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

October 27, 2022

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

Dear Ms. Haupt:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **September 21 2022.** 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

Pamela MCotaRN

PRINTED: 10/04/202 FORM APPROVE OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION			(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MUL A. BUILDI			E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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IN/	AME OF	PROVIDER OR SUPPLIER			51	TREET ADDRESS, CITY, STATE, ZIP CODE	09/	21/2022	
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В	URLIN	GTON HEALTH & RE	HAB			URLINGTON, VT 05401			
	Y4VID	SHIMMADV STA	TEMENT OF DEFICIENCIES						
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I	E 000	conducted an emer during the annual re 9/21/2022. There w	ensing and Protection gency preparedness review ecertification survey on ere no regulatory violations	EO	00	Burlington Health and Rehabilitation provides this plan of correction with admitting or denying the validity of the alleged deficiencies. The plant is prepared and executed solely be required by federal and state law.	thout r existen of correc	ce of tion	
		1				F555			
1	F 000	identified. INITIAL COMMENTS An unannounced, on-site re-certification survey and staff vaccination requirement review was conducted by the Division of Licensing and Protection on 9/19/22 through 9/21/22. The following regulatory violations were identified: Right to Choose/Be Informed Attenda Physician F555 Resident chookers and deficient practice. A house wide paperwork was a proportion of the process and deficient practices. A house wide paperwork was a proportion of the process and deficient practices.			Resident chose to remain anonymore. Residents who are admitted to the the potential to be affected by the deficient practice. A house wide audit of residents ad paperwork was completed to ensure.	center h alleged missions	. Per control de contr		
; (SS=D	CFR(s): 483.10(d)(1)-(5) §483.10(d) Choice of Attending Physician. The resident has the right to choose his or her attending physician. §483.10(d)(1) The physician must be licensed to practice, and §483.10(d)(2) If the physician chosen by the resident refuses to or does not meet requirements specified in this part, the facility		PARTITION of CONTRACTABLE ASSESSMENT ASSESSM		resident was explained the attendi process and the right to have their the in-house Medical Director.	ng physic own PCF	or	
	Administration (Control of Control of Contro					The Admission Coordinator was re-educated of the admission paperwork and the discussion with the resident/responsible party upon admission in regards to this process and the residents right to have their own PCP.		on Romania	
	rage	may seek alternate specified in paragra section to assure pr adequate care and	physician participation as phs (d)(4) and (5) of this ovision of appropriate and treatment.			The Administrator or designee will random weekly audits X 4 on all accensure this process was completed and monthly X 2.	mission	s to	
ADO		§483.10(d)(3) The facility must ensure that each resident remains informed of the name, specialty, and way of contacting the physician and other primary care professionals responsible for his or her care.			ļ	The results of these audits will be the QAPI committee meeting for r determine if any further action is Date of compliance: 10/21/22	eview an	nd to	
700	MION	ALLA OK PROADE	SUPPLIER REPRESENTATIVE'S SIGN.	ATURE		TITLE	ív.	C) DATE	

Any deliciency stalement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other lards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the 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 hese documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
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PROVIDER OR SUPPLIER GTON HEALTH & RE	НАВ		STREET ADDRESS, CITY, STATE, ZIP CO 300 PEARL STREET BURLINGTON, VT 05401	ODE		
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§483.10(d)(4) The resident if the facil physician chosen I unwilling to meet repart and the facility participation to assand adequate care must discuss the aparticipation with tresident's preferent §483.10(d)(5) If the another attending requirements specimust honor that characteristic facility failed to all to choose his/her sinclude: During a confident 10:55 AM, a resident facility that s/h doctor while s/he i while crying, said here. I want my recan only have the During an interviee Admission Licenses/he didn't know reprovider and configive residents the provider.	facility must inform the ity determines that the by the resident is unable or equirements specified in this y seeks alternate physician sure provision of appropriate and treatment. The facility alternative physician he resident and honor the aces, if any, among options. The resident subsequently selects physician who meets the affied in this part, the facility noice. The is not met as evidenced at and staff interviews, the ow 1 of 31 sampled residents attending physician. Findings attending physician. Findings Things are hard enough being agular doctor, but I was told I nursing home's doctor." The ow on 9/20/22 at 12:45 PM, the sed Nurse Assistant stated that esidents could have their own irmed that the facility does not choice to choose their own		Tag F555 POC A on 10/27/2022 by P.Cota	-		
CFR(s): 483.20(k)	(1)-(3)					
	PROVIDER OR SUPPLIER SUMMARY ST. (EACH DEFICIENCE REGULATORY OR I Continued From provider include: Summary ST. (EACH DEFICIENCE REGULATORY OR I Continued From provider include: S483.10(d)(4) The resident if the facility participation to assume and adequate care must discuss the aparticipation with the resident's preferent system include: S483.10(d)(5) If the another attending requirements specimust honor that charmonic that charmonic include: During a confident to choose his/her include: During a confident to choose his/her include: During a confident to all to choose his/her include:	PROVIDER OR SUPPLIER GTON HEALTH & REHAB SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 1 §483.10(d)(4) The facility must inform the resident if the facility determines that the physician chosen by the resident is unable or unwilling to meet requirements specified in this part and the facility seeks alternate physician participation to assure provision of appropriate and adequate care and treatment. The facility must discuss the alternative physician participation with the resident and honor the resident's preferences, if any, among options. §483.10(d)(5) If the resident subsequently selects another attending physician who meets the requirements specified in this part, the facility must honor that choice. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews, the facility falled to allow 1 of 31 sampled residents to choose his/her attending physician. Findings include: During a confidential interview on 9/19/22 at 10:55 AM, a resident stated that s/he was told by the facility that s/he cannot have his/her own doctor while s/he is in the facility. The resident, while crying, said "things are hard enough being here. I want my regular doctor, but I was told I can only have the nursing home's doctor." During an interview on 9/20/22 at 12:45 PM, the Admission Licensed Nurse Assistant stated that s/he didn't know residents could have their own provider and confirmed that the facility does not give residents the choice to choose their own	PROMDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 1 \$483.10(d)(4) The facility must inform the resident if the facility determines that the physician chosen by the resident is unable or unwilling to meet requirements specified in this part and the facility seeks alternate physician participation to assure provision of appropriate and adequate care and treatment. 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During an interview on 9/20/22 at 12:45 PM, the Admission Licensed Nurse Assistant stated that s/he didn't know residents could have their own provider and confirmed that the facility does not give residents the choice to choose their own provider. PASARR Screening for MD & ID	PROVIDER OR SUPPLIER GTON HEALTH & REHAB SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 1 §483.10(d)(4) The facility must inform the resident if the facility determines that the physician chosen by the resident is unable or unwilling to meet requirements specified in this part and the facility seeks alternate physician participation with the resident and honor the resident's preferences, if any, among options. §483.10(d)(5) If the resident subsequently selects another attending physician who meets the requirements specified in this part, the facility must honor that choice. 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WING TOOL HEALTH & REHAB SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY) SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY) REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 1 \$483.10(d)(4) The facility must inform the resident if the facility seeks alternate physician participation to assure provision of appropriate and adequate care and treatment. The facility must discuss the alternative physician participation with the resident and honor the resident's preferences, if any, among options. \$483.10(d)(5) If the resident subsequently selects another attending physician who meets the requirements specified in this part, the facility must honor that choice. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews, the facility falled to allow 1 of 31 sampled residents to choose his/her attending physician. 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PRINTED: 10/04/202 FORM APPROVE OMB NO. 0938-039

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			OWR NO	. 0938-03	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	IPLE CONSTRUCTION	COV	(X3) DATE SURVEY COMPLETED	
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F 645	individuals with a r with intellectual dis \$483.20(k)(1) A nu on or after January with: (i) Mental disorder (i) of this section, u authority has deter independent physiperformed by a pe State mental healt (A) That, because condition of the ince the level of service facility; and (B) If the individual services, whether specialized service (ii) Intellectual disabilicant authority has deterned (A) That, because condition of the ince the level of service (A) That, because condition of the ince the level of service (B) If the individual services, whether specialized service \$483.20(k)(2) Exception—(i)The preadmission of the preadmission of th	nission Screening for mental disorder and individuals sability. rsing facility must not admit, 1, 1989, any new residents as defined in paragraph (k)(3) unless the State mental health mined, based on an cal and mental evaluation rson or entity other than the h authority, prior to admission, of the physical and mental dividual, the individual requires as provided by a nursing il requires such level of the individual requires		Resident #5 and #58 continue center and had their PASARR for accuracy. Residents who are admitted the require a mental disorder or it disability screening prior to accompletion of a PASARR are acalleged deficient practice. A house wide audit was completed accompleted accomplete accompleted accomplete accomplete accomplete accomplete accomplete accomplete accomplete. The Director of Social Services services staff have been reed proper completion of the PAS include answering all question form is complete. The Administrator or designed random weekly audits X 4 or ensure this process was compand monthly X 2. The results of these audits we the QAPI committee meeting determine if any further active Date of compliance: 10/2/2/2/2/2/2/2/2/2/2/2/2/2/2/2/2/2/2/2	to the center intellectual dmission throat risk for this pleted to enscurately. es and the social ducated on the SARR forms to ensure ee will condumall admission pleted as receivill be brough g for review a ion is require	and ough cial ne o the otto	

for determinations in the case of the readmission

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDI	TIPLE CONSTRUCTION NG	, ,	OATE SURVEY COMPLETED
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F 645	being admitted to transferred for car (ii) The State may preadmission screparagraph (k)(1) of to a nursing facilit (A) Who is admitted the hospital after received the hospital, (B) Who requires condition for which in the hospital, and (C) Whose attention is likely to require facility services. §483.20(k)(3) Definition of the individual intellectual disability and individual intellectual disability and individual intellectual disability and intellectual disability and intervised in the survey of the survey of a PASARR (a Screening for Individual for Individual intellectual disability prior to of a PASARR (a Screening for Individual for Individual intellectual disability failed to the survey of	the nursing facility, was re in a hospital. It choose not to apply the seening program under of this section to the admission try of an individual-led to the facility directly from a siving acute inpatient care at the individual received care and ling physician has certified, to the facility that the individual reset than 30 days of nursing facility that the individual reset than 30 days of nursing facility that the individual reset than 30 days of nursing facility that the individual reset than 30 days of nursing facility that the individual reset than 30 days of nursing finition. For purposes of this is considered to have a mental reset to the action of the second reset to have a mental reset to the second reset to have a mental reset to a second reset to have a mental reset to the second reset to have a mental reset to the second reset to have a mental reset to the second reset to have a mental reset to the second reset to have a mental reset to the second reset to have a mental reset to the second reset to have a mental reset to the second reset	The state of the s	45		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION NG	11.	(X3) DATE SURVEY COMPLETED	
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F 645	so that an individureceive care and setting appropriate include: 1. Facility failed to	completed prior to admission al identified with MD or ID services in the most integrated to their needs). Findings	F 64	45			
	Resident #5. Resident #5 was admitted to the facility on 2/15/18 with diagnoses including schizophrenia, major depressive disorder, and cerebral infarct (a type of stroke blocking blood vessels to the brain). Review of a record filed as "updated PASARR" signed 8/16/21 in resident #5's medical record revealed PASARR Part C Intellectual Disability or Related Condition was incomplete. This section contains 5 questions that must be answered. If response to any question in part C is a yes, a level II Developmental Disabilities PASARR is required. The following questions in part C were left without a response: Question 1- Does this individual have a diagnosis of intellectual/developmental disability? Question 2-Does this individual have a related condition (e.g. cerebral palsy, epilepsy, brain injury) resulting in significant impairment in intellectual functioning and adaptive behavior. The Director of Social Services was interviewed on 9/20/22 at approximately 2:00 PM and confirmed these questions should have been answered and that the form is incomplete.			Tag F645 POC Acce 0/27/2022 by S.St		ta	
	2. Per record reviet to the facility on 7 anxiety disorder, runspecified psych known physiologic	the form is incomplete. ew, Resident #58 was admitted /21/22 with diagnoses including major depressive disorder, osis not due to a substance or all condition, and cognitive			,		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
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	PASARR signed 7/ which further action nursing facility. Par PASARR is checke likely to require les and would therefore the remainder of the individual's stay ex admitting nursing h submit the form in PASARR indicates evidence that this i intellectual/develor condition, signaling Disabilities PASAR evidence in Reside PASARR Level I or completed after the submitted to the far Per interview on 9/ Director of Social S #58's 7/20/22 PAS not produce PASAI If follow ups to Res or documentation i not needed. Develop/Implement CFR(s): 483.21(b)(1) The implement a comp care plan for each resident rights set §483.10(c)(3), that	20/22 revealed two areas in was to be taken by the A of Resident #58's degree indicating that they are is than 30 days in the facility equalify for an exception for the screening, unless the ceeds 30 days, in which the some is to complete and full. Part C of resident #58's that there is presenting individual may have an immental disability or related in a Level II Developmental in the required. There was no ent #58's medical record that a reparamental that a reparamental in the record that the record that a reparamental in the record	F 64	Resident #5, #16, #54 and #59 coreside at the center and are having met. 1. Any resident who requires we intake monitoring due to dial potential to be affected by the deficient practice. A house wide audit was condestidents receiving dialysis the ensure weights and intake are monitored and documented care planned. Licensed nurses were educate completion, documentation and feeling of weights and intake for dial as care planned per NSG253 Hemodialysis (HD) - Communication Policy. The Director of Nursing or designed the process of the proc	eight and ysis have the e alleged ucted of eatment to e being consistently as ed on the and monitoring g ysis residents Dialysis: nication and designee will dits X4 and esidents to ake monitoring

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTERS FOR MEDICARE & MEDICAID SERVICES		& MEDICAID SERVICES				OMB NO. 0938-0		
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F 656	assessment. The or describe the following (i) The services that or maintain the resiphysical, mental, a required under §48 (ii) Any services that under §483.24, §48 provided due to the under §483.10, included treatment under §4 (iii) Any specialized rehabilitative service provide as a result recommendations. findings of the PAS rationale in the resident's represent (A) The resident's represent (A) The resident's godesired outcomes. (B) The resident's godesired outcomes. (B) The resident's godesired outcomes. (C) Discharge, For this purities, for this purities, for this purities, for this purities, as appropriat requirements set for section. This REQUIREME by: Based on observatinterview, and recommenders and recommenders.	tified in the comprehensive omprehensive care plan musting - trace to be furnished to attain dent's highest practicable and psychosocial well-being as 3.24, §483.25 or §483.40; and at would otherwise be required 3.25 or §483.40 but are not a resident's exercise of rights uding the right to refuse 83.10(c)(6). It services or specialized the set he nursing facility will of PASARR and the trace of the facility disagrees with the ARR, it must indicate its dent's medical record. With the resident and the trace of the facilities must document and the sessed and any referrals to be seed and any referral to the seed and	F 6	3.	Any residents who have dyshave the potential to be affer alleged deficient practice. A house wide audit was concresidents who have dysphagensure their care plans reflections and the region were educated on the developlans with the proper diets. The Director of Nursing or deconduct random weekly audit monthly X2 on residents with diets to ensure the care plans reflect the dietary orders. Any resident who has an acturisk for this alleged deficient. A house wide audit was conditioned and the care plan accurate "actual wound" in addition to be actual wound. It is also that the care plans to individually goals, and intervention. The Director of Nursing or deconduct random weekly audit.	ducted or gia diets to ct this. distered di oping of esignee voits X4 and hodysphales accurate ual woun practice. diucted of ounds to ely reflect of at risk ed on the ficate "act tions in posignee work and the signee work and	the f o ietician care vill d gia ely d is at ts for".	
	develop and/or imp	interview, and record review, the facility failed to develop and/or implement a comprehensive care plan for 4 of 31 sampled residents (Residents #5,			monthly X2 on residents with	new skir	1	

issues to ensure the care plans accurately

reflect the actual wound.

PRINTED: 10/04/202 FORM APPROVE OMB NO, 0938-039

> (X3) DATE SURVEY COMPLETED C 09/21/2022

> > (X5) COMPLETION DATE

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STATEMENT	RS FOR MEDICARE FOR DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		CONSTRUCTION	OMB (X3)
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F 656	reveals the resident facility on 5/6/22 wistage renal disease (difficulty swallowing focus "The resident [related to] renal facalculus [kidney sto [history] of hydrone urine accumulation swelling of kidneys the following intervoutput," and "Obtain Resident #54's care nutritionally at risk on HD [hemodialysthe following intervintakes," and "recolast weight docume record was on 6/1/2 evidence that intak monitored and record.	edical record for Resident #54 to was re-admitted to the sth diagnoses that include end (ESRD) and dysphagia eg). Resident #54's care plant needs dialysis (hemo) illure, [history] of renal one], absence of kidney, phrosis [a condition of excess in kidney(s) that causes []," updated 3/14/22, reveals entions: "monitor intake and n weight per protocol." e plan focus "Resident may be related to dysphagia, ESRD is]," updated 7/22/22, reveals entions: "record and monitor rd and monitor weights." The ented in the Resident #54's 2022 and there was no e and output was being		656	4. Any resident with the car for offloading of heels is alleged deficient practice. A house wide audit was coresidents who require offlowensure the care planned in place following the care planted of heels and ensuring the cointerventions are being followed. The Director of Nursing or conduct random weekly aumonthly X2 on residents we offloading to ensure the calinterventions are being followed. The results of these four audits to QAPI and reviewed for furth if required.	at risk for e. nducted pading of tervention. ed on of care pland lowed. designed udits X4 and the rho require pland lowed.

(LPN) and Licensed Nurse Aide (LNA) on 09/21/22 at 9:33 AM, the LPN stated that weights are done at the dialysis facility but could not find consistent documentation of weights from the dialysis facility. The LNA stated that they do not monitor Resident #54's intakes or outputs because it does not come up on the LNA assignment.

Per interview on 9/20/22 at 4:01 PM, the Assistant Director of Nursing could not find weights, intakes, or outputs for Resident #54 and plan intervention risk for this

ducted of ding of heels to rventions are in

d on offloading re planned wed.

esignee will its X4 and o require heel planned wed.

will be brought r interventions

Date of compliance: 10/24/22

Tag F656 POC Accepted on 10/27/2022 by S.Stem/P.Cota

STATEMENT OF I		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
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2. im wa dia de of Re K sw ph reg thi all ca an order or all "re who had not be the can	The facility failed paired swallow for a sadmitted to the agnoses including pressive disorder stroke blocking leader for a second review review review and consistency, so meals, single bit a consistency, so meals, single bit are plan was review a consistency of	d to develop a care plan for or Resident #5. Resident #5 facility on 2/15/18 with g schizophrenia, major or, and cerebral infarct (a type plood vessels to the brain). The plood vessels to the brain of the plood vessels that the pure texture, the plood vessels that and supervision with the plood vessels that the plant of the plood vessels that the plood vessels that the plant of the plood vessels that the plood vessels that the plant of the plood vessels that the plood ves		656				

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		resident has a sign (entry of materials portions of the resp for choking, and the care plan. 3. Facility failed to actual wound for Rewas admitted to the diagnoses including osteoarthritis, polyr lumbar region and a There is no care play #16's current wound Physicians order we paste every shift are buttock wound. A slidentified a pressur acquired, 4.1 cm x plan was reviewed problem for risk for mention of a current Director of Nursing and he/she confirm be on the care plan. 4. Facility failed to i regarding positionin #59 was admitted to diagnoses including cognitive communic weakness, and oste 10:55 AM the reside his/her bed on his/h supportive devices. were two signs. One	age Pathologist stated the ificant history of aspiration such as food or drink into biratory system), is at high risk is problem should be on the develop a care plan for an esident #16. Resident #16 facility on 2/8/22 with grajor depressive disorder, neuropathy, spinal stenosis general muscle weakness. In place to address resident d. Record review revealed a ritten 8/12/22 to apply Triad as needed to the left kin assessment on 9/8/22 to ulcer stage I, facility 3.0 cm (centimeter). The care and noted to contain a skin impairment but no at wound. The Assistant was interviewed on 9/20/22 to this actual problem should	F 6	56			

NAME OF PROVIDER OR SUPPLIER BURLINGTON HEALTH & REHAB STREET ADDRESS, CITY, STATE, ZIP CODE 300 PEARL STREET BURLINGTON, VT 05401 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLE	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475014	A. BUILDIN	G	co	C C C C C C C C C C C C C C C C C C C	
F656 Continued From page 10 indicating how the resident should be positioned. The turn clock indicated the resident should be positioned. The turn clock indicated the resident should he positioned on his/her left side between 10:00 AM and 12:00 PM. The second sign said keep heels floated using pillows, heels off of pillow every time (every time underlined) signed "therapy". At 11:00 AM the Unit Manager confirmed the resident should have both heels elevated. On 09/20/22 at 9:00 AM Resident #59 was found with both heels on bed, no extra pillow or heels up device in bed. The LPN confirmed the resident has his/her heels on the bed without the support device and was not familiar with the resident having or needing foam boots. A record review revealed an order from the Physician written 1/27/22; Ensure patients heels are floated OFF of the bed at all times and is wearing her foam protector boots (when not in wheelchair) every day and evening shift AMD as needed. The care plan was reviewed and noted to contain the problem: Potential for pressure ulcer development with interventions to include; off load heels for pressure reduction while in bed using heels up pillow, assist with turning and repositioning approximately every two hours and as needed. On 09/20/22 at approximately 10:00 AM the Unit Manager confirmed the care plan was not being followed as written. F 692 SS=D CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and enteral fluids). Based on a resident's			3		5/21/2022			
indicating how the resident should be positioned. The turn clock indicated the resident should he positioned on his/her left side between 10:00 AM and 12:00 PM. The second sign said keep heels floated using pillows, heels off of pillow every time (every time underlined) signed "therapy". At 11:00 AM the Unit Manager confirmed the resident should have been turned and should have both heels elevated. On 09/20/22 at 9:00 AM Resident #59 was found with both heels on bed, no extra pillow or heels up device in bed. The LPN confirmed the resident has his/her heels on the bed without the support device and was not familiar with the resident having or needing foam boots. A record review revealed an order from the Physician written 12/72/2: Ensure patient's heels are floated OFF of the bed at all times and is wearing her foam protector boots (when not in wheelchair) every day and evening shift AND as needed. The care plan was reviewed and noted to contain the problem: Potential for pressure ulcer development with interventions to include; off load heels for pressure reduction while in bed using heels up pillow, assist with turning and repositioning approximately every two hours and as needed. On 09/20/22 at approximately 10:00 AM the Unit Manager confirmed the care plan was not being followed as written. F 692. Nutrition/Hydration Status Maintenance CFR(s): 483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and enteral fluids). Based on a resident's	PREF	X (EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A	HOULD BE	(X5) COMPLETION DATE	
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		92 Nutrition/Hydration CFR(s): 483.25(g) §483.25(g) Assis (Includes naso-go both percutaneous percutaneous en enteral fluids).	ted nutrition and hydration. astric and gastrostomy tubes, us endoscopic gastrostomy and doscopic jejunostomy, and ased on a resident's	F 69	92			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED C 475014 B. WING 09/21/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **300 PEARL STREET BURLINGTON HEALTH & REHAB BURLINGTON, VT 05401** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) F 692 Continued From page 11 F 692 F692 ensure that a resident-Resident #10 continues to reside at the facility §483.25(g)(1) Maintains acceptable parameters and has had the fluid restriction order of nutritional status, such as usual body weight or desirable body weight range and electrolyte discontinued. Residents who require fluid balance, unless the resident's clinical condition restrictions are at risk for this alleged deficient demonstrates that this is not possible or resident practice. preferences indicate otherwise; A house wide audit was conducted on residents §483.25(g)(2) Is offered sufficient fluid intake to who require fluid restrictions to ensure they are maintain proper hydration and health; not given fluids exceeding the restrictions. §483.25(g)(3) Is offered a therapeutic diet when Licensed staff were educated on following the there is a nutritional problem and the health care provider orders a therapeutic diet. care plan of residents on fluid restrictions. This REQUIREMENT is not met as evidenced bv: The Director of Nursing or designee will conduct ct Based on observations, interviews, and record random weekly audits X4 and monthly X2 on review, the facility failed to ensure that one residents who require fluid restrictions to applicable resident was offered sufficient fluid intake to maintain proper hydration and health. ensure the care plans are being followed. Findings include: The results of these audits will be brought to Facility failed to maintain proper hydration for QAPI and reviewed for further interventions if Resident #10. Review of Resident #10's medical required. record reveals the resident was admitted to the facility on 4/30/21 with diagnoses that included chronic systolic (congestive) heart failure. A fluid Date of compliance: 10/21/22 restriction was ordered (a fluid restriction is used to avoid overloading the heart in persons with heart failure). The physicians order dated 5/3/21 stated: Fluid restriction 1500 cc: Dietary 960cc, 7-3 shift 220cc, 3-11 shift 220cc, 11-7 shift

Tag F 692 POC Accepted on 10/27/2022 by S.Stem/P.Cota

100cc. Resident #10's care plan contained the same breakdown of allotted amounts of fluids per

shift. On 09/19/22 a LNA (Licensed Nursing Assistant) was observed providing Resident #10

a cup of ice, when asked about the fluid

		T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	SS=G	restriction, the LNA restriction. Review of the recorfor the past between the allotted amount times during the day evening shift, and enight shift. During an interview conducted 9/20/22 he/she confirmed the given fluids in excess and that the care plan Management CFR(s): 483.25(k) §483.25(k) Pain Mar The facility must ensprovided to resident consistent with professor plan, and the repreferences. This REQUIREMEN by: Based on interview facility failed to ensuadministered per physampled residents (finclude: Per record review, For the facility on 9/12	denied awareness of a d of fluids provided by shift n 09/01/22-09/20/22 reveals of fluids was exceeded nine y shift, ten times during the ighteen times during the with the Unit Manager at approximately 1:00 PM, he resident should not be ss of the ordered amounts an was not being followed. nagement. sure that pain management is s who require such services, essional standards of ehensive person-centered esidents' goals and IT is not met as evidenced and record review, the ure pain medication was ysician order for 1 of 31 Resident #368 was admitted 2/22 for pain management	F6		Resident #368 no longer resides at Any resident admitted and received medication is at risk for this alleged practice. A house wide pain assessment was on current residents to ensure pair managed and medication was admordered. Nurses were educated on the phair protocol for ordering and obtaining for newly admitted residents, inclusively admitted residents, inclusively admitted on pain management in the Director of Nursing or designer random weekly audits X4 and mor residents who are admitted to ensure received their pain medication as of the results of these audits will be I QAPI and reviewed for further interequired. Date of compliance: 10/21/22	ing pain ed deficients conduction is being ninistered remacy g medical ding the tes were the resident will conduct they cordered.	nt ted d as tions STAT ents. nduct
		to the facility on 9/12/22 for pain management and therapy following back surgery. Resident #368 had an order for "HYDROmorphone HCI Tablet 2 MG Give 1 tablet by mouth every 3 hours as needed for Pain -Start Date-			manuscher verze Verserper	Tag F697 POC Approved 10/27/2022 by S.Stem/P.O		

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OMB NO. 0938-039 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED A. BUILDING С 475014 B. WING_ 00/24/2022

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NAME OF	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE	
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			BURLINGTON, VT 05401	
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	Continued From page 13 09/12/2022" [Dilaudid, used to treat severe pain]. Per interview on 09/19/22 at 01:09 PM, Resident #368 stated that s/he didn't have his/her pain medication for almost 15 hours after admission. S/he said s/he was admitted to the facility around 5 PM in the evening and his/her pain was okay at first but became increasingly worse after arrival. S/he informed the nurse repeatedly of his/her pain. S/he was finally offered Tylenol and Robaxin [methocarbamol; a muscle relaxant] around 2:00 AM which didn't help manage the pain completely. S/he stated the nurse told her/him that the Dilaudid wasn't available because the pharmacy was closed, and the day shift would have to work on getting it. S/he reemphasized that it was the worst pain s/he had felt since surgery, s/he constantly asked for pain medication, and didn't get any relief until the following morning around 8:00 AM when s/he received her first dose of Dilaudid since being admitted to the facility. Per review of Resident #368's Medication Administration Record, Hydromorphone was not administered until 7:50 AM on 09/13/2022. Per interview on 9/20/22 at 11:05 AM, the Director of Nursing stated that Resident #368's Dilaudid was not available because the pharmacy did not have the faxed physician's orders. A faxed order is required to gain access to the CubeX [medication dispenser holding emergency medications], which is where the nurse would get the Dilaudid from at that time.	F 6		

Per interview on 9/20/22 at 2:16 PM, the Admission's Licensed Nurse Aide (ALNA)

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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	CENTE	RS FOR MEDICAR	E & MEDICAID SERVICES			0	FORM APPRO MB NO. 0938-
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BURLINGTON HEALTH & REHAB (X4) ID SUMMARY STATEMENT OF DEFICIENCIES			STREET ADDRESS, CITY, STATE, ZIP CODE 300 PEARL STREET BURLINGTON, VT 05401				
PREFIX TAG F 697	confirmed that Resident #368's order for Dilaudid was not faxed to the pharmacy until the following morning and it was the responsibility of the nurse that admitted Resident #368 to fax the order to the pharmacy on admission. S/he later revealed the order was faxed to the pharmacy at 7:30 AM on 9/13/22. Dialysis			397	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIATE F698 Resident #54 continues to reside a	BE COMPLE	
F 698 SS=D				698	practice.	eir needs met. It who receives dialysis has the I be affected by the alleged deficient	
		§483.25(I) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by:				A house wide audit was conducted receiving dialysis treatment to ensistandards for professional commu being adhered to utilizing the dialy communication process. Licensed nurses were educated or documentation and monitoring of	sure the nication is ysis n the review of
	a managaran	Based on interview and record review, the facility failed to ensure residents who require dialysis receive services, consistent with professional standards of practice, and the comprehensive, person-centered care plan for one of 31 residents (Resident #54). Findings include:				residents as care planned per NSG261 Dialy Hemodialysis (HD) Provided by a Certified Dialysis Facility" to ensure ongoing communication and collaboration with the certified dialysis facility.	
		Review of the medical record for Resident #54 reveals the resident was re-admitted to the facility on 5/6/22 with diagnoses that include end stage renal disease, anemia in chronic kidney disease, unspecified hydronephrosis, acquired absence of kidney, and dependence on renal dialysis. Per review of Resident #54's care plan, the resident is scheduled for dialysis treatments on Tuesdays, Thursdays, and Saturdays. Facility policy titled "NSG261 Dialysis: Hemodialysis (HD) Provided by a Certified				The Director of Nursing or designeer random weekly audits X4 and mont dialysis residents to ensure the combooks are being utilized and complet the center and the dialysis facility put he results of these audits will be but QAPI and reviewed for further interrequired.	hly X2 on all amunication eted by both er policy.
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Dialysis Facility," re "Patients who requi consistent with prof practice Profession include: Ongoing collaboration with the regarding HD care and from the dialysis center is kept in a band from the dialysis facility which includes president receiving of the treatment. The documentation between the nursing center is facility for the above portion of the communication of the communication to the treatment of the communication of the communication of the communication of the communication beauthere, the nurse is seacility to get the infinite had not been done of the communication bind from his/her dialysis acknowledge their resident comediant comes backnowledge their resident comediant comes backnowledge their resident comediant communication binder commun	evised on 6/1/21, states are HD services receive care dessional standards of conal standards of practice of communication and the certified dialysis facility and services." 1/20/22 at 3:30 PM, a Licensed N) stated that communication is facility and the nursing binder. The binder travels to its facility with the resident. It is to return documentation and post weights for the lialysis and any concerns with LPN could not find the veen the dialysis facility and for Resident #54's past four 1/2, 9/15/22, 9/17/22, and 1/2,		Tag F698 PO		1	
	SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE Continued From pa Dialysis Facility," re "Patients who requi consistent with prof practice Professic include: Ongoing collaboration with the regarding HD care Per interview on 09 Practical Nurse (LP between the dialysis center is kept in a b and from the dialysis center is kept in a b and from the dialysis center is kept in a b and from the dialysis resident receiving d the treatment. The documentation betw the nursing center of appointments (9/13 9/20/22). This LPN by nursing center st facility for the above portion of the comm The LPN stated that look at the commun resident comes bac there, the nurse is s facility to get the inf this had not been do Per interview on 9/2 Assistant Director or center staff are to re communication bind from his/her dialysis acknowledge their re	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 15 Dialysis Facility," revised on 6/1/21, states "Patients who require HD services receive care consistent with professional standards of practice Professional standards of practice include: Ongoing communication and collaboration with the certified dialysis facility regarding HD care and services."	A BUILD A TOTOLOR OR SUPPLIER NOTON HEALTH & REHAB SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 15 Dialysis Facility," revised on 6/1/21, states "Patients who require HD services receive care consistent with professional standards of practice include: Ongoing communication and collaboration with the certified dialysis facility regarding HD care and services." Per interview on 09/20/22 at 3:30 PM, a Licensed Practical Nurse (LPN) stated that communication between the dialysis facility and the nursing center is kept in a binder. The binder travels to and from the dialysis facility with the resident. The dialysis facility is to return documentation which includes pre and post weights for the resident receiving dialysis and any concerns with the treatment. The LPN could not find documentation between the dialysis facility and the nursing center for Resident #54's past four appointments (9/13, 9/15/22, 9/17/22, and 9/20/22). This LPN discovered sheets filled out by nursing center staff to send to the dialysis facility portion of the communication sheet was blank. The LPN stated that the nurse is supposed to look at the communication sheet every time the resident comes back from dialysis and if it is not there, the nurse is supposed to call the dialysis facility to get the information. S/he stated that this had not been done for the above dates. Per interview on 9/20/22 at 4:01 PM, the Assistant Director of Nursing stated that nursing center staff are to review the dialysis communication binder when a resident returns from his/her dialysis appointment and acknowledge their review by signing the bottom	A BUILDING 475014 A BUILDING B. WING STREET ADDRESS, CITY, STATE 300 PEARL STREET BURLINGTON, VT 05401 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) COntinued From page 15 Dialysis Facility," revised on 6/1/21, states "Patients who require HD services receive care consistent with professional standards of practice include: Ongoing communication and collaboration with the certified dialysis facility regarding HD care and services." Per interview on 09/20/22 at 3:30 PM, a Licensed Practical Nurse (LPN) stated that communication between the dialysis facility with the resident. The dialysis facility with the resident. The dialysis facility with the resident. The dialysis facility with the resident receiving dialysis and any concerns with the treatment. The LPN could not find documentation between the dialysis facility and the nursing center staff to send to the dialysis facility portion of the communication sheet was blank. 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Per interview on 9/20/22 at 4:01 PM, the Assistant Director of Nursing stated that nursing center staff are to review the dialysis communication binder when a resident returns from his/her dialysis appointment and acknowledge their review by signing the bottom	IDENTIFICATION NUMBER: 475014 A BUILDING STREET ADDRESS, CITY, STATE, ZIP CODE 300 PEARL STREET BURLINGTON, VT 05401 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 15 Dialysis Facility," revised on 6/1/21, states "Patients who require HD services receive care consistent with professional standards of practice Professional standards of practice Professional standards of practice Professional standards of practice. Professional standards of practice include: Ongoing communication and collaboration with the certified dialysis facility regarding HD care and services." 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F 758 SS=D	dialysis facility, the dialysis facility of the enter a nursing not dialysis office was this process was not past four appointm professional standa outlined in the facil Free from Unnec FCFR(s): 483.45(c)(S483	is not completed by the nursing staff would notify the he missing information and e into the record that the notified. S/he confirmed that of followed for Resident #54's ents and did not meet the ards of communication as ity policy. Sychotropic Meds/PRN Use (3)(e)(1)-(5) Itropic Drugs. Ychotropic drug is any drug ctivities associated with and behavior. These drugs is limited to, drugs in the set of the	F 69	Resident #28 and #90's PRN discontinued. Residents who are prescribed medications are at risk for the practice.	met. psychotropics were d PRN psychotropic dis alleged deficient ducted of residents medications to duce or a resident's medical repic medications dumented rationale dent's chart. signee will conduct monthly X2 on all PRN psychotropic day stop or the al. Il be brought to r interventions if
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	OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STAT 300 PEARL STREET BURLINGTON, VT 05401	E, ZIP CODE	9/21/2022	
(X4) I PREF TAG	IX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE	
F 7	§483.45(e)(3) Resi psychotropic drugs unless that medica diagnosed specific in the clinical reconsultation of the clinical r	dents do not receive pursuant to a PRN order tion is necessary to treat a condition that is documented d; and orders for psychotropic drugs tys. Except as provided in the attending physician or the believes that it is PRN order to be extended the or she should document their dent's medical record and the for the PRN order. orders for anti-psychotic the days and cannot be attending physician or the exaluates the resident for the of that medication. In is not met as evidenced rview and record review, the ture that PRN (as needed) the provider believes that the PRN order to be defined and the resident's medical tated duration for the PRN pled residents (Resident #28	F7	758			

AND PLAN OF CORRECTION IDE		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			ATE SURVEY MPLETED
	PROVIDER OR SUPPLIER GTON HEALTH & RE	475014 HAB	B. WING_	STREET ADDRESS, CITY, STATE, ZIF	CODE	9/21/2022
				BURLINGTON, VT 05401		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIC DATE
The second secon	Per record review, dated 8/3/2022 for 2mg/ml, give .25ml needed for restless listed as indefinite. Review form dated Hospice as rational of a stop date. Confirmation per in Director of Nursing 4:00 pm, that the at provide an end date Lorazepam as requived an end date Lorazepam as requived and Anxiety. Per record review, the dated 9/7/2022 for give 1 tablet by mouth for Anxiety, only to a trimming toenails are date listed as indefinity. Confirmation per int Director of Nursing 6 10:30am, that the at provide an end date	there is a physician order "Lorazepam Concentrate by mouth every 4 hours as , agitation," with the end date In the Medication Regiment 8/24/2022 the physician listed e but did not address the lack terview with the Assistant on 9/20/22 at approximately tending physician did not e for the PRN order of ired by Federal Regulation. w, Resident #90 has de but are not limited to with Behavioral Disturbances here is a physician order Lorazepam Tablet 0.5mg, oth every 24 hours as needed be administered when and is anxious," with the end	F 75	Tag F758 POC Appr by S.Stem/P.Cota	oved on 10/2	7/2022