VERMONT

AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

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

March 2, 2023

Ms. Amy Walker, Administrator
Burlington Health & Rehab
300 Pearl Street
Burlington, VT 05401-8531

Dear Ms. Walker:

Enclosed is a copy of your acceptable plans of correction for the investigation survey conducted on **February 14, 2023.** Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M Cota RN

Pamela M. Cota, RN
Licensing Chief

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 02/14/2023

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 3/6/2023
F 000	INITIAL COMMENTS The Division of Licensing and Protection conducted an unannounced onsite investigation of 6 complaints and 2 Facility Reported Incidents (FRI) on 2/13-2/14/2023. The following regulatory violations were identified:	F 000	This plan of correction (POC) was written to follow state and federal guidelines. It is not an admission of noncompliance. However, it is the facility commitment to demonstrate and maintain compliance.	
F 559 SS=D	Choose/Be Notified of Room/Roommate Change CFR(s): 483.10(e)(4)-(6) §483.10(e)(4) The right to share a room with his or her spouse when married residents live in the same facility and both spouses consent to the arrangement. §483.10(e)(5) The right to share a room with his or her roommate of choice when practicable, when both residents live in the same facility and both residents consent to the arrangement. §483.10(e)(6) The right to receive written notice, including the reason for the change, before the resident's room or roommate in the facility is changed. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure each resident's right to receive written notice, including the reason for the change, before the resident's room in the facility is changed. Findings include: 1. Per interview on 2/13/2023 at approximately 11:30 AM, Resident #2 stated that in December of 2022, the facility informed them that they were going to be moved from the second floor to the 3rd floor, but that they did not provide them with written notice or give them a reason for the move. They stated that the facility ultimately did not	F 559	F 559 Specific Correction Action The center followed up with resident #1 and #3 and explained the room change notification process moving forward. All residents/patients that change their room at the center have the potential to be affected by the alleged deficient practice. Audits have been completed to ensure that all residents that have changed rooms since 2/13/23 have been provided a copy of the written Room Transfer form. Education was provided on 2/14/2023 to the Social Services Director in regards providing written room change notices to the residents/responsible parties. An audit was completed 2/28/23 by the Administrator on all residents that had a room change from 2/13-2/28/2023, compliance noted. Audits will be conducted weekly x4 and monthly x3, to Ensure written notices were provided and documented before a room/bed change occurs. Results of the audit will be reported in QAPI Tag F559 accepted on 3/2/23 by L. Lovell [illegible] RN	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [signature] TITLE Administrator (X6) DATE 3/1/2023

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 02/14/2023

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 559	Continued From page 1 make them move rooms after they refused. Per record review, there was no evidence of a written notice of room transfer provided to Resident #2. Per interview on 2/13/2023 at approximately 3:00 PM, the SW (social worker) confirmed that no written notice was given to Resident #2 when they were informed of the need to change their room. 2. Per interview on 2/13/2023 at approximately 12:30 PM, Resident #1 stated that the facility initiated a room change during the summer of 2022, but that they did not receive a written notice or a reason for the room change. Per record review, a room change occurred for Resident #1 on 8/25/2022. A progress note in Resident #1's chart from 8/23/2022 reads, "SSD (Social Services Director) informed [Resident #1] of room change to occur for [them]. [Resident #1] was agreeable and agreed to move on 8/25/22." The record did not show that there was any evidence of a written notice of room transfer. Per interview on 2/14/2023, the Director of Nursing confirmed that no written notice of room transfer could be located for Resident #1.	F 559		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from	F 600		

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 02/14/2023

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 600	Continued From page 2 corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to ensure 1 of 9 applicable residents (Residents #4) were free from verbal abuse. Findings include: Per record review and confirmed via interview, a facility Registered Nurse (RN) verbally abused Resident #4 on 10/18/22. Per review of the facility's own investigation and confirmed by victim and witness statements, an RN began yelling and berating the resident and told the resident to "be quiet". Even after the resident left the area and returned to his/her room the RN continued to harass him/her and said "here comes the water works" when the resident began to cry. Based on corrective actions completed prior to the onsite, this citation is designated as past non-compliance. The following actions were completed by the facility: 1. A report was made to The Agency as required on 10/19/22 and notification was made to Adult Protective Services (APS) on 10/19/22. 2. The Registered Nurse (RN) involved, was immediately suspended, and then terminated	F 600	Past noncompliance: no plan of correction required.	

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 02/14/2023

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 600	Continued From page 3 10/21/22. 3. A report was made to the local police department on 10/21/22 and the Board of Nursing (BON) with a follow-up response from the BON on 1/21/2023. 4. Education regarding abuse prohibition and abuse reporting was provided to all staff on 10/19/22. 5. An analysis of the incident was discussed by the quality team (QAPI) on 10/31/22. 6. The facility updated their Partner Program questionnaire to ask, "Do you feel safe?" The facility updated their Partner Program (A program in which staff members partner with residents to ask them a variety of questions about their care) questionnaire to ask, "Do you feel safe?"	F 600		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.	F 755	F 755 Specific Correction Action 600mg Calcium Tablets were obtained 2/14/2023, no ill effect to resident #3 and administered as ordered. The Central Supply storage closets were completely cleaned out and reorganized for easier inventory tracking on 2/22/23 and an audit was completed to validate medication ordered are available for administration. Education provided to licensed nursing staff regarding the updated process for reporting missing and/or low Supplies. Audits to be conducted weekly x4 and monthly x3 by Administrator or designee to monitor effectiveness. Results will be discussed in QAPI. Tag F755 accepted on 3/21/23 by L. Lovell / D. Widrawick RN	

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 02/14/2023

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 755	Continued From page 4 §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide pharmaceutical services to meet the needs of each resident for one of three sampled residents (Resident #3). Findings include: 1. Per observation of medication administration and subsequent interview on 2/14/23 at approximately 8:00 AM, an LPN informed this surveyor that their cart does not contain 600 mg tablets of calcium. The Resident they were preparing to administer medications to (Resident #3) was to receive 600mg tablets of calcium, but the medication cart only contained 600mg calcium tablets with 5mg of Vitamin D. The LPN checked the medication room on the floor and confirmed that there were no 600 mg calcium tablets there. They stated that the cart has not contained the tablets for the last several days, so they administered the 600 mg calcium tablets with 5mg vitamin D instead. They also stated that	F 755		

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 02/14/2023

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 755	Continued From page 5 they informed the employee who manages central supply about the missing tablets, but they had not been provided. Per record review, Resident #3 has an order for two 600 mg tablets of calcium one time a day. This order was initiated on 11/13/2021. The Medication Administration Record shows that the LPN marked the medication as administered from 2/11/2023 through 2/14/2023. Per observation of central supply and interview on 2/14/2023 at approximately 9:00 AM, the central supply employee confirmed that there were no 600 mg calcium tablets in the facility. They stated that nursing staff can access the central supply room with a key, and they are to write down what they take from it so that the central supply employee can know to order more. Observation of the log does not show that any 600 mg calcium tablets were logged as taken from central supply. They also confirmed that they had not been made aware of the missing supplements prior to 2/14/2023.	F 755		