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

May 21, 2019

Ms. Melissa Greenfield, Administrator
Burlington Health & Rehab
300 Pearl Street
Burlington, VT 05401-8531

Dear Ms. Greenfield:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **May 1, 2019.** 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 05/01/2019

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 An unannounced onsite investigation of two complaints was conducted by the Division of Licensing and Protection from 4/29/19-5/1/19. Based on information gathered, the facility was found to have violations at the Immediate Jeopardy level, which also constitutes Substandard Quality of Care. The facility was informed of the Immediate Jeopardy on 5/1/19 and provided with the required template around 11 AM. At the time of exit, the Immediate Jeopardy (IJ) had not been removed. The facility submitted a removal plan, which alleged removal of the IJ as of the end of the day 5/2/19. During an unannounced onsite visit by the survey agency on 5/7/19, the survey agency confirmed removal of the IJ on 5/2/19. The remaining non-compliance of the following J level citations is at the G (actual harm) level post IJ removal.	F 000	Burlington Health and Rehab provides this plan of correction without admitting or denying the validity or existence of the alleged deficiencies. The plan of correction is prepared and executed soley because it is required by Federal and State law.	5/29/2019
F 561 SS=J	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the	F 561	Resident #1 no longer resides at the center. An audit was conducted to identify any other resident that is not able to participate in activities of choice that could lead to frustration and potentially lead to an unsafe discharge. Department heads, nursing, therapy and social service staff were educated on the importance of recognizing the impact on a resident,based on their psychosocial history,risk of adjustment, Isolation,difficulty accepting placement, loss of status,and or freedom,loss of support network, and coping with decline in overall health status. CNE and or designee will audit weekly x4 then monthly x3 to ensure psychosocial needs are being identified and addressed to promote choice and prevent escalation of behaviors that could result in an unplanned or unsafe discharge. The results of these audits will be reviewed at QAPI for further recommendations. F561 POC accepted 5/16/19 JHasmer RN/PMC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Melissa Greyerd — TITLE: Administrator — (X6) DATE: 5/15/2019

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 561	Continued From page 1	F 561		5/29/2019

facility that are significant to the resident.

§483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility.

§483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility.
This REQUIREMENT is not met as evidenced by:
Based on record review and interviews with the resident and facility staff, the facility failed to promote and support the resident's choice (1 of 4 sampled, Resident #1) to participate in preferred activities and interact with members of the community, both inside and outside the facility, leading to an unsafe discharge. Findings include:

Per record review, Resident #1 entered the facility on 6/27/18, following paraplegia (paralyzed in the lower body), caused by trauma. There was also a clear history of alcohol abuse among the admitting diagnoses. Resident #1 had a medical order allowing 1 beer per day. A note on 1/21/19 relates that Resident #1 was non-compliant with the 1 beer per day order, and thus the order was discontinued. Resident #1 had a written plan of care which outlined "risk of adjustment issues related to isolation, difficulty accepting placement in center, loss of status and/or freedom associated with transition, loss of support network, coping with decline in overall health status, including functional decline". Additionally the care plan stated, "It is important for me to go outside when the weather is good. Family and

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F 561	Continued From page 2	F 561		5/29/2019

staff to assist outdoors, weather permitting". The facility could show no evidence that mental health or medically-related social services were engaged to assist Resident #1 with adjustment issues, or with abrupt withdrawal of alcohol use. On 4/18/19, the facility held a meeting with Resident #1 and informed him/her of their intent to enforce their requirement that all residents sign out and back in whenever leaving the facility. The facility had been allowing Resident #1 to leave and go off site to visit friends down the street. When Resident #1 went off premises on 4/19/19 without signing out, the facility called the police. This experience resulted in Resident #1 exhibiting increased efforts to assert independence and a right to autonomy. When questioned on 4/29/19 at 3:30 PM, Resident #1 stated, "they let me go out and took it back"; "I can have a beer and a cheeseburger". In the wake of this further restriction, Resident #1 verbalized intent to leave the facility whenever s/he wanted, per Interdisciplinary Team (IDT) notes of 4/24/19. Resident #1 had been in discussions regarding autonomy and choices from January, 2019 through 4/24/19, and disagreed with restrictions the facility put in place regarding independence. There is no written evidence that the facility notified the ombudsman or issued a 30 day notice of discharge during the period prior to the 4/24/19 alleged AMA (against medical advice) discharge. Per interview with the Long Term Care ombudsman on 5/1/19 at 8:40 AM, the facility had never contacted him/her about this resident's issues surrounding independence or desire to leave the facility AMA until 4/25/19, the day after discharge.

Due to the disagreement regarding rights to engage in activities outside the facility, the

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F 561	Continued From page 3 Administrator and other facility staff had Resident #1 sign an AMA document at 1:00 PM on 4/24/19. That afternoon, Resident #1 left the premises twice, and subsequently returned both times, indicating to the DNS s/he made a mistake. Per interview with a facility staff member who was a witness to the events during the second return to the facility, s/he stated that when the resident returned, the facility DNS (Director of Nursing Services) asserted the AMA status and refused re-admission to the facility. After asserting the AMA status and refusing re-entry to the resident despite clear needs surrounding care, the administration ordered a maintenance staff person to transport the resident to a hotel and paid for one night. Per observation at hospital at 3:30 PM on 4/29/19, and confirmed by hospital documents dated 4/25/19, Resident #1 deteriorated during the hotel stay and required emergency transport to hospital for treatment of sepsis (a life-threatening infection), urinary tract infection, and failure to thrive.	F 561		5/29/2019
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or	F 600	Resident #1 no longer resides at the center. Residents with known psychosocial and mental health needs were audited to ensure necessary services are in place. Education was provided for Department heads, nursing and social services related to neglect and additional education for Social services for identifying and managing the psychosocial and mental health related issues associated with Alcohol dependence. CNE and or designee will audit for alcohol dependance concerns, alcohol treatment has been offered and that for discharge services identified have been arranged for. Weekly x4 then monthly x 3 and the results will be reviewed by the QAPI committee for further recommendations.	

F600 POC accepted 5/16/19 JHosmer RN/PMC

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F 600	Continued From page 4	F 600		5/29/2019

physical abuse, corporal punishment, or involuntary seclusion;
This REQUIREMENT is not met as evidenced by:
Based on record review and resident interview, the facility failed to provide goods and services to the resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress for 1 of 4 residents sampled (Resident #1). Findings include:

Per medical record review 4/29-5/1/19, Resident #1 is paraplegic (paralyzed in the lower body) due to a 2018 trauma, with other diagnoses including history of alcohol abuse/uncomplicated, bacteremia (infection in the blood), urinary tract infection/UTI, history of fall, epidural (brain) hemorrhage without loss of consciousness, tremor, encephalopathy (brain changes), weakness, neuromuscular dysfunction of bladder with chronic indwelling urinary catheter, [spinal] cord compression, stool incontinence, intervertebral (spine) disc degeneration, and a pressure ulcer on the coccyx. S/he was assessed and care planned to require staff assistance of 1-2 for bed mobility, transfers from bed to chair, personal hygiene, and catheter care. S/he could eat a regular diet with provision and setup by staff.

Leading up to an unsafe discharge on 4/24/19, Resident #1 had known psychosocial and mental health needs that were not addressed by the facility. The facility failed to ensure that the resident received appropriate treatment and services to address his/her alcohol dependence, risk of isolation, feelings of loss of freedom and independence, and coping with an overall decline in health and function, as stated in the written

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F 600	Continued From page 5	F 600		5/29/2019

plan of care and diagnoses. The resident, age 64, was rendered paraplegic by trauma and was admitted to the facility 6/27/18. Record review shows no evidence that the resident was referred for professional mental health assessment and/or professional, medically-related social services to address these issues of trauma, loss, addiction, and adjustment, from admission through discharge on 4/24/19. During interview on 4/29/19 at 12:30 PM, the social worker described only having routine care conferences and doing some research to find placement closer to family. On 4/30/19 at 9:00 AM, the Director of Nursing and Administrator related difficulty finding an alternate placement closer to home. Per interview with the Nurse Practitioner (NP), 4/30/19 at 9:35 AM, s/he confirmed that s/he was unaware of any psychological referral. Record review showed that at least 3 facilities had refused admission. The nearest family lives 2 hours away. During the above interviews, the Administrator, DNS, and NP referred to Resident #1 as "non-compliant" with various aspects of care and services.

From admission through 1/22/19, Resident #1 was allowed 1 beer per day, and had a medical order for this. Due to an incident on 1/21/19 where staff observed Resident #1 allegedly having more than 1 beer with 2 other people, the medical order for 1 beer per day was discontinued. There was no evidence that Resident #1 received referral or treatment for abrupt abstinence from alcohol use. Resident #1 did show a change in behaviors from that time until 4/24/19. This included an "elopement" (leaving the building without signing out) on 4/19/19 to assert his/her right to leave the premises. When Resident #1 again left the premises on 4/24/19, an AMA (against medical

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F 600	Continued From page 6	F 600		5/29/2019

advice) process was initiated by the facility. Facility staff, not the resident, initiated the discussion about discharge AMA when the resident was adamant about wanting to socialize independently outside the facility that day. There is no facility policy that requires residents to sign out AMA when they wish to go on a therapeutic leave. The facility thought the resident was leaving the building to go to a friend's to live, but took no steps to ensure care/services at that discharge location, nor confirm that as an option.

The facility discharged the resident and ordered a maintenence staff person to transport him/her to a local hotel, paying for a one-night stay, on 4/24/19. The facility knew at that time that the family did not intend to care for him/her that evening. The facility knew that the resident could not get from wheelchair to bed, had difficulty dialing a phone, and needed help with catheter care, stool incontinence, all personal hygiene, and could not acquire food, drink, medications or future housing without assistance. The resident was known to have a history of serious UTI with sepsis, and a current deep tissue pressure sore on the buttocks which could become infected without regular hygiene and care.

The facility did not notify the family until some time on 4/25/19 of the hotel location. The facility did not do a Visiting Nurse Association referral by fax until midday, 4/25/19, per copy of fax transmission. This was confirmed by the Administrator and Director of Nursing (DNS) on 4/30/19 at 9:00 AM. Significant harm and risk of death resulted from this discharge, per review of hospital documents.

Per interview of 2 maintenance staff, on 4/29/19

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F 600	Continued From page 7	F 600		5/29/2019

at 11:25 AM, Resident #1 was moved into a hotel room with belongings and medications, and 911 was called from the hotel room at approximately 6:30 PM on 4/24/19. The maintenance person who did the transport was not a caregiver and noted that s/he needed to dial the phone for the resident because Resident #1 "gets shaky when tries to zero in with hands". Per hospital records, dated 4/25/19, Resident #1 reported to the physician that his/her hand tremors increased previously as a "heralding" (warning symptom) to UTI. Resident #1 had a history of hospitalization in July, 2018 and January, 2019, per facility records, both for UTI. Per interview of Resident #1 on 4/29/19 at about 3:30 PM, the rescue squad summoned by the maintenance person transferred the resident to bed, removed a soiled brief, and emptied the catheter bag, which had leaked on the resident's clothing. On 4/25/19, at approximately noon, an anonymous concerned facility staff person, per interview on 4/29/19, called the resident at the hotel. The resident did not know how to use the phone to reach hotel staff, so the staff person called the police and asked for a welfare check. It was later on 4/25/19 that hotel staff called 911 and ambulance response transported the resident to University of Vermont Medical Center (UVMMC) at approximately 6:12 PM, arriving 6: 34 PM, per dispatch records.

Per review of hospital records of 4/25/19, upon emergency department assessment, Resident #1 was not oriented to time, saying s/he had been at the hotel for three days vs the actual 24 hours. The exam revealed the following:
"Mildly tremulous, unstageable ulcer of coccyx, covered in feces, arrives unable to care for self at motel, ruptured foley [catheter] bag, leukocytosis

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F 600	Continued From page 8	F 600		5/29/2019

(high white blood cell count) and fever (100.5 F), abnormal urine dipstick with urine brown and cloudy. Given 1 gram Tylenol for reported headache, and hydrated with intravenous (IV) bolus 1 Liter lactated ringers. Attending [physician] attests to failure to thrive after sudden discharge from rehab, associated AKI (acute kidney infection) in addition to leukocytosis and fever, with UA (urinalysis) consistent with complicated UTI (urinary tract infection). Attending notes that patient reports similar heralding of increased hand tremors with previous UTI. Admitted to hospitable for further UTI care and placement/housing."

Per observation of Resident #1 by this surveyor, on 4/29/19 at 3:30 PM at UVMMC, the resident was receiving IV (Intra-venous) treatment for a multi-drug resistant bacterial infection. The resident therefore is confirmed to have declined to a level of serious harm and potentially life-threatening status of septic UTI during the 24 hour hotel stay, subsequent to sudden discharge by the facility, with no care rendered after 1:00 PM on 4/24/19, despite the resident returning to the facility twice during the afternoon of 4/24/19 clearly in need of care/assistance and indicating to the DNS that s/he made a mistake. The facility did not make any attempt to contact the resident at the hotel or secure caregivers except to fax a VNA referral at 1:30 PM on 4/25/19, with no check of follow through by the VNA. Per interview on 4/30/19 at 9:00 AM, the Administrator and DNS confirmed that the resident was considered discharged after the AMA was signed, 1:00 PM on 4/24/19, and that they had arranged the transport and paid for a one night hotel stay.

See also F0561, F0622, F0626, F0656, F0660,

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F 600	Continued From page 9 F0742 and F0745.	F 600		5/29/2019
F 622 SS=J	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii)	F 622	Resident #1 no longer resides at the center. An audit will be conducted to identify other residents that may be at risk to leave the center and not return to the center, after leaving. Staff will be educated that a resident shall be permitted to return to the center after an AMA, the resident will remain at the center and not be discharged unless their needs cannot be met at the center. CNE and or designee will audit weeklyX4 and monthly x 3 to ensure compliance with transfer and discharge requirements that residents wishing to return to the center are permitted. Results of the audit will be reviewed at QAPI for further recommendations. F622 POC accepted 5/16/19 Thomas/Pmc	

§483.15(c) Transfer and discharge-
§483.15(c)(1) Facility requirements-
(i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless-
(A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;
(B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;
(C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;
(D) The health of individuals in the facility would otherwise be endangered;
(E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or
(F) The facility ceases to operate.
(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or

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F 622	Continued From page 10	F 622		5/29/2019

discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

§483.15(c)(2) Documentation.
When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.
(i) Documentation in the resident's medical record must include:
(A) The basis for the transfer per paragraph (c)(1)(i) of this section.
(B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).
(ii) The documentation required by paragraph (c)(2)(i) of this section must be made by-
(A) The resident's physician when transfer or discharge is necessary under paragraph (c)(1)(A) or (B) of this section; and
(B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section.
(iii) Information provided to the receiving provider must include a minimum of the following:
(A) Contact information of the practitioner responsible for the care of the resident.
(B) Resident representative information including

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

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F 622	Continued From page 11	F 622		5/29/2019

contact information
(C) Advance Directive information
(D) All special instructions or precautions for ongoing care, as appropriate.
(E) Comprehensive care plan goals;
(F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.
This REQUIREMENT is not met as evidenced by:
Based on record review, staff and resident interview, the facility failed to permit 1 of 4 residents sampled (Resident #1) to remain in the facility, and not transfer or discharge. Findings include:

Per record review and staff interviews on 4/29-30/19, the facility alleged that there was a resident initiated AMA (against medical advice) discharge on 4/24/19. This was confirmed by the administrator and Director of Nursing (DNS) on 4/30/19 at 9:00 AM, based on the signature of Resident #1 on an AMA document, signed at 1:00 PM on 4/24/19, and verbal expression of desire to leave the facility during an Interdisciplinary Team (IDT) meeting just prior (per Social Services notes of 4/24/19 and interview on 4/29/19 at 12:30 PM). On 4/29/19 at 2:15 PM, the Recreation Assistant, who was present at the IDT meeting of 4/24/19, stated that Resident #1 had described that s/he simply wanted to go downtown that day. Facility staff, not the resident, initiated the discussion about discharge AMA when the resident was adamant about wanting to socialize independently outside the facility that day.

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 05/01/2019

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F 622	Continued From page 12	F 622		5/29/2019

Based on the behavior of Resident #1, returning to the facility twice on the afternoon of 4/24/19 and verbalizing that s/he made a mistake, this could also be viewed as a "therapeutic leave" on the part of the resident, and an unsafe decision related to potential cognitive changes caused by brewing bacterial urinary tract infection (UTI) and sepsis. The unit manager witnessed Resident #1 in the building at approximately 3:30 PM on 4/24/19 on 4th floor unit, per interview on 4/29/19 at 12:05 PM. The Administrator and DNS stated on 4/30/19 at 9 AM, that on 4/24/19 around 3:30-4 PM they brought Resident #1 into the conference room and allowed phone use to call the daughter and others. It was stated that a staff person had to dial the phone related to hand tremors of Resident #1. Per review of the comprehensive care plan regarding discharge planning, it is clear that a discharge to the community was not the plan. Per Occupational Therapy assessment dated 4/8/19, the resident required supervision outside of the building and per interview on 4/29/19 at 12:45 PM, the OT stated that the resident had poor judgement and safety awareness.

The health status was declining at the time of discharge 4/24/19 (diagnosed 4/25/19 as septic with UTI, requiring hospital admission and intravenous antibiotics). In hospital documents of 4/25/19, Resident #1 reported having been at the hotel for 3 days, when in fact it had been approximately 24 hours from entry to the hotel 4/24/19 6:30 PM, per statement of maintenance person who did the transport in facility van, 4/29/19 at 11:25 AM. This statement of 3 days in the hotel represents evidence of lost orientation to time. Both the maintenance person, who called 911 from the hotel, and the DNS, mentioned that

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F 622	Continued From page 13 on 4/24/19 Resident #1 needed assistance to dial the phone related to hand tremors. Per hospital records, dated 4/25/19, Resident #1 reported to the physician that his/her hand tremors increased previously as a "heralding" (warning symptom) to UTI. Resident #1 had a history of hospitalization in July, 2018 and January, 2019, per facility records, both for UTI. An additional factor is that Resident #1 had a recent history of going off the premises on 4/19/19, per record review and confirmed by the administrator, DNS, and social worker during interviews on 4/29/19. The facility called the police and sent a staff person to bring Resident #1 back to the facility, and re-entry was permitted on 4/19/19. Resident #1 had been in discussions regarding autonomy and choices from January, 2019 through 4/24/19, and disagreed with restrictions the facility put in place regarding independence. There is no written evidence that the facility notified the ombudsman or issued a 30 day notice of discharge during the period prior to the 4/24/19 alleged AMA discharge. Per interview with the Long Term Care ombudsman on 5/1/19 at 8:40 AM, the facility had never contacted him/her about this resident's issues surrounding independence or desire to leave the facility AMA until 4/25/19, the day after discharge.	F 622		5/29/2019
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	F 623	Resident #1 no longer resides at the center. An audit to identify other residents that could be affected by lack of notice prior to discharge was completed. Nursing and social service were educated on the required transfer notice in writing in a language and manner they understand to the patient and the required Ombudsman notification.	

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	475014	A. BUILDING _____ B. WING _____	C 05/01/2019

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F 623	Continued From page 14 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 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;	F 623	The CNE and or designee will complete audits weekly x4 and monthly x 3 to ensure compliance. Results of the audits will be reviewed at QAPI for further recommendations. F623 POC accepted 5/16/19 JHosmer RN/PMC	5/29/2019

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 05/01/2019

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F 623	Continued From page 15	F 623		5/29/2019

(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 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.

§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.

§483.15(c)(8) Notice in advance of facility closure

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 05/01/2019

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

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F 623	Continued From page 16	F 623		5/29/2019

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 record review and interviews, the facility failed prior to discharge to notify 1 of 4 sampled residents (Resident #1) in writing and in a language and manner they understand. The facility also failed to send a copy of any notice to a representative of the Office of the State Long-Term Care Ombudsman. Findings include:

Per interview 4/29/19 at 2:20 PM, the Admissions Director stated that s/he did not provide a transfer/discharge notice with appeal rights and required contact information to Resident #1 on 4/24/19, nor did s/he mail the notice to Resident #1 or the representative. The facility alleged that this was a resident initiated AMA (against medical advice) discharge on 4/24/19. This was confirmed by the administrator and Director of Nursing (DNS) on 4/30/19 at 9:00 AM, based on the signature of Resident #1 on an AMA document, signed at 1:00 PM on 4/24/19, and verbal expression of desire to leave the facility during an Interdisciplinary Team (IDT) meeting just prior (per Social Services notes of 4/24/19 and interview on 4/29/19 at 12:30 PM). Per interview on 4/29/19 at 2:15 PM, the Recreation Assistant [who attended the IDT meeting of 4/24/19] reported that Resident #1 simply wanted to go downtown that day. Based on the behavior of

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 05/01/2019

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

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F 623	Continued From page 17 Resident #1, returning to the facility twice on the afternoon of 4/24/19 and verbalizing that s/he made a mistake, this could also be viewed as a "therapeutic leave" on the part of the resident, and an unsafe decision related to potential cognitive changes caused by brewing bacterial urinary tract infection (UTI) and sepsis. There is no evidence that Resident #1 initiated the AMA discharge process. Refer to F622.	F 623		5/29/2019
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing	F 625	Resident #1 no longer resides at the center. An audit was conducted to identify other residents that could be affected by a transfer with no transfer notice of bed hold at the time of discharge or transfer. Nursing and social service and business office staff were educated on the bed hold notice upon transfer of a resident for hospitalization or therapeutic leave which the facility must provide to the resident and the resident representative written notice which specifies the duration of the bed hold policy. CNE and or designee will audit weekly x4 and monthly x 3 to ensure compliance of bed hold transfer notice delivery. Results of the audits will be reviewed at QAPI for further recommendations. F625 POC accepted 5/16/19 JHosmer RN/PMC	

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 05/01/2019

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BURLINGTON HEALTH & REHAB	300 PEARL STREET BURLINGTON, VT 05401

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F 625	Continued From page 18 facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to provide a written notice of the duration of the bed hold for 1 of 4 residents sampled (Resident #1) prior to therapeutic leave, or discharge. Findings include: Per the Admission Director, 4/24/19 2:20 PM, no bed hold notice was issued to Resident #1 or the representative prior to or reasonably thereafter on 4/24/19. Per the Administrator and Director of Nursing during interview on 4/30/19 at 9:00 AM, Resident #1 was considered discharged against medical advice when transported from the facility to a hotel on 4/24/19. Based on the behavior of Resident #1, returning to the facility twice on the afternoon of 4/24/19 and verbalizing that s/he made a mistake, this could also be viewed as a "therapeutic leave" on the part of the resident, and an unsafe decision related to potential cognitive changes caused by brewing bacterial urinary tract infection (UTI) and sepsis. Refer to F622.	F 625		5/29/2019
F 626 SS=J	Permitting Residents to Return to Facility CFR(s): 483.15(e)(1)(2) §483.15(e)(1) Permitting residents to return to facility. A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the	F 626	Resident #1 no longer resides at the center. An audit was completed to identify other residents that have left the center and are seeking to return. There are no residents in this status at this time. The nursing staff and social services have been educated that if a patient returns from a therapeutic leave they are permitted to readmit to the center.	

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	475014	A. BUILDING _____ B. WING _____	C 05/01/2019

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F 626	Continued From page 19 following. (i) A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, returns to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident- (A) Requires the services provided by the facility; and (B) Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services. (ii) If the facility that determines that a resident who was transferred with an expectation of returning to the facility, cannot return to the facility, the facility must comply with the requirements of paragraph (c) as they apply to discharges. §483.15(e)(2) Readmission to a composite distinct part. When the facility to which a resident returns is a composite distinct part (as defined in § 483.5), the resident must be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of return, the resident must be given the option to return to that location upon the first availability of a bed there. This REQUIREMENT is not met as evidenced by: Based on record review, staff and resident interviews, the facility failed to permit return to the facility after a therapeutic leave for 1 of 4 residents in the sample (Resident #1). Findings include: Per record review, staff and resident interviews, Resident #1 returned to the facility 4/24/19 at	F 626	An audit will be completed weekly x4 and monthly x 3 to ensure patients are readmitted after a therapeutic leave. The results of the audit will be reviewed at QAPI for further recommendations. F626 PoC accepted 5/16/19 JHosmerRN/PMC	5/29/2019

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 05/01/2019

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

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F 626	Continued From page 20	F 626		5/29/2019

least twice after having been considered discharged against medical advice (AMA) by the facility (signature on 4/24/19 at 1:00 PM, per AMA document). The facility thought the resident was leaving the building to go to a friend's to live, but took no steps to ensure care/services at that discharge location, nor confirm that as an option. At 3:30-4 PM, Resident #1 was observed in the building on the 4th floor, per interviews with the nurse unit manager (4/29/19 at 12:05 PM), the Nurse Practitioner (4/30/19 9:35 AM), as well as by both the Administrator and Director of Nursing/DNS (4/30/19 at 9:00 AM). Per facility records, and these interviews, Resident #1 again left the premises, allegedly going to the hospital [where he presented as homeless needing housing and was turned away] and returned again to the facility at approximately 5:00 PM, clearly in need of care, indicating to the DNS s/he made a mistake. During the above interviews, witnesses placed Resident #1 in the building again, meeting in the ground floor conference room with administrator, DNS, Assistant DNS, and Business Manager regarding funds. The Assistant DNS was confirmed having dialed the phone for Resident #1 to talk with his/her daughter and others because the resident could not independently dial the phone due to hand tremors. At approximately 5:30 PM on 4/24/19, the Occupational Therapist (OT) confirmed having talked to Resident #1 from a window, as s/he was outside near the rear of the building, and asked Resident #1 to meet him/her at the entrance. Confirmed during this interview on 4/29/19 at 12:45 PM, the OT described that s/he went to the DNS and advised that Resident #1 was not safe and capable of living alone in the community. The DNS stated clearly to the OT, per this interview, that Resident #1 was AMA and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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BURLINGTON HEALTH & REHAB	300 PEARL STREET BURLINGTON, VT 05401

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F 626	Continued From page 21	F 626		5/29/2019

not to receive medical care nor allowed to stay at the facility that night. S/he stated that when the resident returned, the facility DNS (Director of Nursing Services) asserted the AMA status to the resident and refused re-admission to the facility. When interviewed at the hospital on 4/29/19 at 3:30 PM, the resident said s/he did not specifically ask for re-admission because the DNS "told me [s/he] would call the cops; they did that before so I knew they would". The facility had called the police on 4/19/19 and allowed return to the facility after Resident #1 left the premises in a perceived elopement (notes of 4/19/19, confirmed by administrator and DNS 4/30/19 at 9:00 AM).

The facility then arranged for the one-night stay at a hotel for the night of 4/24/19 instead of readmitting the resident who had extensive care needs, and had a maintenance person transport the resident, with plastic bags of clothing, belongings, and medications, and a list of area healthcare providers, along with the electric wheelchair. The facility did not permit the resident to re-admit to the facility after a "therapeutic leave" and mis-understanding of the AMA discharge due to possible altered mental status and brewing infection. After spending approximately 24 hours in the hotel, and having 3 emergency 911 responses for care and welfare checks, Resident #1 was admitted to the hospital on 4/25/19. Hospital records showed a multi-drug resistant urinary tract infection which represented substantial health risk to Resident #1. The facility not only did not permit return, but failed also to provide community services to a vulnerable person who could not, by their assessment and care plan, transfer him/herself from chair to bed, had an indwelling urinary catheter, was dependent on caregivers for hygiene, and had

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	475014	A. BUILDING _____ B. WING _____	C 05/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 626	Continued From page 22 trouble using a telephone. A fax was sent by the facility to the Visiting Nurse Association at 1:30 PM on 4/25/19, with no evidence of any effort to check on Resident #1, and knowing the family was not coming promptly to assist (per interview administrator and DNS, 4/30/19 at 9:00 AM).	F 626		5/29/2019
F 656 SS=J	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 resident's representative(s)- (A) The resident's goals for admission and	F 656	Resident #1 no longer resides at the center. An audit has been completed of careplan implementation for residents at risk for unmet psychosocial needs and desire for community activities. An audit was completed for discharge residents to ensure they have community services arranged prior to discharge to meet their care needs. Social Service and Licensed staff have been educated on implementation of care plan interventions related to desire for community activity and arranging community services prior to discharge. CNE or designee will audit residents who have expressed a desire for community activities to ensure interventions are implemented weeklyX4 the monthly X4. CNE or designee will audit residents pending discharge to ensure community services are arranged to meet their care needs weekly X4 then monthly X4. The results of these audits will be reviewed at QAPI for further recommendations. F656 POC accepted 5/16/19 JHomerRN/PMC	

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 05/01/2019

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

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F 656	Continued From page 23	F 656		5/29/2019

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 record review and staff interviews, the facility failed to implement the written plan of care for 1 of 4 residents in the sample (Resident #1). Findings include:

After admission 6/27/18 with paraplegia due to trauma, and a history of alcohol abuse, the facility developed a care plan based on the assessed needs and preferences of Resident #1. This included a preference to go outside, weather permitting, and risk of social isolation related to change in customary lifestyle, difficulty accepting placement in the center, loss of status and/or freedom, loss of support network, and coping with decline in overall health and functional decline. Staff were directed in the written plan of care to: evaluate mood state or behavioral symptoms impacting social isolation; encourage to make decisions independently and provide positive feedback; encourage expression of thoughts and feelings associated with the change or loss of customary lifestyle/routines; encourage to participate in activity preferences; family and staff to assist outdoors, weather permitting. On 4/18/19, a care plan was also developed for risk of elopement related to history of leaving grounds

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 05/01/2019

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F 656	Continued From page 24	F 656		5/29/2019

without signing out. This directed staff to notify the physician, observe location when out of bed, remind to sign out/in when leaving. Additionally the care plan included risk for seizure activity related to tremors. Monitor for signs/symptoms of impending seizures.

Resident #1 stated during interview on 4/29/19 at 3:30 PM that s/he expressed to facility staff that s/he had not been out of the building all year, that rehab means getting out and mingling with people.Contrary to the care plan which states that staff or family will support the resident to go outside, Resident #1 was allowed to go outside and off the premises a few times alone. On 4/19/19 when Resident #1 left the premises, the facility called police. During the care plan meeting of 4/24/19, Resident #1 asserted the desire to go downtown that afternoon. This was confirmed by a staff witness during interview at 2:15 PM on 4/29/19. The facility did not implement care strategies to safely allow such community activity.The facility instead initiated an Against Medical Advice (AMA) discharge on 4/24/19. Per record review, staff and resident interviews, the resident left the facility and returned on 4/24/19 at least twice after having been considered discharged against medical advice (AMA) by the facility (signature on 4/24/19, 1:00 PM, per AMA document). First the resident was documented as leaving the building to go to a friend's to live. Later, Resident #1 was observed in the building and on the 4th floor at 3:30-4 PM, per interviews with the nurse unit manager (4/29/19 at 12:05 PM) and by the Nurse Practitioner (4/30/19 9:35 AM), as well as by both the administrator and Director of Nursing/DNS (4/30/19 at 9:00 AM). Per facility records, and these interviews, Resident #1 again left the premises, allegedly

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 05/01/2019

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

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F 656	Continued From page 25	F 656		5/29/2019

going to the hospital [where he presented as homeless in need of housing and was turned away] and returned at approximately 5:00 PM. During the above interviews, witnesses placed Resident #1 in the building again, meeting in the ground floor conference room with administrator, DNS, Assistant DNS, and Business Manager regarding funds. The Assistant DNS was confirmed having dialed the phone for Resident #1 to talk with his/her family and others due to hand tremors preventing the resident from dialing the phone independently. At approximately 5:30 PM on 4/24/19, the Occupational Therapist (OT) confirmed having talked to Resident #1 from a window, as s/he was outside near the rear of the building, and asked Resident #1 to meet him/her at the entrance. Confirmed during this interview on 4/29/19 at 12:45 PM, the OT described that Resident #1 said they would not let him/her back in the building and s/he had no place to go. The resident stated "I made a mistake". The OT went to the DNS and advised that Resident #1 was not safe and capable of living alone in the community. The DNS stated clearly to the OT, per this interview, that Resident #1 was "AMA and that's too bad; I'll get him/her a hotel".

When interviewed at the hospital on 4/29/19 at 3:30 PM, the resident said the DNS "told me you've got to get out of here; we'll call the cops." The facility had called police on 4/19/19 and allowed return to the facility after Resident #1 left the premises in a perceived elopement (notes of 4/19/19, confirmed by administrator and DNS 4/30/19 at 9:00 AM).

The facility then arranged for the one-night stay at a hotel for the night of 4/24/19, and had a maintenance person transport the resident, with

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 05/01/2019

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

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F 656	Continued From page 26 plastic bags of clothing, belongings, and medications, and a list of area healthcare providers, along with the electric wheelchair. The facility did not permit the resident to re-admit to the facility after a therapeutic leave due to possible altered mental status and brewing infection. After spending approximately 24 hours in the hotel, and having 3 emergency 911 responses for care and welfare checks, Resident #1 was admitted to hospital on 4/25/19. Hospital records showed a multi-drug resistant urinary tract infection which represented substantial health risk to Resident #1. The facility not only did not permit return, but failed also to provide community services to a vulnerable person who could not, by their assessment and care plan, transfer him/herself from chair to bed, had an indwelling urinary catheter, and had trouble using a telephone. A fax was sent by the facility to the Visiting Nurse Association at 1:30 PM on 4/25/19, with no evidence of any effort to check on Resident #1, and knowing the family was not coming promptly to assist (per interview administrator and DNS, 4/30/19 at 9:00 AM). Refer to F561.	F 656		5/29/2019
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the	F 657	Resident #2 no longer resides at the center. An audit has been completed of residents who are cognitively intact with a BIM's score of 13-15 to ensure their care plan for cognition is accurate. An audit of residents with skin breakdown has been completed to ensure their care plan reflects the change in skin condition and related interventions. An audit of residents ADL's care plans has been completed to ensure the information is accurate and reflects residents current ADL status.	

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 05/01/2019

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

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F 657	Continued From page 27	F 657	Licensed staff and Social Services has been educated regarding accurate completion of the cognitive care plans for residents scoring a BIMs of 13-15. Licensed staff has been educated on updating and revising the skin care plan with changes in skin condition and related interventions. Licensed staff has been educated on updating and revising the ADL care plan for residents with changes in ADL status. CNE and or designee will conduct audits of care plans for residents who are cognitively intact scoring a BIM's between 13-15 will be completed weekly X4 then monthly X3 to ensure the care plan is accurate. CNE and or designee will conduct audits of residents with identified skin concerns to ensure a care plan is in place with related interventions. CNE or designee will conduct audits of care plans for residents with changes in ADL status to ensure the care plan has been updated with changes. The results of these audits will be reviewed at QAPI for further recommendations. F657 POC accepted 5/16/19 JHosmer RN/PMC	5/29/2019

resident.
(C) A nurse aide with responsibility for the resident.
(D) A member of food and nutrition services staff.
(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.
(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.
(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced by:
Based upon record review and interview, the facility failed to assure the plan of care was revised to reflect the care and services provided to one of two residents (Resident #2). Findings include:

1. Per record review, Resident #2's care plan completed by the Social Worker (SW) dated 4/8/19, did not accurately reflect the resident's mental status. The care plan states Resident #2 has impaired/decline in cognitive function or impaired thought processes related to a condition other than delirium. The interventions include monitor conditions that may contribute to cognitive loss/dementia, including metabolic causes, respiratory problems, CVA, delusions, hallucinations, psychiatric disorder, poor nutrition, hearing or vision impairment, new/acute heath problem, head injury, pain fever, dehydration or

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	475014	A. BUILDING _____ B. WING _____	C 05/01/2019

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

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F 657	Continued From page 28	F 657		5/29/2019

alcohol withdrawal. Evaluate needs for psych/behavioral health consult.

Per record review of the Brief Interview for Mental Status (BIMS), which was completed upon admission by the SW states Resident # 2 has a score of 15. BIMS is used to obtain a snapshot of how well a person is functioning at the moment. A score of 13-15 is cognitively intact.

Per staff interview, SW confirmed on 4/30/19 at 8:15 AM that the care plan for Resident #2 was inaccurate as written on 4/8/19 and the resident was mentally alert and cognitively intact. SW did not revise the care plan prior to the resident's discharge on 4/25/19. SW stated the computer generated care plan auto populates and staff completing the care plan need to make adjustments as needed. Stated she/he should have revised the care plan from "has cognitive impairment" to "has the potential for cognitive impairment".

2. Per record review, Nursing note dated 4/11/19 states, "Noted two 1 centimeter by 1 centimeter to patient mid-spine after patient complained of soreness. Noted redness with mild drainage. Applied 3 by 3 inch Optifoam dressing".

Per staff interview and confirmed with with the Unit Manager on 4/29/19 at 12:57 PM, Resident #2's care plan for "Has actual skin breakdown dated 3/25/19 " related to surgery was not revised to include skin breakdown noted on 4/11/19 to mid thoracic spine in 2 areas.

3. Per record review, Resident #2's care plan dated 3/25/19 states resident requires assistance/is dependent for Activities in Daily

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 05/01/2019

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

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F 657	Continued From page 29 Living (ADL) care in bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion. Interventions include extensive assist of 2 for transfers using a walker. Per staff interview and confirmed with Unit Manager on 4/29/19 1:08 PM, Resident # 2 was admitted post surgery and was dependent for assistance in bathing, grooming personal hygiene, dressing, eating, bed mobility transfers, locomotion, toileting and extensive assistance with transfer, and the care plan was not revised to include the 4/8/19 the care conference review which indicated the Resident #2 was upper body moderate assist, lower body maximum assist, transfers moderate assist. Ambulation minimum assist with Contact Guard Assist (CGA).	F 657		5/29/2019
F 660 SS=J	Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix) §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes.	F 660	Resident #1 no longer resides at the center. An audit of residents with potential discharge has been conducted daily by the IDT team during morning meeting monday through friday to review and ensure safe discharge plans are made and appropriate outside resources are identified and referrals made. The Ombudsman will be notified when appropriate. Center has implemented a weekend and off shift process should an unplanned situation arise concerning an unsafe discharge or AMA discharge. Social Services and Nursing Management have been educated on the discharge planning process, policy OPS406. CNE or designee will audit residents being discharged weeklyX3 then monthly X4 to ensure concerns related to discharge are addressed and appropriate outside resources have been notified along with the Ombudsman as appropriate. The results of these audits will be reviewed at QAPI for further recommendations.	

F660 POC accepted 5/16/19 JHosmer RN/PMC

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 05/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 660	Continued From page 30	F 660		5/29/2019

(iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan.
(iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs.
(v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan.
(vi) Address the resident's goals of care and treatment preferences.
(vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community.
(A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose.
(B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities.
(C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why.
(viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that

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 05/01/2019

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F 660	Continued From page 31	F 660		5/29/2019

the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences.
(ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer.
This REQUIREMENT is not met as evidenced by:
Based on record review, and confirmed by interviews, the facility failed to consider need for care and capacity, and to inform and consult the office of the State Long Term Care Ombudsman, regarding the desire of 1 of 4 residents sampled (Resident #1) to discharge. Findings include:

Resident #1 was admitted for care on 6/27/18 after paraplegia, caused by trauma and complicated by alcohol abuse. The facility developed a plan of care which included discharge planning for a desire to move to a facility closer to family on the New Hampshire border, and indicated the resident is dependent on staff for care, assistance with a urinary catheter, a pressure ulcer, adjustment concerns, and other issues. At the time of alleged discharge against medical advice (AMA), 4/24/19, the facility failed to consider the caregiver/support person availability, capacity, and capability to perform required care unassisted in the community. Resident #1 was also assessed and care planned

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 05/01/2019

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 660	Continued From page 32 as needing staff support for fecal incontinence, lower body paraplegia with inability to transfer without 1-2 person assistance, and hand tremors which impaired ability to dial a telephone. The facility thought the resident was leaving the building to go to a friend's to live, but took no steps to ensure care/services at that discharge location, nor confirm that as an option. Per interview with the Long Term Care ombudsman on 5/1/19 at 8:40 AM, the facility failed to contact the ombudsman and involve him/her in exploration of alternative options for placements, transfers or discharges. The facility made a hasty discharge arrangement 4/24/19, to transport the resident to a hotel and paid for one night, knowing that the family did not intend to care for him/her. This was confirmed by Administrator interview of 4/30/19 at 9 AM. Per hospital documents dated 4/25/19, the resident required Emergency Medical Services for transport to hospital from the hotel. Diagnoses included failure to thrive and urinary tract infection (UTI) with multi-drug resistant sepsis (life-threatening infection). The resident was admitted for UTI hospital care and homeless status. Per review of the comprehensive care plan regarding discharge planning, it is clear that a discharge to the community was not the plan. Per Occupational Therapy assessment dated 4/8/19, the resident required supervision outside of the building and per interview on 4/29/19 at 12:45 PM, the OT stated that the resident had poor judgement and safety awareness.	F 660		5/29/2019
F 742 SS=J	Treatment/Srvcs Mental/Psychoscial Concerns CFR(s): 483.40(b)(1) §483.40(b) Based on the comprehensive	F 742	Resident #1 no longer resides at the center. An audit of residents with a history of alcoholism, adjustment disorders and trauma history was conducted to ensure appropriate treatment	

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 05/01/2019

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F 742	Continued From page 33 assessment of a resident, the facility must ensure that- §483.40(b)(1) A resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder, receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being; This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to ensure 1 of 4 residents sampled (Resident #1) received appropriate treatment and services to attain the highest practicable mental and psychosocial well-being, related to trauma, new paraplegia with loss of independence, adjustment problems, and a history of alcohol abuse. Findings include: Per record review, the facility failed to ensure that the resident received appropriate treatment and services to correct his/her alcohol dependence, risk of isolation, and feelings of loss of freedom and independence, and coping with an overall decline in health and function, as stated in the written plan of care and diagnoses. The resident, age 64, was rendered paraplegic by trauma and was admitted to the facility 6/27/18. Record review shows no evidence that the resident was referred for professional mental health assessment and treatment to address these issues of trauma, loss, addiction, and adjustment from admission through discharge 4/24/19. During interview on 4/29/19 at 12:30 PM, the social worker described having routine care conferences and doing some research to find placement closer to family. On 4/30/19 at 9:00	F 742	and services were offered to maintain the highest practicable well-being. Social Services and Nursing Management has been educated on identification of concerns to be addressed related to alcohol dependence, psychosocial, functional,emotional and cognitive well-being. CNE or designee will conduct audits weekly X4 then monthly X3 of residents with a history of alcohol dependance, adjustment disorders and trauma history to ensure appropriate treatment and services are offered to maintain the highest practicable well-being. The results of these audits will be reviewed at QAPI for further recommendations. F742 POC accepted 5/16/19 JHasmerRN/PMC	5/29/2019

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 05/01/2019

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F 742	Continued From page 34 AM the Director of Nursing and administrator related difficulty finding an alternate placement. Per interview with the nurse practitioner, 4/30/19 at 9:35 AM, s/he confirmed that s/he was unaware of any psychological referral. Record review showed that at least 3 facilities had refused admission. The nearest family lives 2 hours away. From admission through 1/22/19, Resident #1 was allowed 1 beer per day, and had a medical order for this. Due to an incident on 1/21/19 where staff observed Resident #1 allegedly having more than 1 beer with 2 other people, the medical order for 1 beer per day was discontinued. There was no evidence to suggest that Resident #1 received referral or treatment for abrupt abstinence from alcohol use. Resident #1 did show a change in behaviors from that time until 4/24/19. This included an elopement on 4/19/19 to assert the right to leave the premises. When Resident #1 again left the premises on 4/24/19, an AMA (against medical advice) process was initiated by the facility. Facility staff, not the resident, initiated the discussion about discharge AMA when the resident was adamant about wanting to socialize independently outside the facility that day. Despite leaving and returning to the facility that afternoon at least twice, the facility moved forward with a less than orderly discharge to a hotel, alone and without care. This culminated in emergency services and transport to hospital for treatment of a urinary tract sepsis (life-threatening infection) and homeless status, per hospital documents of 4/25/19, and as confirmed by surveyor observation at 3:30 PM on 4/29/19 at the hospital bedside.	F 742		5/29/2019
F 745	Provision of Medically Related Social Service	F 745		

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F 745 SS=J	Continued From page 35 CFR(s): 483.40(d) §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide professional, medically related social services to ensure 1 of 4 residents sampled (Resident #1) attained their highest practicable physical, mental and psychosocial well-being related to trauma, new paraplegia with loss of independence, adjustment problems, and a history of alcohol abuse. Findings include: Per record review, the facility failed to ensure that the resident received appropriate treatment and services to correct his/her alcohol dependence, risk of isolation, feelings of loss of freedom and independence, and coping with an overall decline in health and function, as stated in the written plan of care and diagnoses. The resident, age 64, was rendered paraplegic by trauma and was admitted to the facility 6/27/18. Record review shows no evidence that the resident was referred for professional mental health assessment and/or professional, medically-related social services to address these issues of trauma, loss, addiction, and adjustment from admission through discharge 4/24/19. During interview on 4/29/19 at 12:30 PM, the social worker described having routine care conferences and doing some research to find placement closer to family. On 4/30/19 at 9:00 AM the Director of Nursing and Administrator related difficulty finding an alternate placement closer to home. Per interview with the Nurse Practitioner (NP), 4/30/19 at 9:35 AM, s/he	F 745	Resident #1 no longer resides at the center. An audit of residents with a history of alcoholism, adjustment disorders and trauma history was conducted to ensure appropriate treatment and services were offered to maintain the highest practicable well-being. Social Services has been educated on identification of concerns to be addressed related to alcohol dependence, psychosocial, functional, emotional and cognitive well-being. CNE or designee will conduct audits weekly X4 then monthly X3 of residents with a history of alcohol dependance, adjustment disorders and trauma history to ensure appropriate treatment and services are offered to maintain the highest practicable well-being. The results of these audits will be reviewed at QAPI for further recommendations. F745 POC accepted 5/16/19 JHosmer RN/PMC	5/29/2019

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F 745	Continued From page 36 confirmed that s/he was unaware of any psychological referral. Record review showed that at least 3 facilities had refused admission. The nearest family lives 2 hours away. During the above interviews, the Administrator, DNS, and NP referred to Resident #1 as "non-compliant" with various aspects of care and services. From admission through 1/22/19, Resident #1 was allowed 1 beer per day, and had a medical order for this. Due to an incident on 1/21/19 where staff observed Resident #1 allegedly having more than 1 beer with 2 other people, the medical order for 1 beer per day was discontinued. There was no evidence to suggest that Resident #1 received referral or treatment for abrupt abstinence from alcohol use. Resident #1 did show a change in behaviors from that time until 4/24/19. This included an elopement on 4/19/19 to assert his/her right to leave the premises. When Resident #1 again left the premises on 4/24/19, an AMA (against medical advice) process was initiated by the facility. Despite leaving and returning to the facility that afternoon at least twice, indicating s/he had made a mistake, the facility moved forward with a less than orderly discharge to a hotel, alone and without care. This culminated in emergency services and transport to hospital for treatment of a urinary tract sepsis (life-threatening infection) and homeless status, per hospital documents of 4/25/19, and as confirmed by surveyor observation at 3:30 PM on 4/29/19 at the hospital bedside.	F 745		5/29/2019
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information.	F 842	Resident #2 no longer resides at the center. An audit has been completed of residents who are cognitively intact with a BIM's score of 13-15 to ensure their care plan for cognition is accurate.	

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F 842	Continued From page 37 (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.	F 842	Licensed staff and Social Services has been educated regarding accurate completion of the cognitive care plans for residents scoring a BIMs of 13-15. CNE and or designee will conduct audit of care plans for residents who are cognitively intact scoring a BIM's between 13-15 will be completed weekly X4 then monthly X3 to ensure the care plan is accurate. The results of these audits will be reviewed at QAPI for further recommendations. F842 POC accepted 5/16/19 JHosmerRN/PMR	5/29/2019

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F 842	Continued From page 38 §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based upon record review and interview, the facility failed to assure that 1 of 2 resident health records was accurately documented by the social work staff. (Resident #2). Finding include: 1. Per record review, Resident #2's care plan completed by the Social Worker (SW) dated 4/8/19, states Resident #2 has impaired/decline in cognitive function or impaired thought processes related to a condition other than delirium. The interventions include monitor conditions that may contribute to cognitive loss/dementia, including metabolic causes,	F 842		5/29/2019

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F 842	Continued From page 39	F 842		5/29/2019

respiratory problems, CVA, delusions, hallucinations, psychiatric disorder, poor nutrition, hearing or vision impairment, new/acute heath problem, head injury, pain fever, dehydration or alcohol withdrawal. Evaluate needs for psych/behavioral health consult.

Per record review of the Brief Interview for Mental Status (BIMS), which was completed upon admission by the social worker, states Resident # 2 has a score of 15. BIMS is used to obtain a snapshot of how well a person is functioning at the moment. A score of 13-15 is cognitively intact. SW stated that Resident #2 was mentally alert and cognitively intact.

Per staff interview, the SW confirmed on 4/30/19 at 8:15 AM that the care plan for Resident #2 was inaccurate as written on 4/8/19 and the resident was mentally alert and cognitively intact. The SW did not correct the inaccurate documentation in the care plan prior to Resident #2's discharge on 4/25/19. SW stated the computer generated care plan auto populates and staff completing the care plan need to make adjustments as needed. Stated she/he should have revised the care plan.

May 2, 2019

Pam Cota
Dail
Division of Licensing and Protection
HC 2 South
280 State Dr
Waterbury, VT 05671

Dear Ms. Cota,

Please accept this revised abatement plan for the Immediate Jeopardy template provided to the center relative to an AMA discharge that occurred on April 24, 2019 and investigated on April 29 and 30 by the Division of Licensing and Protection: determined to constitute immediate jeopardy with verbal notice to the center on May 1.

The center alleges compliance as of May 2nd for removal of immediate jeopardy based on the information provided below. The center remains committed to further development of this plan to maintain long term compliance and prevent any recurrence.

The preliminary fact analysis notes:

- Neglect
- Accommodation of Needs
- Discharge Requirements
- Permitting resident to return
- TX/SVcs for psychosocial concerns
- Social Services.

Burlington Health and Rehab submits this allegation of compliance to ensure full compliance with CMS expectations.

Abatement plan:

Neglect:
The center leadership group has reviewed the definition of neglect which is defined as: the failure of the center, it's employees, or service providers to provide goods and services to a patient that are necessary to avoid physical harm, pain, mental anguish or emotional distress. Licensed staff and Social Services received education related to unsafe discharges as related to potential neglect as defined in the center's abuse policy. The education was provided to center staff and was focused on review of OPS Policy 300 Abuse Prohibition with special attention to staff understanding the definition of neglect and its application to this situation.

Accommodation of needs:

The center leadership reviewed policy OPS 200 Accommodation of Needs with the purpose to educate staff in the requirement to accommodate resident needs and preferences and to provide a safe, clean, comfortable and homelike environment. Licensed and Social Service staff have been educated to be directed toward assisting the resident in maintaining and or achieving independent functioning, dignity, and well being to the extent possible in accordance with the resident's own needs and preferences.

Discharge Requirements:
Center leadership has reviewed pending discharges to ensure appropriate care and services are provided.

The new process to review and ensure safe discharge plans is: the IDT to review upcoming discharges at morning meeting. The team will actively solicit issues and concerns related to the potential discharge and appropriate outside resources will be identified and referrals made by SW. (ie alcohol counseling, ombudsman, resident's family or advocate, physician, medical director or APS as appropriate). During the morning meeting of the IDT, held Monday through Friday, the CED or CNE/Asst CNE will drive the discussion to identify issues early on to prevent escalation resulting in an unsafe discharge. Identified concerns and follow up will be documented in the medical record. Should a situation arise concerning an unsafe discharge or AMA discharge on a weekend or off hours, the supervisor will contact the CED or CNE. Education has been provided to the supervisors regarding this notification.

Social Service staff have received education from Carol Eckert, Genesis Director of Social Work Clinical Practice and Education, a member of the Genesis National Specialty Practices Leadership team. The Education was provided over Zoom on May 1, 2019, and reviewed the following policies:

OPS 403: Discharge Against Medical Advice

OPS 406: Discharge Planning Process

NUR 120 Leave of Absence/Therapeutic Leave

Instructions for the Completion of Social History and Initial Assessment
(please see attached policies for your review). Center staff have presented your suggestions for revision to the AMA Discharge Policy to the Genesis Policy Committee for review. The Center will commit to making attempts to reach an independent advocate (as listed in your email) prior to AMA discharge if at all possible while we wait for the changes to be made to the official Genesis policy.

There are currently no residents seeking to discharge against medical advice. The Center staff understands the concerns presented related to assessing psychosocial issues that may be a trigger for a resident wishing to leave the center AMA and is committed to resolving all such

concerns through timely referral to appropriate providers, community agencies, partners, counselors etc. The nursing leadership team reviewed current resident status via observation, chart review, resident and staff interviews and determined there are no residents likely to suffer a serious adverse outcome as a result of the noncompliance noted above.

Unit Managers compiled a list of all residents who are deemed non compliant with care who have risk factors for a potential inappropriate discharge. An audit was completed,care plans were reviewed and revised. The center will review residents at risk for inappropriate discharge during weekly behavior rounds to determine root cause for the inappropriate discharge so those concerns can be addressed and possibly eliminate the need for discharge until a safe and appropriate discharge can be achieved.

Permitting Residents to return:
Licensed and Social Service staff received education regarding allowing residents to be readmitted to the center upon request, including returns from therapeutic leaves and discharges against medical advice. The policy NSG 120 Leave of Absence/ Therapeutic Leave were reviewed so that staff understand the purpose of a therapeutic leave or leave of absence based on patient centered plan of care and goals.

TX/SVC for psychosocial concerns:
In house residents were assessed for unaddressed psychosocial needs including Hx of ETOH, drug abuse, adjustment disorder, life altering medical events resulting in admission to the SNF. Appropriate referrals for additional services were made as applicable. The care care plans of those residents were reviewed and revised after being identified through an audit process. AA was contacted and will initiate weekly meetings at the center for Residents. An updated schedule of AA meetings in the area is available and transportation to meetings will be provided to residents who wish to attend. A contract with Deer Oaks for additional psychosocial support has been initiated. Services to begin the week of 5/ 6.

Social Services:
The Regional Social Worker provided education to the center Social Service staff to identify concerns to be addressed related to psychosocial, functional, emotional, and cognitive concerns.

See additional comments above related to the education provided by Carol Eckert.

In conclusion, significant education was provided on May 1. 134 staff received education. Day shift staff received education prior to leaving for their shift on May 1. Evening shift received education prior to leaving their shift on May 1. Night shift staff scheduled to work May 1 attended a phone session to receive the education. The policies reviewed include:
OPS 403 Discharge Against Medical Advice
OPS 404 Discharge and Transfer
OPS 406 Discharge Planning Process

NSG 120 Leave of Absence/therapeutic Leave
NSG 206 Behavior Management of symptoms
OPS 415 Behavioral Healthcare and Services
OPS 200 Accommodation of Needs
OPS 300 Abuse Prohibition
SS100 Assessment

Additional training was conducted on May 2, 2019 to confirm understanding and education resulting in 18 nursing staff receiving further reinforcement of this education on May 2nd to reiterate the importance of early detection and involvement of the ombudsman and other disciplines to prevent escalation of the situation to AMA discharges..

I hope this updated plan has addressed your questions. Please be assured the center leadership understands your concerns as presented on May 1, and is diligently working to ensure psychosocial needs of our residents are addressed and any discharge from the center involves a safe and detailed discharge plan.

Sincerely,

Melissa Greenfield

Melissa Greenfield
Center Executive Director

Cc: RVPO