



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

February 24, 2020

Mr. Ross Farnsworth, Administrator  
Burlington Health & Rehab  
300 Pearl Street  
Burlington, VT 05401-8531

Dear Mr. Farnsworth:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **January 29, 2020**. 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,

A handwritten signature in cursive script that reads "Pamela M. Cota RN".

Pamela M. Cota, RN  
Licensing Chief

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/14/2020  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  475014	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 01/29/2020
NAME OF PROVIDER OR SUPPLIER  BURLINGTON HEALTH & REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 300 PEARL STREET BURLINGTON, VT 05401		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS  An unannounced on-site investigation of 3 complaints was conducted on 01/29/20 by the Division of Licensing and Protection. The following regulatory violations were identified:		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.	2/26/20
F 609 SS=D	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 by:		F 609	Resident #1 was discharged from the Center.  Investigation completed and final summary report sent to DLP 2/20/20.  Other residents could be affected by this alleged deficient practice.  Staff will be re-educated on the reporting requirements of alleged abuse, neglect, exploitation, and/or mistreatment.  Staff knowledge of reporting will be audited by CNE and/or designee weekly x 4 and monthly x 3.  The results of the audits will be reviewed by the CED and will also be reviewed at QAPI for further recommendations.  CNE/CED will be responsible for overall compliance of the plan of correction.	

*F609 Poc accepted 2/24/20 mestrandrd/pme*

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

TITLE

(X6) DATE

*Ross Farnsworth*

*Center Executive Director*

*2/20/2020*

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 Based on record review and confirmed by staff interview the facility failed to report to the State Licensing Agency, within the required time frame, injuries of an unknown source for 1 applicable resident, (Resident #1). This citation is a repeat that was cited on 06/26/19. The findings include the following:  Per medical record review for Resident #1, nurses' notes and an interaction communication form completed by the Registered Nurse (RN) on 01/05/20 at 07:00 identify a change in condition with a large bruise noted over the right eye, right scalp, forehead, in the morning. The RN evaluated the resident and identified the injuries as an unobserved event/injury.  Per review of the RN documentation on the narrative event summary dated 01/05/20 at 7 AM, evidences ["a small purple area on the right side of scalp, late Saturday evening, 01/04/20. Today it is noted with a bruise above the right eye and scattered across his/her forehead and the bruise on his/her scalp is a lot larger in size"]. Circumstances of the event documented on the same narrative summary form evidences ["possibilities may include resident bumping his/her head against the Hoyer (mechanical lift), and possibly when Licenses Nurse Aides (LNA's) were turning him/her, they may have bumped his/her head against the wall".]  Per review of the nurses' notes dated 01/05/20 at 1500, the Licensed Practical Nurse (LPN) documents, ["continues with forehead bruising and starting to spread to eyes. Has a bump on the right side of his/her head"].  Per phone interview on 01/29/20 at approximately	F 609	2/26/20

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F 609	Continued From page 2  3:15 PM, confirmation was made by the RN that s/he did not make a report of injuries of unknown source to the licensing agency. S/he confirms that s/he has no understanding of how to make a report. S/he voiced that s/he reported the incident to the Director of Nurses (DNS). In-service documentation identifies that the RN has completed an in-service education at the facility on abuse reporting in July 2019.  Confirmation was made by the DNS on 01/29/20 at approximately 3:30 PM, that the injuries reported to him/her at the time of the notification were not described as documented. The facility did not suspect abuse, rather an unobserved event/injury.  The facility policy titled Abuse Prohibition identifies that injuries of unknown source are defined as an injury with both of the following conditions: 1) The source of the injury was not observed by any person or the source of the injury could not be explained by the resident and 2) the injury is suspicious because of the extent of the injury or the location of the injury or the number of injuries observed at one particular time. The Summary Report dated 01/05/20 confirms that both above conditions were met.  Per review of the Chief Medical Examiner's preliminary report identifies that Resident #1 died on 01/16/20 with an immediate cause of death being generalized medical deconditioning. Other significant conditions are identified as blunt impact of the head identified as scalp and facial contusions.	F 609			2/26/20
F 610	Investigate/Prevent/Correct Alleged Violation SS=D CFR(s): 483.12(c)(2)-(4)	F 610			



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F 610 Continued From page 3

§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:

§483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.

§483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.

§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 by:

Based on interview and record review the facility failed to complete a thorough investigation of injuries of an unknown source and report the result of the investigation to the State Licensing Agency for 1 applicable resident sampled, (Resident #1). The findings include the following:

Per medical record review both nurses notes and interaction communication form completed by the Registered Nurse (RN) on 01/05/20 at 07:00 identify a change in condition with a large bruise noted over right eye, right scalp, forehead, in the morning. The RN evaluated the resident and identified the injuries as an unobserved event/injury.

Per review of the RN documentation on the

F 610 Resident #1 was discharged from the Center.

Investigation completed and final summary report sent to DLP 2/20/20.

Other residents could be affected by this alleged deficient practice.

Staff will be re-educated on the Risk Management System and the expectation/importance of completing a thorough investigation on all alleged violations of abuse, neglect, exploitation, and mistreatment.

Staff knowledge of the need for a full investigation into alleged abuse will be audited by the CNE and or designee weekly x 4 and monthly x 3.

The results of the audits will be reviewed by the CED and reviewed by QAPI for further recommendations.

CNE/CED will be responsible for overall compliance of the plan of correction.

*F610 POC accepted 2/21/20 M. B. STRANDED HAWK*

2/26/20

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F 610	Continued From page 4  narrative event summary dated 01/05/20 at 7 AM, evidences ["a small purple area on the right side of scalp, late Saturday evening, 01/04/20. Today it is noted with a bruise above the right eye and scattered across his/her forehead and the bruise on his/her scalp is a lot larger in size"]. Circumstances of the event documented on the same narrative summary form evidences ["possibilities may include resident bumping his/her head against the Hoyer (mechanical lift), and possibly when Licenses Nurse Aides (LNA's) were turning him/her, they may have bumped his/her head against the wall".]  Per review of the nurses' notes dated 01/05/20 at 1500, the Licensed Practical Nurse (LPN) documents, ["continues with forehead bruising and starting to spread to eyes. Has a bump on the right side of his/her head"].  Confirmation was made by the Director of Nurses on 01/29/20 at approximately 3:30 PM that the investigation is not completed for the incident of unknown injuries that occurred to Resident #1 on 01/05/20. The summary of the event form identifies ongoing investigation and no report has been sent to the Licensing Agency as required.  Per review of facility policy titled Abuse Prohibition that includes Injuries of Unknown Source identifies the following: 7.4 Report allegations involving injuries of unknown source within 24 hours if the event does not result in serious bodily injury; 7.8 The investigation will be thoroughly documented in the Risk Management System (RMS). Ensure that documentation of witnessed interviews are included; 9.2 Report findings of all completed investigations within five (5) working days to the agency.	F 610		2/26/20	



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F 656 SS=D	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 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	F 656	F 656  Resident #1 was discharged from the Center.  Other residents could be affected by this alleged deficient practice.  Staff will be re-educated on the requirement to develop and implement a comprehensive, person-centered care plan for each resident. Staff will be re-educated on how to access the Kardex.  Alerts will be set on all changes made to care plans.  Staff knowledge of the need for the development and implementation of comprehensive, person-centered care plans will be audited by the CNE or designee weekly x 4 and monthly x 3.  CNE will be responsible for overall compliance with plan of correction.  <i>F656 POC accepted 2/21/20 M.Bertrand/RW/Pna</i>		2/26/20

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F 656 Continued From page 6

F 656

2/26/20

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 confirmed by staff interview the facility failed to ensure that the Resident Centered Comprehensive Care Plan was implemented for 1 of 3 sampled residents, (Resident #1).

This citation is a repeat that was cited on 10/24/18.

The findings include the following:

Per record review Resident #1 was admitted to the facility in May 2019 with diagnosis to include but not limited to Alzheimer's Disease, Pulmonary Embolism, Hypertension, Chronic Kidney Disease, Osteoarthritis and Chronic Pain. The resident began receiving Hospice Services (health care that focuses on the terminally ill resident) in October 2019.

Per record review a significant change Minimum Data Set (MDS) assessment was conducted on 10/04/19 (State mandated assessment). The assessment identified that the resident was an extensive assist with 2 staff members for care. The Resident centered-care plan initiated on 06/01/19 identifies that the resident requires assistance for Activities of Daily Living (ADL's) with 2 staff for bed mobility. The resident is incontinent of urine and requires incontinence care every 2-3 hours and s/he is identified to be resistive to care, can become combative at times. According to the Resident Assessment Instrument manual, bed mobility is defined as how the resident moves from lying position, turns side to side and positions body while in bed.



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F 656	Continued From page 7  Per interview with Employee #1 on 01/29/20 at approximately 1 PM, confirmation was made that during the overnight shift on 01/04/20 through 01/05/20, Resident #1 was provided incontinent care at 6 AM only. Employee #1 confirms that the resident doesn't drink much during the evening shift, therefore s/he is only incontinent once during the night shift. The employee stated ["all resident care plans are the same. Residents are checked and changed with one staff member during the overnight shift"]. Resident #1's care plan was provided to the employee evidencing the need for 2 staff members for bed mobility. The employee confirmed s/he was unaware of that need or that the resident was to be checked every 2-3 hours.  Confirmation was made by the Director of Nurses on 01/29/20 at approximately 3 PM that staff are expected to know the needs of the residents as identified on the care plan. Staff did not utilize two staff members for bed mobility nor did the staff provide incontinence care every 2-3 hours as directed.	F 656			2/26/20
F 842	Resident Records, - Identifiable Information SS=B 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.	F 842	F 842	Resident #1 was discharged from the Center.  Other residents could be affected by this alleged deficient practice.  Staff will be re-educated on the importance and requirement that documentation in a resident record must be complete, accurate, concise, and comprehensive.	2/26/20

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F 842	Continued From page 8 §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.  §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	F 842	F 842  Staff will be re-educated on how to properly identify and notify the resident responsible party following an incident, accident, or change in condition.  Staff knowledge of the need for accurate/timely documentation in resident records and the ability to identify/notify the resident contact will be audited by the CNE and/or designee weekly x 4 and monthly x 3.  The results of the audits will be reviewed by the CED and reviewed at QAPI for further recommendations.  CNE will be responsible for overall compliance with plan of correction.  <i>F842 POL accepted 2/21/20 MB-ethraud/pw/pna</i>	2/26/20	



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F 842	<p>Continued From page 9</p> <p>(iii) For a minor, 3 years after a resident reaches legal age under State law.</p> <p>§483.70(i)(5) The medical record must contain-</p> <ul style="list-style-type: none"> <li>(i) Sufficient information to identify the resident;</li> <li>(ii) A record of the resident's assessments;</li> <li>(iii) The comprehensive plan of care and services provided;</li> <li>(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;</li> <li>(v) Physician's, nurse's, and other licensed professional's progress notes; and</li> <li>(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.</li> </ul> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and confirmed by staff interview the nursing staff failed to ensure that 1 of 3 sampled resident's medical record had accurate documentation identifying the date and time of injuries of unknown origin and the timely notification to the appropriate resident representative of those injuries, (Resident #1). This citation is a repeat that was cited on 06/26/19.</p> <p>The findings include the following:</p> <ol style="list-style-type: none"> <li>1. Resident #1's record inaccurately documented notification of an emergency contact. Per record review Resident #1 was admitted to the facility in May 2019 with an identified Emergency Contact #1 Health Care Representative. The resident's Contact #2 who was recently admitted to another health care organization for long term care services and suffers with Alzheimer's Disease.</li> </ol> <p>Per review of nurses notes, documentation identifies that on 01/05/20 at approximately 07:00,</p>	F 842		2/26/20

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NAME OF PROVIDER OR SUPPLIER  BURLINGTON HEALTH & REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 300 PEARL STREET BURLINGTON, VT 05401	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
			(X5) COMPLETION DATE

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Resident #1 was identified with large bruise noted over right eye, right scalp, and forehead. Nurses' notes dated 01/05/20 at 7:15 AM identify the Contact #2 was notified of the findings.

Per phone interview on 01/29/20 at approximately 3:45 PM, confirmation was made by the Registered Nurse (RN) that s/he did not notify Contact #2. S/he had documented that the call had been made. However, later realized that the task was not completed and asked the Unit Manager to inform the appropriate contact. There is no evidence in the medical record identifying that the injuries of unknown origin were communicated to Contact #1 or #2 as requested by the RN.

2. Resident #1's record contains conflicting or inaccurate dates regarding the first appearance of an injury of unknown origin. Per review of the Risk Management System (RMS) Event Summary Report completed by the RN on 01/05/20 at 7 AM, identifies that Resident #1 had an unobserved event/injury/bruise. The narrative description on the RMS report, describes a small purple area on the right side of scalp late Saturday evening, 01/04/20. On 01/05/20 the RN identifies a bruise above the resident's right eye, scattered across his/her forehead and the scalp bruise is a lot larger in size.

Per review of the nurses notes, there is no evidence that identifies that the bruising on the right side of scalp was first identified on Saturday evening 01/04/20. Interview with Employee #1 on 01/29/20 at approximately 1 PM, confirms that he/she did not observe any bruising on the resident's head, right eye or forehead during personal care provided on 01/04-01/05/20 during

F 842

2/26/20



DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED  
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  475014	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 01/29/2020
NAME OF PROVIDER OR SUPPLIER  BURLINGTON HEALTH & REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 300 PEARL STREET BURLINGTON, VT 05401		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 842	Continued From page 11 the overnight shift.  Per phone interview with the RN on 01/29/20 at approximately 3:15 PM confirmation was made that s/he evaluated the resident on 01/05/20 at 7 AM and identified the injuries as an unobserved event/injury.  The above information was shared with the Director of Nurses on 01/29/20.	F 842			2/26/20