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 Reporting Line (888) 700-5330
To Report Adult Abuse: (800) 564-1612

February 21, 2018

Ms. Jessica Jennings, Administrator
Burlington Health & Rehab
300 Pearl Street
Burlington, VT 05401-8531

RE: Complaint Survey Findings - Past Non-Compliance

Dear Ms. Jennings:

On **February 5, 2018**, the Division of Licensing and Protection, completed a complaint investigation at Burlington Health & Rehab. As a result of that survey, the Division determined that at a point in time prior to the date of our visit you were not in substantial compliance with the federal regulations applicable to long term care facilities.

Statement of Deficiencies Form CMS 2567

Enclosed is a statement of deficiency generated as a result of the survey. All references to regulatory requirements in the enclosure and in this letter are found in Title 42, Code of Federal Regulations. As the cited deficiencies were corrected at the time of our visit, no plan of correction is required. Please **sign page 1 and return a signed copy of the 2567 to this office.**

Informal Dispute Resolution

In accordance with §488.331, you have one opportunity to question cited deficiencies through an informal dispute process. To be given such an opportunity, you are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies to Suzanne Leavitt RN, MS, Assistant Division Director, Division of Licensing and Protection. **This written request must be received by this office by March 5, 2018.**

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
	475014	A. BUILDING _____ B. WING _____	C 02/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BURLINGTON HEALTH & REHAB	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 unannounced, onsite investigations of one complaint and one facility self-report on 2/5/18. Regulatory violations were cited as a result; however, by the time the onsite investigation was initiated, the facility had already taken steps to correct the deficient practice, and the citations are therefore considered past non-compliance.	F 000		
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interviews and record review, the facility failed to ensure that 1 applicable resident (Resident # 1) received treatment and care in accordance with professional standards of practice and the comprehensive person-centered care plan regarding implementation of diet orders. Findings include: Per interview and record review, Resident #1 was given the wrong meal on 1/26/18 and left unattended. Per review of internal investigation information and per interviews, Resident #1 choked on whole grapes and subsequently expired at the facility on 1/26/18. Resident #1	F 684	Past noncompliance: no plan of correction required.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Executive Director 2/21/18

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 684	Continued From page 1 had a diagnosis of Dysphagia, oral pharyngeal phase (an abnormality of swallowing). There is a physician's order dated 7/14/16 for a diet with dysphagia puree texture with honey thickened liquids. There is a care plan for risk for impaired swallowing that includes an intervention to provide a dysphagia pureed diet as ordered. The care plan for Activities of daily living (ADLs) stated that Resident #1 required extensive assist of 1 person for eating. Per interview with the Center Nurse Executive (CNE) on 2/5/18 at 12:57 PM, a staff member brought another resident's tray to Resident #1's room on 1/26/18. Resident #1's roommate stated that this person was a "tall woman" later identified by staff as a facility Registered Nurse (RN). A staff Licensed Nursing Assistant (LNA) brought the correct meal tray to Resident #1 "a while later" as described by Resident #1's roommate. This LNA discovered Resident #1 in distress and alerted nursing staff. In a written statement by the RN that delivered the incorrect tray to Resident #1, the RN stated Resident #1 "refused the potatoes and asked for fruit so I placed the cup of grapes on [his/her] lap so [s/he] could reach them better". The RN then wrote that h/she left the room. The CNE confirmed that this RN was the person that delivered the incorrect meal tray to the Resident #1 and that Resident #1 was an extensive assist of 1 for eating and should not have been left alone with grapes. In a 2/5/18 interview at 3:03 PM, a facility LNA stated that h/she set up the regular diet tray that was delivered to Resident #1 that was meant for a resident 5 doors down from Resident #1's room.	F 684		

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F 684	Continued From page 2 The LNA confirmed that h/she observed whole grapes on the table in front of Resident #1 on 1/26/18. The LNA also confirmed that the aforementioned RN said that h/she gave Resident #1 the grapes. This citation will be considered past non-compliance. The facility has taken significant steps to correct the issues. Staff have been educated, management has audited meal tickets and resident photographs are now on meal tickets. Per observation of the noon meal on 2/5/18, staff were observed following proper procedures regarding meal trays.	F 684		
F 800 SS=G	Provided Diet Meets Needs of Each Resident CFR(s): 483.60 §483.60 Food and nutrition services. The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. This REQUIREMENT is not met as evidenced by: Based on interviews and record review, the facility failed to ensure that 1 applicable resident (Resident # 1) received their physicia-ordered therapeutic diet and adequate dining assistance. Findings include: Per interview and record review, Resident #1 was given the wrong meal on 1/26/18 and left unattended. Per review of internal investigation information and per interviews, Resident #1 choked on whole grapes and subsequently expired at the facility on 1/26/18. Resident #1 had a diagnosis of Dysphagia, oral pharyngeal	F 800	Past noncompliance: no plan of correction required.	

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F 800	Continued From page 3 phase (an abnormality of swallowing). There is a physician's order dated 7/14/16 for a diet with dysphagia puree texture with honey thickened liquids. There is a care plan for risk for impaired swallowing that includes an intervention to provide a dysphagia pureed diet as ordered. The care plan for Activities of daily living (ADLs) stated that Resident #1 required extensive assist of 1 person for eating. Per interview with the Center Nurse Executive (CNE) on 2/5/18 at 12:57 PM, a staff member brought another resident's tray to Resident #1's room on 1/26/18. Resident #1's roommate stated that this person was a "tall woman" later identified by staff as a facility Registered Nurse (RN). A staff Licensed Nursing Assistant (LNA) brought the correct meal tray to Resident #1 "a while later" as described by Resident #1's roommate. This LNA discovered Resident #1 in distress and alerted nursing staff. In a written statement by the RN that delivered the incorrect tray to Resident #1, the RN stated Resident #1 "refused the potatoes and asked for fruit so I placed the cup of grapes on [his/her] lap so [s/he] could reach them better". The RN then wrote that h/she left the room. The CNE confirmed that this RN was the person that delivered the incorrect meal tray to the Resident #1 and that Resident #1 was an extensive assist of 1 for eating and should not have been left alone with grapes. In a 2/5/18 interview at 3:03 PM, a facility LNA stated that h/she set up the regular diet tray that was delivered to Resident #1 that was meant for a resident 5 doors down from Resident #1's room. The LNA confirmed that h/she observed whole	F 800		

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F 800	Continued From page 4 grapes on the table in front of Resident #1 on 1/26/18. The LNA also confirmed that the aforementioned RN said that h/she gave Resident #1 the grapes. This citation will be considered past non-compliance. The facility has taken significant steps to correct the issues. Staff have been educated, management has audited meal tickets and resident photographs are now on meal tickets. Per observation of the noon meal on 2/5/18, staff were observed following proper procedures regarding meal trays.	F 800		