VERMONT

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

November 14, 2018

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

Dear Ms. Jennings:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **October 24, 2018**. 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
	475014	A. BUILDING _____ B. WING _____	C 10/24/2018

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

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E 000	Initial Comments An unannounced onsite Emergency Preparedness review was completed by the Division of Licensing and Protection from 10/22-24/18. The facility was found in substantial compliance with Emergency Preparedness regulations.	E 000	Burlington Health and Rehab Center provides this plan of correction without admitting or denying the validity or existence of the allege deficiency. The plan of correction is prepared and executed solely because it is required by federal and state law.	
F 000	INITIAL COMMENTS An unannounced onsite re-certification survey and investigation of one complaint was completed by the Division of Licensing and Protection from 10/22-24/18. Based on information gathered, the following regulatory deficiencies related to both the survey and the complaint were identified. Of note, this is the third consecutive re-certification survey with violations around the facility having sufficient nursing staffing.	F 000	F655 Resident # 312 care plan was Updated to include a dialysis plan of Care. All residents receiving dialysis have the potential to be affected by this alleged deficient practice.	
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders.	F 655	The nurses will be educated regarding Development of a baseline comprehensive Care plan by November 23, 2018. The Director of Nursing and or her designee will perform weekly audits of Dialysis admissions to assure care plan initiated x 4 and then monthly x 3 with results to be reviewed at CQI meeting for further review and recommendations. Correction Action will be completed by November 23, 2018. F-655 POC accepted 11/13/18 J. Hosmer RN / S. Perry, RN	

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

Executive Director 11.13.18

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 655	Continued From page 1 (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to assure that a baseline care plan was developed for 1 resident (#312) who is on dialysis in a sample of 31. Findings include: Per record review, Resident #312 was admitted on 10/12/2018. The resident has dialysis every Tuesday/Thursday/Saturday related to End Stage Renal Disease. The resident was admitted after a fall at home on 9/30/18 which resulted in a fracture of the proximal femur. S/he is very alert and is aware of her/his fluid restrictions, stating	F 655		

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F 655	Continued From page 2 there is an 1800 ml fluid restriction in place. The resident has been in the facility for 11 days, so no Comprehensive Care Plan is yet due or in place. There is no care plan for dialysis found in the initial baseline care plan. The unit Registered Nurse on duty confirmed, on the morning of 10/23/18, that there was no care plan for Dialysis for this resident.	F 655		
F 656 SS=E	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 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	F 656	F656 The care plans for residents # 101, #62, #4, #72, #18 were updated to reflect the residents care. All residents have the potential to be affected by this alleged deficient practice. Education will be provided to the nurses regarding Development/Implementation of Comprehensive Care Plans by November 23, 2018. The Director of Nursing and or her designee will perform weekly audits of care plans x 4 and then monthly x 3 with results to be reviewed at CQI meeting for further review and recommendations. Correction Action will be completed by November 23, 2018. F-656 POC accepted 11/13/18 J. Hosmer RN / S. Perry, RN	

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F 656	Continued From page 3 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 observation, record review, and staff interview, the facility failed to develop a written comprehensive care plan for 5 of 27 residents in the applicable sample (Residents #4, 18, 62, 72, 101). Findings include: 1. Per observation during initial tour of the unit on the morning of 10/22/18, the room of Resident #101 is posted with a sign asking visitors to check with a nurse, and a cart containing personal protective equipment is stationed near the door. During record review and staff interview, it is confirmed that Resident #101 has an infectious disease diagnosis which requires precautions to prevent spread of the infection. The written comprehensive care plan for Resident #101 does not contain specific strategies to direct staff in providing care with infectious disease precautions. On 10/23/18 at 4:03 PM, the Director of Nursing confirmed that no care plan section was developed for infectious disease precautions for Resident #101. 2. Per record review for Resident # 62, staff failed	F 656		

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F 656	Continued From page 4	F 656		

to include daily weights in the care plan. There is a physician order dated 9/29/18 for daily weight every day shift for CHF (congestive heart failure) management. Per review of the weight log in the electronic medical record (EMR), there were 13 missed weights between 9/29/18 - 10/22/18. Additionally, the order for daily weights is not reflected in the resident's plan of care. This was confirmed by the Unit Manager on 10/23/18 at 1:47 P.M.

3. Per record review and observation during survey, Resident #4 is in a wheelchair and totally dependent on staff for activities of daily living. According to the medical record, the resident developed a pressure ulcer on their heel on 6/17/18. Although treatment was initiated and continued until it healed, a plan of care was never developed to reflect the actual skin breakdown. Per interview on 10/24/18 at 11:59 AM, the Unit Manager confirmed that there was a care plan for Skin Integrity risk, however that there was not a care plan developed for actual skin breakdown after the resident developed a pressure ulcer.

4. Per record review, Resident #72 had a care plan in place for being at high risk of skin breakdown with interventions in place. The resident developed a Stage 2 pressure ulcer on the coccyx on 9/21/18. The care plan did not reflect the development of the pressure ulcer. Per interview on 10/24/18 at 11:15 A.M., the Unit Manager confirmed that the care plan had not been revised to indicate that Resident #72 had developed a pressure ulcer.

5. Per record review, Resident #18 is on precautions for Clostridium Difficile (C-Diff) and the personal protective equipment for staff is

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F 656	Continued From page 5 noted at the door of the room. There is no care plan present in the record for precautions and/or C-Diff. The facility Director of Nursing Services (DNS) confirmed on the afternoon of 10/23/18 that there was no care plan available for Infection Control/ Precautions available for this resident.	F 656		
F 658 SS=F	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to assure that the care plans for residents were developed, revised or reviewed and approved by a Registered Nurse for 22 of 31 residents (Residents# 312, 18, 61, 87, 108, 49, 62, 311, 309, 72, 31, 57, 25, 4, 101, 34, 6, 93, 20, 43, 42, 9) reviewed in the sample, and this has the potential to affect all residents of the facility. Findings include: 1). During the record reviews of care plans it was noted that for a majority of the care plans reviewed in the Electronic Medical Record (EMR), there were either entire care plans initiated or partially initiated by Licensed Practical Nurses (LPN's), or revisions by LPN's throughout the care plans reviewed. These care plans were for Residents# 312, 18, 61, 87, 108, 49, 62, 311, 309, 72, 31, 57, 25, 4, 101, 34, 6, 93, 20, 43, 42, 9. In an interview on the afternoon of 10/23/18, the	F 658	F658 Resident care plans #312, 18, 61, 87, 108,49,62,311,309,72,31,57,25, 4, 101, 34, 6, 93, 20,43, 43, 42, 9 were reviewed and revised by a RN. All residents have the potential to be affected By this alleged deficient practice. Education will be provided to the nurses regarding F658 Professional Standards of Comprehensive Care Plans by November 23, 2018. The Director of Nursing and or her designee will perform weekly audits for RN involvement. x 4 and then monthly x 3 with results to be reviewed at CQI meeting for further review and recommendations. Correction Action will be completed by November 23, 2018. F-658 POC accepted 11/13/18 J. Hosmer RN/S. Leary, RN	

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F 658	Continued From page 6 Director of Nursing (DNS) confirmed that LPN's create and revise care plans. Further, there is no sign off by RN's approving the care plan and no process for RN's to review the care plans when completed or revised by LPN's. In the State Board of Nursing Scope of Practice & Decision Tree for RN, APRN, and LPN the following is stated: "LPN role in assessment, planning, and implementation of a strategy of care: -LPNs may not independently assess the health status of an individual or group and may not independently develop or modify the plan of care. LPNs may contribute to the assessment and nursing care planning processes; however, patient assessment and care plan development or revision remain the responsibility of the RN/APRN/licensed physician/licensed dentist. -LPNs may not modify a patient care protocol. If the situation and/or data collected by the LPN are not clearly consistent with a protocol, the LPN must consult with the supervising professional or authorized provider before taking action or making a recommendation to a patient."	F 658		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's	F 690		

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F 690	Continued From page 7 comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure that a resident with an indwelling catheter had complete physician orders and a care plan that reflected current status for one sampled resident (Resident #25). Findings include: Per record review, Resident #25 was admitted to the facility at the end of June 2018 with an indwelling Foley Catheter in place. Per review of the monthly physician orders since admission, there was no order to indicate what size catheter to use and how much water to insert in the	F 690	F690 Resident #25 orders were updated to reflect the size of the residents catheter, the amount of water to insert in the balloon, and the frequency of changes. All residents with a foley catheter have the potential to be affected by this alleged deficient practice. Education will be provided to the Nurses Regarding the center's policy for Foley Catheter Management by November 23, 2018. The Director of Nursing and or her designee will perform weekly audits of orders for residents with a catheter x 4 and then Monthly x 3 with results to be reviewed at CQI meeting for further review and recommendations. Correction Action will be completed by November 23, 2018. F-690 POC accepted 11/13/18 J. Hosmer RN/S. Perry, RD	

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F 690	Continued From page 8 balloon that holds it in place. There were also no orders to indicate how frequently to change the catheter. The doctor ordered a twice daily flush of the catheter by nursing to keep it patent and to clear sediment. Per review of the plan of care for this resident, there was no mention of the twice daily flushes, the size of the catheter, or how frequently to change it. The nurse on floor stated that they were the last one to change the catheter, and that they used the catheter and balloon size indicated by hospital notes, and confirmed that there were no orders from the primary care physician for these specifics in the resident's record. Per interview on 10/24/18 at 9:35 AM, the Unit Manager confirmed that the primary care physician had not written specific orders for the parameters of the Foley catheter since the resident was admitted, and that the plan of care had not been revised to reflect current treatment regarding the catheter.	F 690		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following	F 725		

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F 725	Continued From page 9 types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure there was sufficient nursing staff to maintain the highest practicable physical, mental, and psychosocial well-being of each resident on at least two of four units reviewed. This is a repeat violation for the third consecutive re-certification survey. Sufficient nursing staff was also cited during the re-certification surveys on December 14, 2017 and October 26, 2016. Findings include: During the Resident Council group meeting held during survey, multiple residents [who wished to remain anonymous] complained of long wait times for staff to answer call bells. There were two residents who claimed to have had incontinence episodes due to an extended wait time for staff response to call bells. One resident complained that it was very difficult to find staff to assist if they had to use the bathroom during meal times. Other interviews were conducted with residents who are dependent on staff for basic activities of daily living. One resident stated that they had to wait 45 minutes to get assistance when they were in an uncomfortable position in	F 725	F725 No residents were negatively affected By this alleged deficient practice. All residents have the potential to be affected by this alleged deficient practice. The Administrator and Director of Nursing reviewed the CMS pathway related staffing to use as a guide for interviewing residents to determine that they feel staffing is adequate. The center administration is aware of the staffing requirements and continue to seview on a daily basis as well as throughout the day the staffing needs of the center. The center has an active recruitment plan in place and utilizes several traveling companies. The administrator and or her designee will meet with a sample of residents weekly x 4 and then monthly x 3 to assure that their needs are being met. Results will be reviewed during CQI for further review and recommendations. Corrective Action will be completed by November 24, 2018. F725 POC accepted 11/13/18 J. Hasmer RN / S. Berry, RN	

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F 725	Continued From page 10	F 725		

bed and unable to reposition independently. Multiple residents reported long wait times to get into bed, especially those who needed a two person assist to transfer. Besides specific examples listed, a number of residents and family members (from four (4) family interviews) stated that there was not enough staff at the facility, including hearing frequent complaints from the Licensed Nursing Assistants that they were "short staffed".

Per review of the log of electronic call bell wait times for Units C & D (fourth and fifth floors), call light waits of 20 minutes or more were noted. Since these two units accounted for the majority of complaints of long waits, these were the units reviewed for the 24 hours of each day:

On Unit C (4th floor):
10/20- Waits noted (minutes)- 27, 24, 35, 43, 68, 21, 26, 23, 58, 47;
10/21- Waits noted (minutes)- 23, 21, 23, 21, 43, 46, 25, 23, 38;
10/22 Waits noted (minutes)- 29, 20, 39, 31, 58, 22, 24, 23;
10/23 Waits noted (minutes)- 22, 21, 34, 24, 28; (note this is a partial day of survey)

On Unit D (5th floor):
10/21-Waits noted (minutes)- 27, 37, 32, 25, 49, 56, 27, 30, 44, 50, 27, 32, 37, 36, 43, 37, 62, 27, 38, 32, 33, 38, 49, 66, 55, 34;
10/22 -Waits noted (minutes)- 28, 44, 40, 64, 23, 43, 40, 28, 58, 22, 26, 26, 27, 26, 52, 38, 47;

Per observation on 10/22/18 at 10:30 AM Resident #309, who is recovering from a pelvic fracture, was seated in a bedside chair when the surveyor entered the room. The resident stated "I

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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 725	Continued From page 11 had to get into my chair alone because I was hurting and no one came." The resident further stated, "I know I'm supposed to wait for someone to come but I was on the commode and I was hurting too bad to wait anymore." At that point a Licensed Nursing Assistant (LNA) entered the room and observed "Someone helped you out. I'm sorry I was so long. I was caring for another resident." The resident stated s/he had not been assisted but just couldn't wait and asked the LNA to put the slide board away, stating "I didn't use it." The LNA did as asked and left the room. In reviewing the plan of care, the resident requires assistance to transfer and should use a slide board. The Registered Nurse (RN) on the unit stated that the resident should have had an assist to move to her/his chair.	F 725		

Genesis

Date: November 13, 2018

To: Ms. Pamela Cota, RN

Re: Burlington Health & Rehab Center
Plan of Correction,
Credible Allegation of Compliance, and
Request for Re-survey

Dear Ms. Cota:

On October 24, 2018 surveyors from Division of Licensing and Protection completed an inspection at Burlington Health Care & Rehab Center. As a result of the inspection, the surveyors alleged that the Facility was not in substantial compliance with certain Medicare and Medicaid certification requirements. Enclosed you will find the Statement of Deficiencies (HCFA-2567) with the Facility's Plan of Correction for the alleged deficiencies. Preparation of the Plan of Correction does not constitute an admission by the Facility of the validity of the cited deficiencies or of the facts alleged to support the citation of the deficiencies.

Please also consider this letter and the Plan of Correction to be the Facility's credible allegation of compliance. The facility will achieve [or has achieved] substantial compliance with the applicable certification requirements on or before November 23, 2018. Please notify me immediately if you do not find the Plan of Correction acceptable.

This letter is also our request for a re-survey, if one is necessary, to verify that the Facility achieved substantial compliance with the applicable requirements as of the dates set forth in the Plan of Correction and credible allegation of compliance.

Thank you for your assistance with this matter. Please call me if you have any questions.

Yours truly,

Jessica Jennings, RN
Administrator

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