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

November 6, 2023

Ms. Carol Erhart, Administrator
Burlington Health & Rehab
300 Pearl Street
Burlington, VT 05401-8531

Dear Ms. Erhart:

Enclosed is a copy of your acceptable plans of correction for the complaint investigation conducted on **October 13, 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,

PamelaMCotaRN
Pamela M. Cota, RN
Licensing Chief

Enclosure

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 10/13/2023

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

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F 000	INITIAL COMMENTS The Division of Licensing and Protection conducted an onsite, unannounced investigation of a facility reported incident (ACTS #22278) on 9/19/2023, 10/9/23, and 10/10/23 with additional offsite record review that ensued through 10/13/23, to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. The following regulatory deficiencies were identified:	F 000	This plan of correctin was written to follow state and federal guidelines. It is not an admission of noncompliance. However, it is the facility's commitment to demonstrate and maintain compliance.	
F 600 SS=G	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 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 observation, interview, and record review, the facility failed to protect the resident's right to be free from physical abuse by another resident for three applicable residents (Resident #1, #3, and #5). Findings include: 1. Record review reveals that Resident #1 has diagnoses that include personality disorder,	F 600	F600 Specific Corrective Action 1. Resident #1, #3 and #5 are free from signs of Abuse, Neglect and Exploitation shown through Partner Program interviews and observations, IDT assessments and other documentation such has recreation participation logs. Education was completed with 100% of staff on OPS300 Abuse Prohibition, Redirecting People with Behaviors and Safegarding & Dementia. In-Person education was done by the National Director of memory support from Genesis. A plan has been created for continued improvement to the unit designated for the center's dementia residents. Regular meetings have been set up with the center and the National Director for continued sustainable support. 2. The DON & Clinical Lead completed an audit of all resident records to include plans of care were completed in an evaluation for those at risk for Abuse, Neglect and Exploitation.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	LNHA	11/1/23

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 600	Continued From page 1 depression, and dementia. On 7/11/23, Resident #1 is assessed to have a BIMS of 4 (brief interview for mental status; a cognitive assessment score indicating severe cognitive impairment). Resident #2 has diagnoses that include schizophrenia, depression, and post-traumatic stress disorder. On 8/14/23, Resident #2 is assessed to have a BIMS of 14 (indicating cognitive intactness). Review of facility resident to resident incident reports dated 9/15/23 for Residents #1 and #2 reveal that Resident #1 was found by nursing staff on the floor in the dining room at approximately 4:30 PM complaining of left arm and hand pain. Resident #2 was standing over Resident #1. A 9/15/23 progress note reveals that Resident #1 was sent to the emergency room after the incident and returned to the facility with a fracture to his/her left wrist. A 9/18/23 skin assessment reveals that Resident #1 has bruising on his/her left arm, left hip and coccyx. Per interview on 9/19/23 at 8:55 AM Resident #2 confirmed that s/he had swung at Resident #1 on 9/15/23. S/he stated it was "because [Resident #1] was touching my walker and told me to go [explicit word] my mother." Resident #2 reported that s/he had previously been touched by Resident #1. On 9/19/23 at 9:03 AM, the Administrator reported that an incident had occurred between Resident #1 and #2 the previous month. Review of the facility's investigation dated 9/1/23 reveals that Resident #2 reported that Resident #1 had entered their room and grabbed their genitals while they were in their bed on 8/29/23. The facility investigation summary substantiated the	F 600	F600 continued 3. Systematic review was completed with revision to include, but not limited to: Abuse, Neglect & Exploitation education is included in new employee orientation, annual education and added in the agency staff guidebook located at each nurses station. As those with dementia may be at higher risk for Abuse, Neglect & Exploitation, additional training has been added to new employee, orienation, annual education and agency guidebooks to support the staff to proactively look for those at greater risk and/or that may have indicatoins of signs of Abuse, Neglect or Exploitation experienced. The Social Services Director/Designee will work to identify resdients at risk and include them for review and discussion with the IDT. Those that complete Partner Rounds and/or manager on duty (MOD) have been educated on risk identification, notification and follow up related to possible signs of Abuse, Neglect and Exploitation. 4. The NHA will review the above system. The Quality Manager/designee and the Social Services Director/designee will review the completion of the Partner Program documentation and MOD documentation to evaluate for signs of Abuse, Neglect and Exploitation. This will be discussed at the monthly QA meeting. Date of Compliance 11/4/23	

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F 600	Continued From page 2 event occurred without harm. Review of surveillance footage of the dining area on 9/15/23 at approximately 4:45 PM reveals Resident #2 sitting at a table with a few other residents when Resident #1 begins to move Resident #2's walker away from Resident #2. Resident #2 pulls the walker closer to themselves and Resident #1 immediately moves Resident #2's walker away again. This happens a couple more times before Resident #2 stands up from the table and strikes Resident #1, who then falls backwards onto the floor. No interventions by staff were observed in the footage until staff responded to Resident #1 being on the floor. Review of a facility investigation report summary dated 9/20/23 substantiates the event did occur and resulted in harm for Resident #1. 2. Record review reveals that Resident #3 has diagnoses that include dementia with behavioral disturbances, communication deficit, anxiety, and depression. On 7/19/23, Resident #3 is assessed to have a BIMS of 3 (indicating severe cognitive impairment). Resident #4 has diagnoses that include dementia with behavioral disturbances and depression. On 9/20/23, Resident #4 is assessed to have a BIMS of 6 (indicating severe cognitive impairment). Review of facility resident to resident incident reports dated 9/27/23 for Residents #3 and #4 reveal that Residents #3 and #4 were seen having a verbal disagreement at Resident #4's doorway. Resident #3 spit on Resident #4. Resident #4 then raised his/her cane and hit Resident #3 on their left shoulder. Witness statements indicate that this event occurred at	F 600	**Tag F 600 POC accepted on 11/3/23 by S. Stem/P. Cota**	

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F 600	Continued From page 3	F 600		

approximately 5:00 PM. A 10/9/23 skin assessment reveals that Resident #4 has bruising on his/her left shoulder. A facility investigation summary dated 10/3/2023 substantiates the event did occur. This report reveals that Residents #3 and #4 had not had prior aggression with each other, however, Resident #3's medical record reveals a history of resident to resident altercations.

Resident #3's care plan states that s/he "wanders, exhibits physical behaviors and is at risk for resident to resident altercation related to: Cognitive Loss/Dementia, Poor impulse control," created on 3/24/23, and has multiple interventions to prevent being harmed or harming others including, "Redirect [Resident #3] if wandering, entering other rooms," created on 7/10/23, and "Monitor [Resident #3]'s whereabouts and redirect to staff supervised area as needed," created on 7/10/23.

Review of facility resident to resident altercation investigation summaries reveal the following substantiated events: A 6/13/23 facility investigation summary reveals that on 6/8/23 Resident #3 entered Resident #6's room, yelled profanities, and hit Resident #6 on their right cheek. A 7/10/23 facility investigation summary reveals that on 7/6/23 Resident #3 entered Resident #6's room and Resident #6 struck Resident #3 on the back of their head. An 8/11/23 facility investigation summary reveals that on 7/6/23 Resident #3 entered Resident #6's room, grabbed, kicked, and struck Resident #6 in the face.

3. Record review reveals that Resident #5 has diagnoses that include severe dementia with

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F 600	Continued From page 4	F 600		

agitation and psychotic disturbances, anxiety, cognitive communication deficit, and depression. On 8/1/23, Resident #5 is assessed to have a BIMS of 5 (indicating severe cognitive impairment). Resident #6 has diagnoses that include osteogenesis imperfecta (brittle bone disease) and cognitive communication deficit. On 8/17/23, Resident #6 is assessed to have a BIMS of 15 (indicating cognitive intactness) and uses a wheelchair for independent locomotion.

Review of facility resident to resident incident reports dated 10/1/23 for Residents #5 and #6 reveal that Resident #6 was seen in the dining room approaching Resident #5 around a table, then punching Resident #5 in the jaw. Witness statements indicate that this event occurred at approximately 5:00 PM. A facility investigation summary dated 10/6/2023 substantiates the event did occur.

Per interview on 10/9/23 at 3:50 PM, Resident #6 indicated that on 10/1/23 s/he was provoked by Resident #5 pulling on the tablecloth while waiting for dinner, almost spilling his/her drink. S/He confirmed that s/he did hit Resident #6 and revealed that s/he has been involved in altercations with other residents before. S/He explained that Resident #3 used to come into his/her room and it had been physical.

Review of Resident #6's medical record and facility reported resident to resident altercations reveal that Resident #6 has a history of physical behaviors. Resident #6's care plan states that s/he "exhibits, or has the potential to exhibit physical behaviors related to: Poor impulse control, hit another resident" created on 7/9/23. A 7/10/23 facility resident to resident altercation

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F 600	Continued From page 5 investigation summary reveals that on 7/6/23 Resident #3 entered Resident #6's room and Resident #6 struck Resident #3 on the back of their head.	F 600	F609 Specific Corrective Action 1. The NHA submitted the missing reports to APS and the Burlington Police where applicable on 10/10/23. APS sent responses on 10/12/23, the Burlington Police accepted a records request on 10/10/23 but have not yet produced the documentation. Any records that are unavailable, will be resubmitted.	
F 609 SS=E	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interviews and record review, the	F 609	The Market Advisors/Designee completed education with the center leadership in regards to the correct reporting process per policy OPS300 Abuse Prohibition to include reporting Abuse, Neglect & Exploitation to the local police, DAIL, APS and other agencies as required. 2. The Clinical Advisor for Genesis VT completed an audit of state reportables to ensure incidents were reported to the Burlington Police Department, APS and any other required agencies depending on the situation. Requests for any missing documentation was submitted to corresponding agency. 3. Systematic review has been completed and revised as indicated. Orientation for those in Center Leadership positions has been updated to include correct reporting process for Abuse, Neglect & Exploitation as well as added to the annual education for the same group of center leaders. The Market Operations Advisor or Clinical Market Advisor will conduct monthly audits to ensure indicents were reported to local law enforcement and other agencies as required. 4. The NHA will complete ongoing audits to ensure all reportables were reported to the required agencies. Any concerns/trends identified will be address in QA. Date of compliance 11/4/23	

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F 609	Continued From page 6 facility failed to implement policies and procedures for ensuring the reporting of a reasonable suspicion of a crime in accordance with section 1150B of the Act for 7 of 7 sampled alleged abuse allegations. Facility policy titled "OPS300 Abuse Prohibition" states: "7. Immediately upon receiving information concerning a report of suspected or alleged abuse, mistreatment, or neglect, the Administrator or designee will perform the following ..." "7.5 Notify local law enforcement, Licensing Boards and Registries, and other agencies as required." "11 All documentation related to allegations of abuse will be maintained at the Center for not less than three (3) years." The policy includes a table titled External Abuse Reporting Requirements which indicates the reporting of abuse to law enforcement requirements are no later than two hours after forming a suspicion that abuse occurred with serious bodily injury and no later than 24 hours after forming a suspicion that abuse occurred with no serious bodily injury. Per review of facility resident to resident abuse allegation investigation files, several files did not include evidence that the event was reported to law enforcement. Per interview on 10/10/23 at approximately 10:30 AM, the Market Clinical Lead revealed that the Administrator could not produce any of the missing evidence that the reports were submitted to law enforcement. S/He reported that the Administrator's email receipts of the submissions	F 609	**Tag F 609 POC accepted on 11/3/23 by S. Stem/P. Cota**	

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F 609	Continued From page 7 were unattainable. S/He stated that the facility would be submitting any missing reports. Per review of investigation files and additional evidence of reports, the following facility resident to resident abuse allegations were reported outside of the required timeframes to law enforcement within 24 hours (2 hours if serious bodily injury occurred): An allegation of a physical resident to resident abuse occurred on 6/6/23 at 10:15 PM; this event was reported to law enforcement on 6/11/23 at 10:30 PM. An allegation of a physical resident to resident abuse occurred on 7/6/23 at 12:15 PM; this event was reported to law enforcement on 10/10/23 at 2:45 PM. An allegation of a physical resident to resident abuse occurred on 8/11/12 at 10:13 AM; this event was reported to law enforcement on 10/11/23 at 11:27 AM. An allegation of a sexual resident to resident abuse occurred on 8/29/23 at 7:30 AM; this event was reported to law enforcement on 10/10/23 at 3:02 PM. An allegation of a physical resident to resident abuse occurred on 9/15/23 at 4:30 PM; this event was reported to law enforcement on 9/18/23 at 3:04 PM. This event resulted in serious bodily injury for a resident, requiring the event to be reported within two hours. An allegation of a physical resident to resident abuse occurred on 9/27/23 at 5:00 PM; this event was reported to law enforcement on 10/10/23 at 3:15 PM. An allegation of a physical resident to resident abuse occurred on 10/1/23 at 5:00 PM; this event was reported to law enforcement on 10/4/23 at 11:59 PM.	F 609		

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F 609	Continued From page 8 On 10/13/23 at 1:14 PM, the Interim Administrator confirmed that the Administrator at the time of the above events did not maintain records to show that s/he reported the alleged resident to resident abuse incidents to law enforcement in the required timeframe.	F 609		