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

April 22, 2021

Mr. Shawn Hallisey, Administrator
Burlington Health & Rehab
300 Pearl Street
Burlington, VT 05401-8531

Dear Mr. Hallisey:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **March 30, 2021.** 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

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

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 03/30/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The Division of Licensing Protection conducted an unannounced onsite investigation of 5 complaints and 3 self-reported incidents 3/29-3/30/2021. The following regulatory violation was identified as a result of these investigations.	F 000	Burlington Health and Rehabilitation 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 solely because it is required by Federal and State applicable law.	4/5/21
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other	F 880	Resident's #1 & #3 remain in center. The oxygen tubing and tubing for the nebulizer machines have been changed, dated and signed off in the TAR for the residents listed above. Residents with oxygen/nebulizer tubing have the potential to be affected by this alleged deficient practice. All residents with oxygen/nebulizer tubing were audited on 3/30/21 for compliance with Policy and Procedure compliance. All Licensed Nurses and Licensed Nursing Assistants have been re-educated on the importance and need for proper care, labeling and storage of oxygen and nebulizer dellevery systems as well as the expected procedure. This was completed by 4/1/21 by the CNE and designee. A Root Cause Analysis was completed by designated team and results brought to QAPI for further review and recommendations. (Attached) CNE/Designee will complete random audits of oxygen and nebulizer tubing changes to ensure compliance. These audits will be completed weekly x4, then monthly x2. Results of the audits will be brought to the QAPI committee for review and recommendations as needed. F880 POC accepted 4/21/21 RTremblay, RN / PMC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Shawn T. Halley | TITLE: Administrator | (X5) DATE: 4/21/21

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.

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 03/30/2021

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 880	Continued From page 1 persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation and confirmed by staff interview, the facility failed to maintain an Infection Control Program that provides a safe,	F 880		

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 03/30/2021

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 880	Continued From page 2 sanitary, and comfortable environment regarding the handling of respiratory equipment for 2 of 9 residents (Residents #1, and #2). Finding include the following: 1. Per observation on 3/29/21 at 9:35am, Resident #1's oxygen tubing with nasal cannula was resting on the resident's bed, unprotected and/or covered. The oxygen tubing had a date of 3/2/21 attached, indicating this was the last time the tubing had been changed. Resident #1's nebulizer tubing was looped over the top of the nebulizer machine unprotected and uncovered, and there was no date indicating the last time the tubing had been changed. 2.Per observation on 3/29/21 at 9:55am, Resident #2's oxygen tubing with nasal cannula was hanging on a knob of the nightstand several inches from the floor unprotected and uncovered, and there was no date indicating the last time the tubing had been changed. Resident #2's nebulizer tubing was looped over the top of the nebulizer machine unprotected and uncovered, and there was no date indicating the last time the tubing had been changed. The Licensed Practical Nurse (LPN) confirmed that it wasn't sanitary for the tubing to be just placed anywhere convenient, it could easily fall onto the floor and that Infection Control Practices had not been followed. On 3/29/21 at approximately 1:30pm the Director of Nursing Services provided a copy of the facility policy for "Procedure: Oxygen: Nasal Cannula" and stated that was for all types of respiratory tubing. The policy indicates that tubing is to be changed every 7 days, dated, and stored in a treatment bag when not in use.	F 880		

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

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 03/30/2021

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

ROOT CAUSE ANALYSIS REPORT

smartsheet

ORGANIZATION	
FACILITY	BURLINGTON HEALTH AND REHAB – QUEEN CITY NURSING
DATE OF EVENT: 3/30/2021	DATE RCA COMPLETED: 4/2/2021

EVENT DETAILS	
EVENT DESCRIPTION	LIST RCA TEAM MEMBERS
DURING A COMPLAINT SURVEY VISIT IT WAS DISCOVERED THAT 2 RESIDENTS (ONE RECEIVING OXYGEN THERAPY AND ONE RECEIVING NEBULIZER TREATMENTS) HAD NOT HAD THEIR OXYGEN TUBING CHANGED PER POLICY. FURTHER INVESTIGATION REVEALED THAT ON 2 OCCASSIONS THE TREATMENT RECORD HAD BEEN SIGNED OFF BY NURSING STAFF THAT THE CHANGE HAD OCCURRED WHEN IT HAD NOT.	AMANDA NAGELL, RN, CNE SHANNON BAUGHMAN, LPN, ACNE DANIELLE MARDIGRAS, RN, NPE/IP SHELLIE STEVENS, RN, RDCS TEAM LEADER: AMANDA NAGELL, RN, CNE

BACKGROUND SUMMARY	
Answer these questions with a brief summary. Attach supporting documents, if available.	
Describe the event, and include any harm that resulted. Also identify the cause, if known	*Description:* TUBING ON OXYGEN DELIVERY SYSTEM AND NEBULIZER DELIVERY SYSTEM WAS NOT CHANGED PER POLICY AND WAS NOT STORED PER POLICY. NURSING SIGNED OFF THAT TASK WAS COMPLETED WHEN IT WAS NOT. NO HARM OCCURRED.

Was there any deviation from the expected sequence?	☐ YES X ☐ NO	*If YES, explain the deviation. TUBING IS TO BE CHANGED ONCE WEEKLY PER POLICY AND PLACED IN LABELED BAG POST USE*
If deviation occurred from the expected sequence, was it likely to have contributed to the adverse event?	☐ YES X ☐ NO ☐ UNKNOWN	*If YES, explain the contribution.* *THE CENTER HAD DETERMINED "TUBING TUESDAYS" HOWEVER THE STOCK ORDER IN THE Emar AUTOMATICALLY SET THE CHANGE DAY FOR SUNDAYS. SOME HAD BEEN TRANSCRIBED TO TUESDAYS WHILE OTHERS HAD NOT.*
Was the expected sequence described in policy, procedure, written guidelines, or included in staff training?	☐ YES X ☐ NO ☐ UNKNOWN	*If YES, explain the source.* *CENTER HAS POLICY AND PROCEDURE DESCRIBING EXPECTED SEQUENCE BUT NOT SPECIFIC DAY OF THE WEEK.*
Was there a human action or inaction that contributed to the adverse event?	☐ YES X ☐ NO ☐ UNKNOWN	*If YES, explain how the actions contributed.* *HUMAN ACTION: TWO SEPARATE NURSING STAFF SIGNED OFF ON THE TREATMENT RECORD THAT THEY COMPLETED THE CHANGING OF THE TUBING* *HUMAN INACTION: DID NOT COMPLETE THE TASK OF CHANGING THE TUBING PER ORDER*
Was there a defect, malfunction, misuse of, or absence of equipment that contributed to this event?	☐ YES ☐ NO X ☐ UNKNOWN	*If YES, describe the equipment and how it appeared to contribute.*

Did the procedure/activity involved in the event being carried out take place in the usual location?	☐ YES X ☐ NO ☐ UNKNOWN	*If NO, explain where and why a different location was utilized.*
Was the procedure/activity carried out by regular staff familiar with the consumer and activity?	☐ YES X ☐ NO ☐ UNKNOWN	*If NO, describe who carried out the activity and why regular staff were not involved.*
Did the involved staff have the correct credentials and skills to carry out the tasks expected of them?	☐ YES X ☐ NO ☐ UNKNOWN	*If NO, explain the perceived inadequacy.*
Was the staff trained to carry out their expected responsibilities?	☐ YES X ☐ NO ☐ UNKNOWN	*If NO, explain the perceived inadequacy.*
Were the staffing levels considered adequate at the time of the incident?	☐ YES X ☐ NO ☐ UNKNOWN	*If NO, explain why.*

Were there any additional staffing factors identified as responsible for or contributing to the adverse event?	☐ YES ☐ NO X ☐ UNKNOWN	*If YES, explain those factors.*
Was there any inaccurate or ambiguous information that contributed to or caused the adverse event?	☐ YES ☐ NO X ☐ UNKNOWN	*If YES, explain what information and how it contributed.*
Was there any lack of communication or incomplete communication that contributed to or caused the adverse event?	☐ YES X ☐ NO ☐ UNKNOWN	*If YES, explain who, what, and how it contributed.* *PREVIOUSLY DISCUSSED ORDER ENTRY ISSUE OF TWO DIFFERENT DAYS OF WEEK DESIGNATED AS SET DAYS*
Were there any environmental factors that contributed to or caused the adverse event?	☐ YES ☐ NO X ☐ UNKNOWN	*If YES, explain what factors and how they contributed.*
Were there any organizational or leadership factors contributing to or causing the adverse event?	☐ YES ☐ NO X ☐ UNKNOWN	*If YES, explain what factors and how they contributed.*

Were there any assessment or planning factors that contributed to or caused the adverse event?	☐ YES ☐ NO X ☐ UNKNOWN	*If YES, explain the factors and how they contributed.*

Were there any other factors that are considered relevant to the adverse event?	☐ YES ☐ NO X ☐ UNKNOWN	*Describe:*

Rank in order the factors considered responsible for the adverse event, beginning with the proximate cause, followed by the most important to less important contributory factors. Attach the Contributory Factors Diagram, if available.
1. STAFF SIGNED OFF ON TASK AS IF IT HAD BEEN COMPLETED
2. STAFF INACTION TO COMPLETE TASK PER POLICY
3. ORDER IN EMAR NOT DAY OF WEEK CENTER WAS USING

Was there a root cause identified?	☐ YES X ☐ NO ☐ UNKNOWN	*If YES, explain the root cause.* *LICENSED STAFF SIGNED OFF ON COMPLETION OF TASK BUT DID NOT COMPLETE TASK PER POLICY.*

RISK-REDUCTION ACTIONS TAKEN

List the actions that have already been taken to reduce the risk of a future occurrence. Note the date of implementation.

DATE	EXPLAIN ACTION TAKEN
3/30/21	WHOLE HOUSE AUDIT OF IND. WITH TUBING TO IDENTIFY THOSE AT RISK AND ENSURE POLICY FOLLOWED
3/30/21	LICENSED STAFF RE-EDUCATED ON POLICY AND PROCEDURE AND THE IMPORTANCE AND NEED FOR PROPER CARE, LABELING AND STORAGE OF OXYGEN AND NEBULIZER DELIVERY SYSTEMS
4/2/21	ALL ORDERS ON TARS CORRECTED TO STATE TUESDAYS AS DAY OF WEEK TO CHANGE

PREVENTION STRATEGIES

List the recommended actions planned to prevent a future occurrence of the adverse event. Begin with a rank of 1 (highest). Provide an estimated cost (if known) and any additional considerations/recommendations for implementing the strategy.

STRATEGY	ESTIMATED COST	SPECIAL CONSIDERATIONS
• SET DAY OF WEEK TO "TUBING TUESDAYS"	NONE	NONE
• WEEKLY AUDIT COMPLETED BY CNE/DESIGNEE TO ENSURE CONTINUED COMPLIANCE	NONE	NONE

INCIDENTAL FINDINGS

List and explain any incidental findings that should be carefully reviewed for corrective action.

NONE

APPROVAL

After review of this summary report, all team members should notify the team leader of either their approval or recommendations for revision. Following all revisions, the report should be signed by the team leader prior to submission.

TEAM LEADER SIGNATURE: *DATE SIGNED:*

SIGNATURE OF TEAM MEMBER:	DATE SIGNED:
ACNE: SHANNON BAUGMAN	
NPE/IP: DANIELLE MARDIGRAS	
REGIONAL CLINICAL: SHELLIE STEVENS	

All information included in this report is considered confidential. It is intended only to promote safety and reduce risk.

Forward completed report to all Root Cause Analysis team members in addition to the following individuals:

FULL NAME	TITLE/ORGANIZATION	EMAIL ADDRESS
SHAWN HALLISEY	CENTER EXECUTIVE DIRECTOR	EXECUTIVEDIR@QUEENCITYREHAB.COM

Genesis

PROCEDURE:
OXYGEN: NASAL CANNULA

These policies and procedures are not intended to replace the informed judgment and professional discretion of individual clinicians, nor are they intended to establish the standard of care applicable to the assessment or treatment of any particular condition and the unique needs of each patient.

1. Verify order.
2. Determine appropriate oxygen source and need for humidification by using the following table:

LPM	% O_2	Humidity Needed?	Oxygen Source
0.5	22	N	Concentrator, Liquid Oxygen, Compressed Gas
1	24	N	Concentrator, Liquid Oxygen, Compressed Gas
2	28	N	Concentrator, Liquid Oxygen, Compressed Gas
3	32	N	Concentrator, Liquid Oxygen, Compressed Gas
4	36	Y	Concentrator, Liquid Oxygen, Compressed Gas
5	40	Y	Concentrator, Liquid Oxygen, Compressed Gas
6	44	Y	10 Liter Concentrator, Liquid Oxygen, Compressed Gas
7	48	Y	10 Liter Concentrator, Liquid Oxygen, Compressed Gas
8	52	Y	10 Liter Concentrator, Liquid Oxygen, Compressed Gas

3. Gather supplies:
   - 3.1 Oxygen source per table above
   - 3.2 Nasal cannula labeled with date of initial set-up (high flow cannula if using a 10-liter concentrator)
   - 3.3 Flow meter, if applicable
   - 3.4 Nipple adapter if liter per minute less than four
   - 3.5 Humidifying device if liter flow ≥ four liters (high pressure humidifier if using 10-liter concentrator)
   - 3.6 Pre-filled humidifier
   - 3.7 Treatment bag
   - 3.8 "No Smoking – Oxygen In Use" sign
4. Introduce yourself to the patient and verify patient identification.

PROCEDURE:
OXYGEN: NASAL CANNULA

5. Explain the procedure and provide privacy.
6. Explain safety rules. Post "No Smoking – Oxygen In Use" sign on patient's door.
7. Cleanse hands.
8. Place oxygen source in room according to equipment specific policy.
9. Attach a nipple adapter to the oxygen outlet of the oxygen source.

   Note: Some concentrators come with a built-in adapter and only require an adapter if a humidifier is used.

10. If humidifier is used:
    - 10.1 Label with date;
    - 10.2 Attach humidifier directly to the oxygen outlet of the oxygen source;
    - 10.3 Test pop-off valve located on top of humidifier by occluding the cannula connection port until the valve releases.
11. Connect the cannula to the nipple adapter or humidifier and set the flow rate to the prescribed liter flow.
12. Place the cannula prongs into nose, observing the correct right-side-up position. Adjust the cannula over both ears and tighten to fit under the chin.
13. Monitor patient for skin irritation or breakdown.
14. Monitor patient's response to therapy:
    - 14.1 Respiratory rate,
    - 14.2 Heart rate,
    - 14.3 Breath sounds,
    - 14.4 Breathing pattern,
    - 14.5 Pulse oximetry,
    - 14.6 Color.
15. Cleanse hands.
16. Replace disposable set-up every seven days. Date and store in treatment bag when not in use.
17. Document:
    - 17.1 Date and time oxygen started;
    - 17.2 Method of administration;

PROCEDURE:

OXYGEN: NASAL CANNULA

17.3 Liter flow;

17.4 Patient's response to therapy;

17.5 Skin irritation or breakdown, if applicable;

17.6 Evaluation of heart rate, respiratory rate, pulse oximetry, skin color, and breath sounds post-treatment.

Refer to:

- *Oxygen: Concentrator procedure*
- *Oxygen: High Pressure Cylinders policy and procedure*
- *Oxygen: Liquid System procedure*