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

July 30, 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 **June 26, 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

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 06/26/2019

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 000	INITIAL COMMENTS An unannounced investigation of 3 Facility Reported Incidents & 5 Complaints was conducted by the Division of Licensing & Protection on 6/24-26/2019. The following regulatory deficiencies were identified: Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced	F 000	The filing of this plan of correction does not constitute an admission of the allegations set forth in the Statement of deficiencies. The plan of correction is prepared and executed as evidence of the facility's continued compliance with applicable law. F- 609 Resident #2 and # 3 were offered the opportunity to move to another floor to separate and declined. Other residents have the potential to have physical contact with other residents. Staff will be re-educated on the reporting requirements of potential abusive behavior between residents. Staff knowledge of reporting will be audited by CNE and or designee weekly x4 and monthly X3. The results of the audits will be reviewed at QAPI for further recommendations. F609 POC accepted 7/30/19 MHiggins RN/PMC	7/24/19
F 609 SS=D		F 609		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Melissa Greenfield — TITLE: Administrator — (X6) DATE: 7/17/2019

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 609	Continued From page 1	F 609		7/24/19

by:
Based on observations, record review, and interviews the facility failed to assure that a report of sexual abuse was made to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures for Residents #2 & #3. Findings include:

Per observations conducted during the survey both Residents #2 & #3 were observed to be fully mobile. Resident #3 has a BIMS of 15 and is his/her own decision maker and Resident #2 has Dementia and his/her Daughter is the decision maker for this resident. The residents were observed by both surveyors (separately) to spend time together and they interact playfully.
Per record review Resident #2 was the Alleged Perpetrator in the intake which initiated this investigation. The accusation is that Resident #2 slapped Resident #3 in the face. In a second incident Resident #2 became upset and grabbed R#3's upper arm causing bruising. The facility reported the incident and it was investigated during this visit. When reviewing the record a progress note was found dated 6/2/19. The note stated that the residents were found seated in the back sitting area and Resident #2 had his/her hand up the shirt of Resident #3. Both residents were laughing and they were separated.
There is no evidence that this incident was reported to the State Survey Agency. Additionally the facility Executive Director and the Director of Nursing Services stated that they were unaware of the incident.

F 655 Baseline Care Plan F 655

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F 655 SS=D	Continued From page 2 CFR(s): 483.21(a)(1)-(3)	F 655	F-655	7/24/19

§483.21 Comprehensive Person-Centered Care Planning
§483.21(a) Baseline Care Plans
§483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must-
(i) Be developed within 48 hours of a resident's admission.
(ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to-
(A) Initial goals based on admission orders.
(B) Physician orders.
(C) Dietary orders.
(D) Therapy services.
(E) Social services.
(F) PASARR recommendation, if applicable.

§483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-
(i) Is developed within 48 hours of the resident's admission.
(ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).

§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:
(i) The initial goals of the resident.
(ii) A summary of the resident's medications and

Resident #1was discharged from the center.

Other residents newly admitted could be affected by this alleged deficient practice.

Department heads involved in the care plan process and nurses were re-educated on the process to Develop a baseline care plan.

The CNE and or designee will audit new admissions for the presence of a baseline care plan with in 48 hours of admission per protocol and that a copy will be given to the resident after the post admission meeting per Protocol.

Results of the audits will be reviewed At QAPI for further recommendations.

F655 POC accepted 7/30/19 MHiggins RN/PMC

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F 655	Continued From page 3	F 655		7/24/19

dietary instructions.
(iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.
(iv) Any updated information based on the details of the comprehensive care plan, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to develop a baseline care plan within 48 hours of admission for 1 applicable resident (Resident #1) that included the minimum healthcare information necessary to properly care for the resident. Findings include the following:

Per review of the medical record on 6/24/19 for Resident #1, the resident was admitted to the facility on 3/28/19 for hospice respite care. The care plan developed on 3/30/19 does not contain all the required topics to be addressed. The baseline care plan included some basic information on caring for this resident, however, it does not contain information regarding medications to be prescribed, physician orders, dietary information, social service needs and nothing related to hospice care needs. There was also no evidence that a summary of this plan of care was provided to the resident or resident representative.

Confirmation was made by the Director of Nursing (DNS) on 6/24/19 at 1:45 PM, that the care plan did not address all the required aspects of care that are required in the regulation and that they did not document that a copy of or summary of the baseline care plan was given to the resident or their representative.

F 658 Services Provided Meet Professional Standards — F 658

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F 658 SS=D	Continued From page 4 CFR(s): 483.21(b)(3)(i)	F 658	F-658	7/24/19

§483.21(b)(3) Comprehensive Care Plans
The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-
(i) Meet professional standards of quality.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interview the facility failed to assure that services provided meet professional standards of quality regarding doumentation of a health event, for Resident #4. Findings include:

Per record review Resident #4 is very limited in speech due to cognition, and has a BIMS (a cognition assessment tool) of 3 indicating severe cognitive impairment. According to documentation the resident's speech was limited to 1-2 word statements. During the evaluation the resident was found to have a fractured right humerus.
According to a written statement on 6/6/19 by the LNA, on 5/28/19 at approximately 5 am, the resident complained of pain when a Licensed Nursing Assistant (LNA) lifted the Right Arm to assist in dressing. The LNA immediately stopped moving the arm and went to report the complaint of pain to the 11 pm-7am nurse (the Licensed Pratical Nurse [LPN] on duty) as it was not usual for that resident. The LPN's written statement indicates that on 5/28/19 the resident was evaluated and when asked about the presence of pain would simply say "my butt". The statement dated 6/4/19 indicates there was no bruising or discoloration in the Right shoulder/ arm. There was no grimacing or report of pain when the arm was "touched' according to the statement. An

Resident #4 no longer resides at the Center.
Other residents that have a health event could be affected by this alleged deficient practice.

Nursing staff will re-educated on the standard requirements of documentation of a potential health event to assure a complete and accurate medical record.
Audits by the CNE and or designee to ensure the documentation of health events are noted in the medical record, capturing a change in condition related to the health event.

The audits of changes in condition will be completed Weekly x4 and monthly x3.

Results of the audits will be reviewed at QAPI for further recommendations.

F658 POC accepted 7/30/19 MHiggins RN/PMC

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F 658	Continued From page 5	F 658		7/24/19

LNA statement by a Day Shift LNA states that on 5/28/19 s/he went to get Resident #4 out of bed. When the LNA was trying to put the resident's shirt on the resident complained of pain. The LNA stopped and immediately went to get the LPN assigned to that resident's corridor on the day shift. The day LPN wrote in a statement that at 7-7:30 am on 5/28/19 that the LNA had come to have the nurse check Resident #4. Upon checking the resident the LPN found that the resident's R shoulder was "lower" than the other shoulder. It was also swollen and cold to the touch. The resident repeated "hurt" and "my arm". The note also said, 'Spoke to the night nurse. No report of pain. Notified the NP {Nurse Practitioner} and RN {Registered Nurse} Both in to assess." The resident was sent to the ER (Emergency Room) at 8 am. The written statement by the RN on Day shift states that the LPN called her to assess the resident. The resident showed non-verbal signs of pain. The APRN (Advance Practice Registered Nurse) saw the resident, ice applied, the MD (Medical Doctor) notified.

In a review of the medical record for Resident#4 on 6/24-26/19 there are no progress notes by the facility LPN's or the facility RN regarding the events of the early morning hours of 5/28/19 when Resident # 4 complained of pain and was transferred to the ER. Upon transfer to the ER for evaluation the resident was found to have a fracture of her Right Humerus (long bone in the upper arm).

In an interview on 6/24/19 at 9:30 am the LPN from the day shift stated that there had been nothing during morning report that indicated there had been an issue with Resident#4. S/he stated that when the LNA reported at 7 am the complaint of pain when Resident #4 was being assisted

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F 658	Continued From page 6 s/he asked the 11 pm-7 am LPN if there was anything different during the night for Resident #4 and s/he responded no there wasn't. The day LPN also stated that s/he had not documented anything regarding the incidents described for Resident #4 on 5/28/19. On 6/25/19 at 8 am, via telephone interview the RN on the Day shift confirmed that s/he had not documented her assessment of the resident or any other information in the resident record for the incident on 5/28/19. In an interview on 6/26/19 at 7:05 am the 11 pm-7 am LPN stated that her description of the events in her statement were accurate but she did not find any issues so she didn't write a progress note or mention what happened in report. In an interview on 6/26/19 at 10:45 am the Director of Nurses (DNS) confirmed that it is expected that nursing staff would have documented that events regarding the event on 5/28/19 for Resident #4.	F 658		7/24/19
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. (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	F 842	F-842 Resident #4 no longer resides at the center. Residents having a change in medical condition could be at risk to have Inaccurate medical records. Nursing staff will be re-educated on the process to document a potential health event per protocol.	

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F 842	Continued From page 7 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. §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-	F 842	The CNE and or designee will audit the documentation weekly x 4 and then monthly x3 to ensure complete and accurate documentation. The results of the audits will be reviewed At QAPI for further recommendations. F842 POC accepted 7/30/19 MHiggins RN/PMC	7/24/19

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(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 on record review and interviews the facility failed to assure that the medical record for Resident #4 were complete and accurately documented. Findings include:

Per record review Resident #4 is very limited in speech due to cognition, and has a BIMS (a cognition assessment tool) of 3 indicating severe cognitive impairment. According to documentation the resident's speech was limited to 1-2 word statements.
According to a written statement on 6/6/19 by the LNA, on 5/28/19 at approximately 5 am, the resident complained of pain when a Licensed Nursing Assistant (LNA) lifted the Right Arm to assist in dressing. The LNA immediately stopped moving the arm and went to report the complaint of pain to the 11 pm-7am nurse (the Licensed Pratical Nurse [LPN] on duty) as it was not usual for that resident. The LPN's written statement indicates that on 5/28/19 the resident was evaluated and when asked about the presence of pain would simply say "my butt". The statement dated 6/4/19 indicates there was no bruising or discoloration in the Right shoulder/ arm. There was no grimacing or report of pain when the arm

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F 842	Continued From page 9	F 842		7/24/19

was "touched' according to the statement. An LNA statement by a Day Shift LNA states that on 5/28/19 s/he went to get Resident #4 out of bed. When the LNA was trying to put the resident's shirt on the resident complained of pain. The LNA stopped and immediately went to get the LPN assigned to that resident's corridor on the day shift. The day LPN wrote in a statement that at 7-7:30 am on 5/28/19 that the LNA had come to have the nurse check Resident #4. Upon checking the resident the LPN found that the resident's R shoulder was "lower" than the other shoulder. It was also swollen and cold to the touch. The resident repeated "hurt" and "my arm". The note also said, 'Spoke to the night nurse. No report of pain. Notified the NP {Nurse Practitioner} and RN {Registered Nurse} Both in to assess." The resident was sent to the ER (Emergency Room) at 8 am. The written statement by the RN on Day shift states that the LPN called her to assess the resident. The resident showed non-verbal signs of pain. The APRN (Advance Practice Registered Nurse) saw the resident, ice applied, the MD (Medical Doctor) notified.

In a review of the medical record for Resident#4 on 6/24-26/19 there are no progress notes by the facility LPN's or the facility RN regarding the events of the early morning hours of 5/28/19 when Resident # 4 complained of pain and was transferred to the ER. Upon transfer to the ER for evaluation the resident was found to have a fracture of her Right Humerus (long bone in the upper arm).

In an interview on 6/24/19 at 9:30 am the LPN from the day shift stated that there had been nothing during morning report that indicated there had been an issue with Resident#4. S/he stated that when the LNA reported at 7 am the complaint

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of pain when Resident #4 was being assisted s/he asked the 11 pm-7 am LPN if there was anything different during the night for Resident #4 and s/he responded no there wasn't. The day LPN also stated that s/he had not documented anything regarding the incidents described for Resident #4 on 5/28/19.

On 6/25/19 at 8 am, via telephone interview the RN on the Day shift confirmed that s/he had not documented her assessment of the resident or any other information in the resident record for the incident on 5/28/19.

In an interview on 6/26/19 at 7:05 am the 11 pm-7 am LPN stated that her description of the events in her statement were accurate but she did not find any issues so she didn't write a progress note or mention what happened in report.

In an interview on 6/26/19 at 10:45 am the Director of Nurses (DNS) confirmed that it is expected that nursing staff would have documented that events regarding the event on 5/28/19 for Resident #4.