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

April 13, 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 recertification survey conducted on **March 29, 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

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 _____	03/29/2023

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
E 000	Initial Comments The Division of Licensing and Protection conducted an emergency preparedness review during the annual recertification survey on 3/27/2023. There were no regulatory violations identified.	E 000	This plan of correction was written to follow state and federal guidelines. It is not an admission of noncompliance. However, it is the facility commitment to demostrate and maintain compliance.	
F 000	INITIAL COMMENTS An unannounced, on-site re-certification survey and staff vaccination requirement review was conducted by the Division of Licensing and Protection on 3/26/23 through 3/29/23. The following regulatory violations were identified:	F 000	Date of compliance to be 5/2/2023.	
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;	F 584		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Administrator	4/13/23

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 584	Continued From page 1 §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to ensure a comfortable and safe temperature level for 1 of 31 sampled residents (Resident #52) . Findings include: Per interview at 9:15 AM on 03/27/23, Resident #52 stated s/he had informed multiple staff several times over the last few weeks that her/his room was very cold and the heater was not working. Sometimes staff would come, but the problem was never fixed. S/He said that staff "are not listening to me." During this interview the room [room 501] was observed to be 61 degrees Fahrenheit. On 03/29/2023 at 8:15 AM, Resident #52 stated that s/he was still freezing and was upset. At this time the room was observed to be 60 degrees	F 584	F584 Specific Corrective Action 1. Resident #52's heater was fixed and temps have been registering within the regulatory temps of 71-81 F. 2. An audit of all resident room temperatures was completed to ensure temps between 71-81 or set at individual resident preference. 3. Education to be completed with maintenance staff on repetitive issues/work orders entered in TELS. Bring concerns to the administrator/designee immediately for long term resolutions. Education to be done with staff to include direct care and ancillary on the TELS work order process and reporting repetitive issues to the administrator/designee. 4. Admininstrator/designee will audit TELS work orders weekly x 4, montly x 3 to identify repetitive and systematic issues. Maintenance will also audit TELS work orders weekly x 4, monthly x 3 to identify repetitive and systematic issues and communicate any concerns with Administrator/designee Maintenance will also complete room temp tasks timely, and report any non-regulatory temperatures (outside of 71-81 F) to the Adminsitrator immediately. Any concerns/trends identified will be addressed in real time and discussed in QAPI.	

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F 584	Continued From page 2 Fahrenheit. Record review of the TELS logs [maintenance department work log] reveals that work orders were put in 4 times for Resident #52's heater. A log entry on 3/16/2023 at 9:12 AM reads, "501 Heater not working." A log entry on 3/16/2023 at 12:16 PM reads, "Residents [residents in room 501] are cold stating the heater is not working." A log entry on 3/20/2023 at 1:51 PM reads, "501 No heat." A log entry on 3/21/2023 at 10:43 AM reads, "501 heater blowing cold air." Per interview on 3/29/23 at approximately 10:00 AM, a maintenance staff member explained that s/he reset the heat in room 501 as a response to the above work orders. Per interview at 11:10 AM on 03/29/23, the Maintenance Director stated that when there is a maintenance issue, staff should put a work order into the TELS system. A maintenance staff will perform the work and document the result. In situations like this, maintenance should follow up to make sure the problem was fixed. S/He was aware that the heating unit in room 501 continued to malfunction after the last work order was put in on 3/21/23. S/He confirmed that there were no additional work orders entered into TELS after 3/21/23, no documentation of follow up for room 501's malfunctioning heater, and that the procedure was not followed.	F 584	**Tag F 584 POC accepted on 4/13/23 by S. Stem/P. Cota**	

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F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to revise care plans related to refusal of activities of daily living (ADL) for 5 of 31 sampled residents (Residents #19, #24, #31, #39, and #55). Findings include: Per multiple observations on 3/26/23, 3/27/23, and 3/28/23, Residents #19, #31, #39, and #55	F 657	F657 Specific Corrective Action 1. Comprehensive Care Plans have been updated for resident's #19, #24, #31, #39 specific to refusal of activities of daily living (ADLs). 2. An audit of all resident Comprehensive Care Plans was completed by 4/17/2023 and updates completed specific to refusal of activities of daily living (ADLs). 3. Education to be completed with all staff responsible for completing/updating Comprehensive Care Plans in specific to refusal of ADLs. 4. The Director of Nursing (DON) or designee will conduct weekly audits x4 of 10 random resident/patient care plans to ensure accuracy. Monthly audits x 3 will be completed by DON/Designee on 10 random residents to ensure accuracy. Any concerns identified will be addressed immediately and discussed in QAPI. **Tag F 657 POC accepted on 4/13/23 by S. Stem/P. Cota**	

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F 657	Continued From page 4 was wearing the same clothing on each day, with it becoming increasingly soiled by the third day of observation. Resident #24 was wearing the same clothing on 3/27/23 as s/he had on 3/26/23. Record review reveals the following: Resident #19's care plan reveals that "The resident has an ADL Self Care Performance Deficit r/t [related to] CVA [stroke] and Depression," and a dressing intervention that indicated s/he "requires 1 A [assist] and is able to (do up buttons, do zippers, put on shirt) on [his/her] own." Resident #24's care plan reveals that "The resident has an ADL Self Care Performance Deficit r/t dementia," and a dressing intervention that indicates s/he "requires (1) staff participation to dress." Resident #31's care plan reveals that "The resident has an ADL Self Care Performance Deficit r/t Multiple Myeloma [blood cancer], COPD [chronic obstructive pulmonary disease] and back pain," and a dressing intervention that indicates s/he "is independent with dressing. provide supervision for safety/cueing." Resident #39's care plan reveals that "The resident has an ADL Self Care Performance Deficit r/t Limited Mobility, has ADL deficit r/t cognitive and mobility deficits," and a dressing intervention that indicates s/he "requires 1 staff participation to dress." Resident #55's care plan reveals that "The resident has an ADL Self Care Performance Deficit r/t fatigue, SOB [shortness of breath] and HX [history] of CVA," and a dressing intervention that indicates s/he "dresses independently however may require cues to change clothing." The care plans for Residents #19, #24, #31, #39, and #55 do not include interventions to address refusal of dressing. Per interview on 3/29/2023 at 10:08 AM, a Licensed Nurse Aide confirmed that Residents	F 657		

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F 692	Continued From page 6 related to usual body weight for 1 of 31 residents sampled (Resident #5). Findings include: Per record review, Resident # 5 was admitted to the facility on 6/22/05 with the following diagnoses: multiple sclerosis, dementia, dysphagia [difficulty swallowing], hypothyroidism, and depression. Per Resident #5's vitals, s/he weighed 141.8 pounds on 2/1/23, and 153.2 pounds on 3/15/23, revealing a 11.4-pound weight gain. Facility policy and procedure titled "NSG244 Weights and Heights Procedure" states under the procedure for obtaining and documenting weights that "If the body weight is not as expected, reweigh the patient. The weight will be entered in the [electronic medical record] Weights/Vital signs module on that shift." Further medical record review reveals there was no re-weight documented after the 3/15/23 weight gain for Resident #5. Per interview on 3/29/23 at 9:36 am, the Registered Dietitian confirmed that a re-weight for resident #5 was not documented. Per interview on 3/29/23 at 9:55 am the Registered Nurse Unit Manager (RN UM) stated that on 3/16/23 s/he had instructed a Licensed Nurse Aide to obtain the re-weight for Resident #5. The RN UM states that if this was a true weight gain, nursing would have done an assessment for excess fluid and updated the Provider. The RN UM confirmed that the re-weight should have been obtained and documented.	F 692		

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F 657	Continued From page 5 #19, #24, #31, #39, and #55 had a history of refusal for ADL care. Per interview on 3/29/2023 at approximately 9:00 AM, the Director of Nursing confirmed that if a resident has a history of refusal of care, the care plan should be revised to reflect that, and interventions should be added to address the refusal.	F 657		
F 692 SS=D	Nutrition/Hydration Status Maintenance 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 percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to maintain acceptable parameters of a resident's nutritional status	F 692	F692 Specific Corrective Action 1. Resident #5 was been re-weighed on 3/29/23 and again on 4/1/23. 2. An audit of all resident weights will be completed by the DON/Designee and re-weighed if needed and docmented. Any concerns will be discussed with nursing, dietician and/or provider as needed. 3. Education to nursing staff will be completed regarding Nursing Policy 244 regarding obtaining resident weights and re-weights and documentation. 4. DON/designee will conduct weekly audits x4 and monthly x3 to ensure weights are being completed, documented and re-weighed if required. Any concerns identified will be escalated to DON, dietician and/or provider as needed and discussed in QAPI. **Tag F 692 POC accepted on 4/13/23 by S. Stem/P. Cota**	