

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

June 2, 2016


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 22, 2016**. 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: 03/31/2016
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 03/22/2016
---	---	--	--

NAME OF PROVIDER OR SUPPLIER BURLINGTON HEALTH & REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 300 PEARL STREET BURLINGTON, VT 05401
---	---

(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 unannounced onsite complaint investigation on 3/22/16. A regulatory violation was cited as a result.

F 282 483.20(k)(3)(ii) SERVICES BY QUALIFIED
SS=D PERSONS/PER CARE PLAN

The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.

This REQUIREMENT is not met as evidenced by:

Based on staff interview and record review, the facility failed to implement the plan of care for one applicable resident (Resident # 1). Findings include:

Per record review on 3/22/16, staff failed to complete Neuro Vital Signs (NVS) after a Resident # 1 had an unwitnessed fall on 1/26/16. Facility protocol stated that NVS are to be done every 15 minutes x 1 hour, every 30 minutes x 4 hours, every hour x 2 hours, then once a shift x 72 hours. Review of the neurological Evaluation Flowsheet indicates that NVS were not done between 10:50 AM - 5:50 PM on the day of the fall. The Resident's care plan related to an actual fall stated that NVS were to be done for 72 hours. Both the facility Administrator and the Assistant Director of Nurses confirmed that the NVS were not done on 1/26/16 and that staff had not followed the plan of care.

F 000

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 for the on the summary statement of deficiencies.

F 282

F282 D 483.20(k)(3)(ii)

1. Resident #1 was not effected as a result of this alleged deficient practice.
2. Residents requiring neuro-vital signs have the potential to be affected by this alleged deficient practice.
3. Education provided regarding the requirements for neuro-vital sign as it relates to the plan of care.
4. Weekly neuro-vital sign audits will be conducted by the DNS or designee to monitor the effectiveness of the plan.
5. The results of the audits will be reported to the QAA committee by the DNS or designee monthly x3 months at which time the QAA committee will determine further frequency of the audits.
6. Corrective action to be complete by 4/22/2016.

F282 POC accepted 4/27/16 Rtrawling RN/pme

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

TITLE

(X6) DATE

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.