

**AGENCY OF HUMAN SERVICES** 

## DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection HC 2 South, 280 State Drive Waterbury, VT 05671-2060 http://www.dail.vermont.gov Survey and Certification Voice/TTY (802) 241-0480 Survey and Certification Fax (802) 241-0343 Survey and Certification Reporting Line: (888) 700-5330 To Report Adult Abuse: (800) 564-1612

December 13, 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 November 15, 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,

Jamela Mcota RN

Pamela M. Cota, RN Licensing Chief

|  |   | MEDICAID SERVICES   |                     |   |                 |  |
|--|---|---|---------------------|---|-----------------|--|
|  |   |   |                     | OMB NO. 0938-0391   |                 |  |
| STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         AMP-PLAN OF CORRECTION       IDENTIFICATION NUMBER:         I       IDENTIFICATION NUMBER: |   | (X2) MULTIPLE CONSTRUCTION A. BUILDING  |                     | (X3) DATE SURVEY<br>COMPLETED   |                 |  |
|  | 475014  |   | B. WING             |   | C<br>11/15/2022 |  |
| NAME OF PI   | ROVIDER OR SUPPLIER   |   | s                   | TREET ADDRESS, CITY, STATE, ZIP CODE  |                 |  |
|  |   |   | 3                   | 00 PEARL STREET   |                 |  |
| BURLING  | TON HEALTH & REHAB  |   | E                   | URLINGTON, VT 05401   |                 |  |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>.SC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | BE COMPLETION   |  |
| 10   |   |   |                     | The filing of this plan of correctio  | n does          |  |
| F 000  | INITIAL COMMENTS  |   | F 000               | not constitute an admission of th   | e l             |  |
|  |   |   |                     | allegations set forth in the statem   | ient of         |  |
|  | The Division of Licen   | sing and Protection   |                     | deficiencies. The plan of correcti  |                 |  |
|  |   | ced onsite investigations of  |                     | prepared and executed as eviden   |                 |  |
|  | 3 complaints on 11/16   | •   |                     |   |                 |  |
|  | regulatory violation wa   |   |                     | the facility's continued compliance   | e with          |  |
| F 842<br>SS=D  | Resident Records - Identifiable Information   |   |                     | applicable law.   |                 |  |
|  |   |   |                     | F 842   |                 |  |
|  | §483.20(f)(5) Resider   | nt-identifiable information.  |                     |   |                 |  |
|  |   | elease information that is  |                     | Resident #1 had no untoward effe  | cts             |  |
|  | resident-identifiable to the public.  |   |                     | related to documentation discrepar  |                 |  |
|  |   | lease information that is   |                     |   |                 |  |
|  | resident-identifiable to  |   |                     | All residents that require supervisi  | on              |  |
| 1  |   | ntract under which the agent  |                     | with meals have the potential to b  | e               |  |
| (  | agrees not to use or disclose the information<br>except to the extent the facility itself is permitted<br>to do so. |   |                     |   |                 |  |
|  |   |   |                     | affected by the alleged deficient practice.   |                 |  |
|  | §483.70(i) Medical re   | cords.  |                     | An audit of all residents that requi  | re              |  |
|  | §483.70(i)(1) In accordance with accepted professional standards and practices, the facility                        |   |                     | cted.   |                 |  |
|  |   | al records on each resident   |                     | LNA staff were educated on  |                 |  |
|  | that are-   |   |                     | documentation for residents that  |                 |  |
|  | (i) Complete;   |   |                     |   |                 |  |
|  | (ii) Accurately docum   |   |                     | require supervision with meals.   |                 |  |
|  | (iii) Readily accessible  |   |                     | Random audits of residents will oc  | cur             |  |
|  | (iv) Systematically or  | ganized   |                     |   |                 |  |
|  | 8/83 70(i)/2) The feet  | ility must keep confidential  |                     | weekly times 4, then monthly time   |                 |  |
|  |   | ned in the resident's records,  |                     | until substantial compliance has be   |                 |  |
|  |   | or storage method of the  |                     | achieved. Results will be reported  | to              |  |
|  | records, except when  | -   |                     | QAPI  |                 |  |
|  | (i) To the individual, o  |   |                     | Dimention of municipal to the state   |                 |  |
|  | representative where permitted by applicable law;<br>(ii) Required by Law;  |   |                     | Director of nursing is responsible to<br>ensure accuracy of LNA documentation                                   |                 |  |
|  |   |   |                     |   |                 |  |
|  | (iii) For treatment, pay  |   |                     | Data of compliances Described of  |                 |  |
|  |   | ted by and in compliance  |                     | Date of compliance: December 16   | ',              |  |
|  | with 45 CFR 164.506   | -<br>7  |                     | 2022  |                 |  |
| LABORATORY   | DIRECTOR'S OR PROVIDER  | SUPPLIER REPRESENTATIVE'S SIGNATUR  | RE                  | TITLE   | (X6) DATE       |  |
| ll   | 11 16 AL AL   | mushatre  |                     |   | 5/22            |  |

U iciency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that AL. 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.

DEDADTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 12/01/2022

|                           |   | D HUMAN SERVICES   |  |  | F           | ORM APPROVED                       |  |
|---------------------------|---|--|--|--|-------------|------------------------------------|--|
| CENTER                    | S FOR MEDICARE & I  | MEDICAID SERVICES  |  |  | OME         | <u>3 NO. 0938-0391</u>             |  |
| STATEMENT OF DEFICIENCIES |   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | (X2) MULTIPLE CONSTRUCTION A. BUILDING |  |             | (X3) DATE SURVEY<br>COMPLETED<br>C |  |
| 475014                    |   | 475014   | B. WING                                |  |             | 11/15/2022                         |  |
| NAME OF PF                | OVIDER OR SUPPLIER  |  |  | STREET ADDRESS, CITY, STATE, ZIP COD   | E           |                                    |  |
| BURLING                   | ON HEALTH & REHAB   | -  |  | 300 PEARL STREET   |             |                                    |  |
|                           |   |  |  | BURLINGTON, VT 05401   |             |                                    |  |
| (X4) ID<br>PREFIX<br>TAG  | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)  |  | ID<br>PREFIX<br>TAG                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |             | (X5)<br>COMPLETION<br>DATE         |  |
| F 842                     | Continued From page<br>(iv) For public health a<br>neglect, or domestic v<br>activities, judicial and<br>law enforcement purp<br>purposes, research p<br>medical examiners, fu<br>a serious threat to hea<br>by and in compliance<br>§483.70(i)(3) The fact<br>record information ag<br>unauthorized use.<br>§483.70(i)(4) Medical<br>for-<br>(i) The period of time<br>(ii) Five years from th<br>there is no requireme<br>(iii) For a minor, 3 yea<br>legal age under State<br>§483.70(i)(5) The me<br>(i) Sufficient informati<br>(ii) A record of the res<br>(iii) The comprehensi<br>provided;<br>(iv) The results of any<br>and resident review e<br>determinations condu<br>(v) Physician's, nurse<br>professional's progres<br>(vi) Laboratory, radiol<br>services reports as re<br>This REQUIREMENT<br>by: | e 1<br>activities, reporting of abuse,<br>violence, health oversight<br>administrative proceedings,<br>ooses, organ donation<br>urposes, or to coroners,<br>ineral directors, and to avert<br>alth or safety as permitted<br>with 45 CFR 164.512.<br>lity must safeguard medical<br>ainst loss, destruction, or<br>records must be retained<br>required by State law; or<br>e date of discharge when<br>nt in State law; or<br>ars after a resident reaches<br>law.<br>dical record must contain-<br>on to identify the resident;<br>ident's assessments;<br>ve plan of care and services<br>v preadmission screening<br>valuations and<br>icted by the State;<br>'s, and other licensed<br>as notes; and<br>ogy and other diagnostic<br>equired under §483.50.<br>is not met as evidenced | F 8                                    |  | on 12/13/20 | 22<br>***                          |  |
|                           | facility failed to maint<br>applicable resident (F  | iew and record review, the<br>ain medical records on one<br>Resident # 1) that are<br>tely documented. Findings  |  |  |             | ~                                  |  |

FORM CMS-2567(02-99) Previous Versions Obsolete

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Facility ID: 475014

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| CENTERS FOR MEDICARE & MEDICARE SEMEVICES     OMB INO. 0938-031       APM-RLAY OF CORRECTION     (M1) PROVIDER/OR PURPICE/CLA     (20) MULTIPLE CONSTRUCTION       APM-RLAY OF CORRECTION     475914     BUILING       INALE OF PROVIDER OR SUPPLIER     300 PEARL STREET     BUILING       BURLINGTON HEALTH & REHAB     STREET ADDRESA, GITY, STATE, ZP CODE     300 PEARL STREET       BURLINGTON HEALTH & REHAB     STREET ADDRESA, GITY, STATE, ZP CODE     300 PEARL STREET       BURLINGTON HEALTH & REHAB     STREET ADDRESA, GITY, STATE, ZP CODE     300 PEARL STREET       BURLINGTON HEALTH & REHAB     STREET ADDRESA, GITY, STATE, ZP CODE     300 PEARL STREET       BURLINGTON HEALTH & REHAB     STREET ADDRESA, GITY, STATE, ZP CODE     300 PEARL STREET       BURLINGTON HEALTH & REHAB     STREET ADDRESA, GITY, STATE, ZP CODE     300 PEARL STREET       BURLINGTON HEALTH & REHAB     STREET ADDRESA, GITY, STATE, ZP CODE     300 PEARL STREET       BURLINGTON HEALTH & REHAB     STREET ADDRESA, GITY, STATE, ZP CODE     300 PEARL STREET       BURLINGTON HEALTH & REHAB     DEFORM TO STRUCTION NUMBER PROFILE     Constrements       PAID     STREET ADDRESA, GITY, STATE, ZP CODE     300 PEARL STREET       BURLINGTON HEALTH & REHAB     DEFORM TO STRUCTION NUMBER PROFILE     DEFORM TO STRUCTION NUMBER PROFILE       PAID     State of Thighty STREMAPY STREMA  | DEPARTMENT OF HEALTH AND HUMAN SERVICES FOR |  |  |                |     |  | D: 12/01/2022<br>MAPPROVED |            |  |
|--|---|--|--|----------------|-----|--|----------------------------|------------|--|
| AMP PLAN OF CORRECTION       IDENTIFICATION NUMBER:       A. BUILDING       COMPLETED         475014       B. WING       C       11/15/2022         NAME OF PROVIDER OR SUPPLIER       B. WING       STREET ADDRESS, CITY, STATE, ZIP CODE         BURLINGTON HEALTH & REHAB       STREET ADDRESS, CITY, STATE, ZIP CODE       300 PEARL STREET         BURLINGTON HEALTH & REHAB       ID       PROFUBER'S PLAN OF CORRECTION       Completers PLAN OF CORRECTION         V(A) ID       SUMMARY STATEMENT OF DEFICIENCIES       ID       PROFUBER'S PLAN OF CORRECTION       Completers PLAN OF CORRECTION         VEACH DEFICIENCY MUST BE PRECIDED BY FULL       REGULATORY OR LSC IDENTIFYING INFORMATION)       TAG       CONSERFERENCE TO THE APROPRIATE         VEACH DEFICIENCY OR LSC IDENTIFYING INFORMATION)       TAG       PROFUBER'S PLAN OF CORRECTION       Completers PLAN OF CORRECTION         VEACH DEFICIENCY       REGULATORY OR LSC IDENTIFYING INFORMATION)       TAG       PROFUBER'S PLAN OF CORRECTION       Completers PLAN OF CORRECTION         VEACH DEFICIENCY       REGULATORY OR LSC IDENTIFYING INFORMATION)       TAG       PROFUBER'S PLAN OF CORRECTION       Completers PLAN OF CORRECTION         VEACH DEFICIENCY       REGULATORY OR LSC IDENTIFYING INFORMATION)       TAG       PROFUBER'S PLAN OF CORRECTION       Completers PLAN OF CORRECTION         VEACH DEFICIENCY       REGULATORY OR LSC IDENTIFYING IN  |   |  |  |                |     |  | T                          |            |  |
| 11/15/2022       NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE       BURLINGTON HEALTH & REHAB     STREET ADDRESS, CITY, STATE, ZIP CODE       300 PEARL STREET     BURLINGTON, VT 05401       V0(10)<br>PREFIX<br>TXG     SUMMARY STATEMENT OF DEFICIENCIES<br>(ECAPL DEFICIENCY WEILE PERCECED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)     D<br>PREFIX<br>REGULATORY OR LSC IDENTIFYING INFORMATION)     PREFIX<br>PREFIX     ICAN OF CORRECTIVE.<br>(CONSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)     Continued From page 2<br>Include:     F 842       F 842     Continued From page 2<br>Include:     F 842     F 842       Per record review, Licensed Nursing Assistant<br>(LNA) staff did not accurately document Resident<br># 1 silevel of supervision during meals. Resident<br># 1 silevel of supervision during meals. Resident<br># 1 who has a diagnosis of dysphagia,<br>oropharyngeal phase (difficulty swallowing), has<br>a physician order dated 91/4/22 for all food to be<br>in bowls and to be cut to bite size. The order<br>required staff supervision with all meals and<br>indicated the resident if the meal assistance as<br>"Independent, no help or staff assistance as any<br>"Independent, no help or staff assistance at any<br>time" on 17 occasions. On 11/16/22 at 11:30 AM,<br>a unit LNA stafed that h/hele is aware of Resident<br># 1's need for supervision with meals. When<br>showed the LNA task documentation<br>showed the LNA task documented as<br>stated "I must have put it I the worng column<br>because I was hurrying". The facility Executive<br>Director confirmed in a written document dated<br>11/16/22 that Resident # 1 was documented as  |   |  |  |                |     |  |                            |            |  |
| NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE       BURLINGTON HEALTH & REHAB     STREET ADDRESS, CITY, STATE, ZIP CODE       (K4) ID<br>PREFIX<br>TAG     SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LISC IDENTIFYING INFORMATION)     ID<br>PREFIX<br>TAG     PROVIDER'S PLAN OF CORRECTIVE<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFRENCED TO THE APPROPRIATE<br>DEFICIENCY)     Continued From page 2<br>Include:     ID<br>PREFIX<br>TAG     PROVIDER'S PLAN OF CORRECTIVE<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFRENCED TO THE APPROPRIATE<br>DEFICIENCY)     Continued From page 2<br>Include:     F 842       Per record review, Licensed Nursing Assistant<br>(LNA) staff did not accurately document Resident<br># 1's level of supervision during meals. Resident<br># 1's level of supervision during meals. Resident<br># 1's level of supervision with all meals and<br>indicated the resident is to be upright for all PO<br>[oral] intake. Review of LNA task documentation<br>showed that between 10/17/22 - 11/14/22, staff<br>documented Resident, is meal assistance as<br>"Independent, no help or staff assistance at any<br>time" on 17 occasions. On 11/16/22 at 11:30 AM,<br>a unit LNA stade that his is aware of Resident<br># 1's need for supervision with meals. When<br>showed the LNA task documentation, his the<br>stated "I must have put it I the wrong column<br>because I was hurrying". The facility Executive<br>Director confirmed in a written document dated<br>11/16/22 that Resident # 1 was documented as     In the sident of the preficience is appreciate is to be<br>put the averiate is the averiate is averiate is averiated the resident is averiated averiate is averiated averiate is averiated ave |   |  | 475014   | 475014 B. WING |     |  | 1                          |            |  |
| BURLINGTON, VT 05401         (xi) ID<br>PREFIX<br>TAG       SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)       ID<br>PREFIX<br>TAG       PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED To THE APPROPRIATE<br>DEFICIENCY)       (xi)<br>course in our appropriate<br>DEFICIENCY         F 842       Continued From page 2<br>include:       F 842       F 842         Per record review, Licensed Nursing Assistant<br>(LNA) staff did not accurately document Resident<br># 1's level of supervision during meals. Resident<br># 1, who has a diagnosis of dysphagia,<br>oropharyngeal phase [difficulty swallowing], has<br>a physician order dated 9/14/22 for all food to be<br>in bows and to be cut to bite size. The order<br>required staff supervision with all meals and<br>indicated the resident is to be upright for all PO<br>[oral] Intake. Review of LNA task documentation<br>showed that between 10/17/22 - 111/30 AM,<br>a unit LNA stated that h/she is aware of Resident<br># 1's need for supervision with till meals. When<br>showed that LNA task documentation, h/she<br>stated '' must have put it it he wrong column<br>because I was hurying''. The facility Executive<br>Director confirmed in a written document dated<br>11/16/22 that Resident # 1 was documented as       II  | NAME OF PF                                  | ROVIDER OR SUPPLIER  |  |                | :   | STREET ADDRESS, CITY, STATE, ZIP CODE                                |                            |            |  |
| PREFX<br>TAG       (EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFX<br>TAG       (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)       comPletion<br>DATE         F 842       Continued From page 2<br>include:       F 842       F 842       F 842         Per record review, Licensed Nursing Assistant<br>(LNA) staff did not accurately document Resident<br># 1's level of supervision during meals. Resident<br># 1's level of supervision during meals. Resident<br># 1's level of supervision during meals. Resident<br># 1's level of supervision with all meals and<br>indicated the resident is to be upright for all PO<br>[oral] intake. Review of LNA task documentation<br>showed that between 10/17/22 - 11/14/22, staff<br>documented Resident # 1's meal assistance at any<br>time" on 17 occasions. On 11/16/22 at 11:30 AM,<br>a unit LNA stated that h/she is aware of Resident<br># 1's need for supervision with meals. When<br>showed the LNA task document dated<br>11/16/22 that Resident # 1 was document dated<br>11/16/22 that Resident # 1 was document dated<br>11/16/22 that Resident # 1 was document dated  | BURLING                                     | TON HEALTH & REHAB   |  |                |     |  |                            |            |  |
| include:<br>Per record review, Licensed Nursing Assistant<br>(LNA) staff did not accurately document Resident<br># 1's level of supervision during meals. Resident<br># 1, who has a diagnosis of dysphagia,<br>oropharyngeal phase [difficulty swallowing], has<br>a physician order dated 9/14/22 for all food to be<br>in bowls and to be cut to bite size. The order<br>required staff supervision with all meals and<br>indicated the resident is to be upright for all PO<br>[oral] intake. Review of LNA task documentation<br>showed that between 10/17/22 - 11/14/22, staff<br>documented Resident # 1's meal assistance as<br>"independent, no help or staff assistance at any<br>time" on 17 occasions. On 11/16/22 at 11:30 AM,<br>a unit LNA stated that h/she is aware of Resident<br># 1's need for supervision with meals. When<br>showed the LNA task documentation, h/she<br>stated "I must have put it 1 the wrong column<br>because I was hurying". The facility Executive<br>Director confirmed in a written document dated<br>11/16/22 that Resident # 1 was documented as   | PREFIX                                      | (EACH DEFICIENCY MUST BE PRECEDED BY FULL  |  | PREFI          |     | (EACH CORRECTIVE ACTION SHOULD E<br>CROSS-REFERENCED TO THE APPROPRI |                            | COMPLETION |  |
|  | F 842                                       | include:<br>Per record review, Lic<br>(LNA) staff did not acc<br># 1's level of supervis<br># 1, who has a diagno<br>oropharyngeal phase<br>a physician order date<br>in bowls and to be cut<br>required staff supervis<br>indicated the resident<br>[oral] intake. Review of<br>showed that between<br>documented Residen<br>"independent, no help<br>time" on 17 occasions<br>a unit LNA stated that<br># 1's need for supervi<br>showed the LNA task<br>stated "I must have po<br>because I was hurryin<br>Director confirmed in<br>11/16/22 that Residen | censed Nursing Assistant<br>curately document Resident<br>ion during meals. Resident<br>biss of dysphagia,<br>[difficulty swallowing], has<br>ed 9/14/22 for all food to be<br>t to bite size. The order<br>sion with all meals and<br>is to be upright for all PO<br>of LNA task documentation<br>10/17/22 - 11/14/22, staff<br>t # 1's meal assistance as<br>o or staff assistance at any<br>s. On 11/16/22 at 11:30 AM,<br>t h/she is aware of Resident<br>sion with meals. When<br>documentation, h/she<br>ut it I the wrong column<br>ng". The facility Executive<br>a written document dated<br>at # 1 was documented as | F              | 842 |  |                            |            |  |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: GYKM11

Facility ID: 475014

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