift when downward pressure was applied, and the mattress slid off the bed when the device was pulled. This a risk for falls and injury.

These findings were confirmed by the Manager during the tour of the home on the morning of 11/13/23.

R313 SS=D | XI. RESIDENT FUNDS AND PROPERTY | R313

11.1 A resident's money and other valuables shall be in the control of the resident, except where there is a guardian, attorney in fact (power of attorney), or representative payee who requests otherwise. The home may manage the resident's finances only upon the written request of the resident. There shall be a written agreement stating the assistance requested, the terms of same, the funds or property and persons involved.

This REQUIREMENT is not met as evidenced by:
Based on staff interview and record review there was a failure to ensure a written request was obtained for the management of one applicable

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R313	Continued From page 9 resident's personal funds (Resident #3). Findings include: On the afternoon of 11/13/24 the Manager was requested to provide a written request for the management of Resident #3's personal funds. At 2:56 PM on 11/13/23 the Manager confirmed a written request had not been obtained from Resident #3 for the management of his/her personal funds.	R313		

ATTN: Jo Evans
FAX # 802-241-0343

Deficiency Statement Plan of Correction (POC)

Survey Date: 11/13/2023

Facility Name: Burke Family Women's Rehabilitation Program Inc

Deficiency Regulation	How the deficiency was corrected	Date corrected	System changes to ensure compliance of the regulation	Who will monitor to ensure compliance
R135 Accepted by Jo A Evans RN 1/27/24	All resident assessments will be completed within 14 days of admission to facility. RA's submitted for variance approval prior to admission will be re-done within 14 days of actual admission.	This was completed 12/11/23	This will be monitored on an ongoing basis by Nursing Director [redacted], starting at point of admission	Nursing Director [redacted]
R135 continued	The RA's described will be completed as noted. This began on 12/11/23 and will continue as RA's are due and for new admissions when they occur.	This was completed 12/11/23 and ongoing	This will be monitored on an ongoing basis by Nursing Director [redacted], starting at point of admission	Nursing Director [redacted]
R145 Accepted by Jo A Evans RN 1/27/24	Care Plan for resident found after survey and put in care plan book.	This was completed 12/13/23	Care Plans for each resident will have updated information as needed per diagnosis and will be monitored by RN on an ongoing basis.	Nursing Director [redacted]
R145 continued	Residents #1 and #3 Care Plans were updated/completed 12/18/23. All Care Plans include assessment of needs and reflect care to assist with ADL's, Medications, diet, etc., as well as Person Centered Care Plans, will include Nursing Diagnosis. Plans for residents and review of such with staff to ensure resident safety and well-being. Nursing plans to be fully complete 1/15/24.	12/14/23 Complete	The RN, along with Manager will ensure all staff are completing daily care plan tasks and Monitor on an ongoing basis.	Nursing Director [redacted] and Manager
R162 Accepted by Jo A Evans RN 1/27/24	Physician's orders, to include diagnosis for each medication will be on file for each Resident. Complete medication lists will be updated and signed yearly and signed orders will be placed in resident charts, as well as listed on MAR.	12/14/23 Complete	All medication orders will have provider signature. All records to be reviewed and complete by 1/10/24. RN and Manager will monitor all orders to make sure the Provider signatures are included.	Nursing Director [redacted] and Manager
R179 Accepted by Jo A Evans RN 1/27/24	All Staff will complete a minimum of 12 hours of training upon hire. Including but not limited to the 7 required trainings. The staff will complete a minimum of 12 hours of	2023 will be complete by 12/31/23	RN and Manager are responsible for monitoring training and document hours. All staff will complete a	Nursing Director [redacted] and Manager

Names removed by DLP 1/22/24

[signature] 1/22/24   1/22/2024 Marcilee Kennedy RN

	training including the 7 required training yearly.		minimum 12 hours training including the 7 required trainings upon hire as well as yearly.	
R188 Accepted by Jo A Evans RN 1/27/24	All residents will have updated photos put in charts, and photos will be taken of all new admissions at day of admission. New photos will be updated in charts by 12/20/23	12/14/23 Complete	Photos will be taken of all new admissions at day of admission. If the resident refuses to be photographed, the refusal will be documented in the resident's records.	Manager will be responsible for monitoring photos.
R190 Accepted by Jo A Evans RN 1/27/24	All staff Adult and Child Abuse Registry checks, as well as Vermont (VCIC) and National Criminal Background checks were done prior to hire and re-checks will be complete by 12/29/23. These are kept on file at facility.	12/29/23 Complete	All staff Adult and Child Abuse Registry checks, as well as Vermont (VCIC) and National Criminal Background checks are completed prior to hire and re-checks of all staff are done yearly	Office Manager is responsible for ongoing monitoring these files.
R266 Accepted by Jo A Evans RN 1/27/24	A natural pest control company came to provide initial treatment and write plan. Staff is following all recommendations. All affected items were removed and replaced.	11/19/23 Complete	Manager will ensure that all food storage areas are checked weekly for any signs of re-infestation, and exterminator will be contracted immediately if there are any concerns	Manager will be responsible for ongoing monitoring.
R266	Stair tread rugs were repaired while surveyor on site. 11/13/23 Unstable bed rail secured 12/12/23	12/12/23 Complete	Manager will continuer to monitor on an ongoing basis	Manager will be responsible for ongoing monitoring
R266	There will be key locks installed on cabinet doors (to replace child proof locks that were there), on any cabinet housing chemicals. This will be completed by 12/22/23	12/14/23 Complete	Manager will check all rooms daily to assure that no hazardous chemicals are accessible to residents.	Manager will be responsible for ongoing monitoring
R313 Accepted by Jo A Evans RN 1/27/24	Written requests for funds have been updated and will be signed by the guardian upon admission. On 11/20/23 the request form was signed by the Guardian and returned to the facility. It is now in the resident's chart	11/20/23 Complete	Written requests for funds will be signed by the guardian upon admission.	Manager will be responsible for ongoing monitoring
	1/22/24			

1/22/2024