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

December 27, 2018

Ms. Jessica Jennings, Administrator
Burlington Health & Rehab
300 Pearl Street
Burlington, VT 05401-8531

Dear Ms. Jennings:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **December 4, 2018.** 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

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 _____	R-C 12/04/2018

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 An unannounced onsite revisit to the survey of 10/24/18 was completed on 12/4/18. The facility failed to correct all deficiencies from the original survey. The findings are as follows.	{F 000}	The filing of this plan of correction does not constitute an admission of the allegations set forth in the statement of deficiencies. The plan of correction is prepared and executed as evidence of the facility's continued compliance with applicable law.	
{F 656} SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes.	{F 656}	F-656 The plan of care was reviewed and revised for resident #2 regarding preference for female care giver and preference / ensure shower weekly. Resident #3 did not return to the center. For resident #5 the plan of care was revised to reflect painful, mycotic nails and 4th toe diabetic ulcer. For resident #6 proper transfer technique was reviewed with staff.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

POC sent 12.26.18 MB

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 656}	Continued From page 1 (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, record review and confirmed by staff interview, the facility failed to develop and implement a person-centered care plan that identifies services to meet the residents medical and nursing needs for 4 of 8 sampled residents (Resident #2, #3, #5 and #6). The findings include the following: 1. Per review of care plan meeting notes, dated 11/2/18, identifies that the Resident #2 voiced preference for female caregivers only, for personal care. Per interview with Resident #2 on 12/4/18, in the presence of a family member, confirmation was made that the resident recently needed personal care after lunch. The resident utilized the call light with poor results. The family member located a nurse on the unit and requested the assistance of a female care giver for personal care for Resident #2. The family member left the facility and once in his/her vehicle, Resident #2 called the family member informing him/her that a male care giver came in to provide personal care. Family member confirms that Resident #2 was upset. Per review of the person-centered care plan on 12/4/18, there is no evidence identifying that	{F 656}	Residents with similar conditions could be affected by the alleged deficient practice. An audit was developed to ensure care plans are developed and implemented. Education was provided to nursing staff related to the development and implementation of a comprehensive care plan. CNE or designee will conduct weekly audits x4 to ensure compliance, and then monthly x3 with results to be reviewed at QAPI meeting for further review and recommendations. Date of compliance: January 4, 2019 Doc and 12.26.18 mob /BT	

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{F 656}	Continued From page 2	{F 656}		

Resident #2 has a preference, for female caregivers only for personal care. Per interview with the acting Charge Nurse on 12/4/18 at 10:30 AM, s/he confirms that s/he was unaware of the resident's preference.

2. Per interview with Resident #2 on 12/4/18, in the presence of a family member, confirmation was made that the resident has only received two (2) showers since admission on 10/12/18. The resident voices that a weekly shower is acceptable. The resident confirms that necessary care is not provided unless requested, examples are helping him/her brush teeth, comb hair or wash their back.

Per review of Resident #2's person-centered care plan, identifies that the resident requires extensive assistance of one (1) staff member for bathing/dressing and the resident is to choose the type of bath s/he receives. Per review of the Licensed Nurse Aide (LNA) documentation for bathing, dated 10/23/18 through 12/4/18 identifies that Resident #2 has received a shower on 10/30/18 and sponge baths on 10/23, 11/13, 11/6, 11/20, 11/27 and 12/4/18.

Confirmation was made by the acting Charge Nurse on 12/4/18 at approximately 10:36 AM, that Resident #2 is scheduled to have a bath/shower of his/her choice weekly on Tuesdays. LNA logs evidence that s/he has not consistently had a full bath/shower weekly. Confirmation was also made that facility policy identifies, that all residents receive a bath/shower weekly.

3. Per review of the person-centered care plan for Resident #3, which was last updated on 9/27/18, identifies that Resident #3 is

poc amt 12.26.18 mb/a

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{F 656}	Continued From page 3	{F 656}		

independent with stand-pivot transfer using a rail/arm rest with walker per resident's preference. Per review of the Minimum Data Set (MDS), a mandated assessment, dated 11/1/18 section F (Functional Status) identifies that the resident requires supervision with one (1) staff member for assistance for toilet use.
Per review of the Activities of Daily Living (ADL) documentation completed by the Licensed Nurse Aides (LNA's), identifies that during the look back period for the assessment, the resident did require limited assistance with transfers. Limited assistance is defined as the resident being highly involved in the activity; staff provided guided maneuvering of limbs or other non-weight-bearing assistance.

Per review of the medical record for Resident #3, had a fall on 11/26/18 that resulted an injury. The resident was hospitalized and returned to the facility on 11/29/18 and returned to the hospital on 11/30/18 where s/he remains. Per review of the medical record and confirmed by the Nursing Home Administrator, Director of Nurses and the Unit Manager on 12/3/18 at approximately 1:40 PM, Resident #3 transferred independently without staff present, resulting in a fall with injury. The care plan has not been updated since 9/27/18 identifying the need for assistance.

4. Per review of medical record on 12/3/18 for Resident #5, identifies diagnosis to include, but not limited to, Type 2 Diabetes, major Depressive Disorder, Emphysema, Gait and Mobility Abnormalities and Hammer Toes of the Right Foot. Per review of physician progress note dated 11/13/18, it identifies toe pain as an issue. Assessment questions diabetic ulcer, needs referral to foot clinic, needs debridement, ulcer.

Rc amt 12.26.18 mb/kl

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{F 656}	Continued From page 4	{F 656}		

Per review of Nurse Practitioner (NP) progress note dated 11/27/18 at 9:45 AM, identifies toe nails trimmed successfully. Right 4th toe avoided secondary to underlying possibility of ulcer on the tip of that toe connected adjacently to her thickened nail. Assessment identified severe Onychomycosis and diabetic history. Needs regular foot care.

Per review of Resident #5's care plan that was last updated on 8/10/18 identified the need for assistance for bathing, grooming and personal hygiene, and identifies the resident is diabetic and requires a daily foot check. There is no evidence in the care plan of a focus on the management of Onychomycosis, the possibility of a diabetic ulcer and/or the need for regular foot care.
Confirmation was made by the Unit Manager on 12/3/18 at approximately 2 PM, that the care plan does not identify a problem related to painful long mycotic toe nails with the possibility of a diabetic ulcer to the right foot 4th toe.

5. Per observation on 12/4/18 at approximately 8:20 AM, Resident #6 was transferred by a Licensed Nurses Aide (LNA) from a recliner to a wheelchair and transported to the bathroom. The LNA was observed transferring the resident without the use of a gait belt. Per review of the person-centered care plan, revised on 8/8/18, identifies that Resident #6 requires the use of assistance of one (1) staff member for transfers using a gait belt and rolling walker.

Confirmation was made by the LNA on 12/4/18 at 8:30 AM, that a gait belt was not used during the transfer from chair to chair. The LNA confirmed at 8:30 AM on 12/4/18, that s/he did not follow the

POC amt 12.26/8 MB KI

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{F 656}	Continued From page 5 Care plan as directed to use a gait belt for transfers. Per review of the facility policy Safe Resident Handling dated 5/15/17, identifies a Gait Belt is used with patients who can safely ambulate with assistance and/or perform greater than or equal to 50% of the transfer with stand pivot assistance with one staff member.	{F 656}		
{F 658} SS=F	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to meet professional standards of quality for 1 applicable resident (Resident # 1) by not following physician orders. The facility also failed to ensure that the care plans for residents were developed, revised or reviewed and approved by a Registered Nurse for 3 of 9 residents (Residents #7, 8, 9) reviewed in the sample, and this has the potential to affect all residents of the facility. The findings include the following: 1. Facility staff failed to weigh Resident # 1 as ordered by the physician. There is an physician order dated 11/9/18 to weigh Resident # 1 every day shift, every Friday, for 4 weeks. Review of the clinical record shows that the resident has not been weighed since admission on 11/2/18. On 12/4/18 at 11:38 AM, the Director Of Nurses (DNS) confirmed that Resident # 1 has not been weighed since admission. The DNS also stated	{F 658}	F-658 For resident #1 the order for weighing was reviewed with provider and revised. The care plan was then updated by a registered nurse to reflect current order. Care plans for residents #7, #8, and #9 were reviewed and approved by a registered nurse. All residents could be affected by this alleged deficient practice. Nursing staff will be re-educated on following MD orders for weights, and the Registered Nurses role in care planning. CNE or designee will complete audits to ensure weights are obtained as ordered and Registered nurses are leading the care plan process. CNE and or designee will conduct weekly audits x4 to ensure compliance and then monthly x3 with results to be reviewed at QAPI meeting for further review and recommendations. Date of compliance: January 4, 2019 Acceptance 12.26.18 MB/SL	

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{F 658}	Continued From page 6 that the facility did not have the proper equipment in place to weigh the resident. 2. During the record reviews of care plans for 9 newly admitted residents it was noted that the care plans for 3 of the residents were entirely initiated by Licensed Practical Nurses (LPN's) with no oversight by a Registered Nurse (RN). In an interview on 12/3/18 at 10:50 AM, the Director of Nursing (DNS) confirmed that LPN's created the care plans and there was no indication that an RN reviewed or approved the care plans. In the State Board of Nursing Scope of Practice & Decision Tree for RN, APRN, and LPN the following is stated: "LPN role in assessment, planning, and implementation of a strategy of care: -LPNs may not independently assess the health status of an individual or group and may not independently develop or modify the plan of care. LPNs may contribute to the assessment and nursing care planning processes; however, patient assessment and care plan development or revision remain the responsibility of the RN/APRN/licensed physician/licensed dentist. -LPNs may not modify a patient care protocol. If the situation and/or data collected by the LPN are not clearly consistent with a protocol, the LPN must consult with the supervising professional or authorized provider before taking action or making a recommendation to a patient."	{F 658}		
{F 725} SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure	{F 725}	F-725 For resident #2 a weekly tub or shower per resident preference will be offered and response documented. Rec amt 12.26.18 MB/SL	

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{F 725}	Continued From page 7 resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to ensure there was sufficient nursing staff to maintain the highest practicable physical, mental, and psychosocial well-being of each resident on all four (4) units reviewed. This is a repeat violation for the third consecutive re-certification survey and follow-up review for the most recent recertification survey. Sufficient nursing staff was also cited during the re-certification surveys on December 14, 2017 and October 26, 2016. The findings include the following: 1. Per interview with Resident #2 on 12/4/18, in	{F 725}	For resident #2 care plan has been revised related to preference for female staff for personal care. For resident #2 preferences related to care needs and response to call light has been reviewed with staff. For call lights in general: 1. A quote has been obtained and work is being scheduled to supplement the call bell system to have lights outside resident rooms so all appropriate staff can be aware and answer resident requests for assistance. Anticipated date of completion by vendor is: _____ 2. A communication board will be added to each patient unit to be used to identify events of the day, staff working the unit and other information patients and staff deem appropriate and useful. 3. Staff will be instructed and educated to use phrases that elicit patient preferences and are informative of choices/ and events occurring available to the resident. 4. Staffing schedules have been reviewed and primary assignments have been identified and to be adhered to the extent possible to ensure coverage of all units. BC and 12 26 . 18 MB	

(8)

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{F 725}	Continued From page 8	{F 725}		

the presence of a family member, confirmation was made that the resident has only received two (2) showers since admission on 10/12/18. The resident confirms that necessary care is not provided unless requested, examples are helping him/her to brush teeth, comb hair or wash their back. Per review of Resident #2's person-centered care plan, identifies that the resident requires extensive assistance of one (1) staff member for bathing/dressing and that the resident is to choose the type of bath s/he receives.

Per review of the Licensed Nurse Aide (LNA) documentation for bathing, dated 10/23/18 through 12/4/18 identifies that Resident #2 has received a shower on 10/30/18 and sponge baths on 10/23, 11/13, 11/6, 11/20, 11/27 and 12/4/18. Confirmation was made by the acting Charge Nurse on 12/4/18 at approximately 10:36 AM, that Resident #2 is scheduled to have a bath/shower of his/her choice weekly on Tuesdays. LNA logs evidence that s/he has not consistently had a full bath/shower weekly. Confirmation was also made that facility policy is that all residents receive a bath/shower weekly.

2. Per review of care plan meeting notes, dated 11/2/18 for Resident #2, identifies that the resident voiced preference for female caregivers only, for personal care.

Per interview with Resident #2 on 12/4/18, in the presence of a family member, confirmation was made that the resident recently needed personal care after lunch. The resident utilized the call light with poor results. The family member located a nurse on the unit and requested the assistance of a female care giver for personal

5. Staff meetings have been scheduled to encourage dialogue and improve communication.

CNE and or designee will audit patient and staff satisfaction weekly x4 and monthly x3 the results of audits will be reviewed at QAPI for further recommendations.

Date of compliance: January 4, 2019

BC and 12.26.18 mab

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{F 725}	Continued From page 9	{F 725}		

care for Resident #2. The family member left the facility and once in his/her vehicle, Resident #2 called the family member informing him/her that a male care giver came in to provide personal care. Per family member, Resident #2 was upset.

Per interview with the acting Charge Nurse on 12/4/18 at 10:30 AM, s/he confirms that s/he was unaware of the resident's preference.

3. Per review of the electronic call bell log, dated 11/26/18 through 12/2/18, identifies wait times for Resident #2, of 15-30 minutes on 7 different occasions and wait times 31-52 minutes were on 3 different occasions. The times vary on all three shifts.

Confirmation was made by the Director of Nurses (DNS) on 12/4/18, that the logs do identify the above wait times, but confirmation can not be made that call lights might not have been reset at the time they were answered.

4. Per review of the electronic call bell log wait times, for 3 randomly selected days November 26, December 2 and December 3, 2018, identifies that all 4 units had wait times of 20 minutes or more. On November 26, 2018, evidenced 39 occasions which residents had to wait longer than 20 minutes for staff to respond. On December 2, 2018 there were 31 occasions that wait times were longer than 20 minutes. On December 3, 2018, there were 33 occasions that wait times were longer than 20 minutes.

In the afternoon of 12/4/18, the Director of Nursing (DNS) confirmed that there were wait times above 20 minutes, on these 3 days, however, s/he reported it is possible that the call

Rec amt 12.26.18 MB

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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 725}	Continued From page 10 lights might not have been reset when answered. 5. Per interviews with various residents and staff during the two (2) day follow-up investigations, all confirm that there are numerous traveling staff who are unfamiliar with the residents. Interviews also confirm that not knowing the routines of residents does cause care routines to be altered, extended wait times for services, untimely administration of medications, untimely treatments and family communication to be delayed. Staff voice that they do not feel supported by administration and that over time work hours is more of the expectation vs. a request for assistance. Tasks are added, but no adjustment to routines have been developed. Numerous Unit Mangers, Staff Nurses and ancillary staff have resigned or just not returned to their positions for various reasons. Staff report that communication as to how responsibilities are to be managed or passed on are not shared. Staff input is minimal at best.	{F 725}		

POC cmt 12-26-18 MB/81

Burlington Health & Rehab Center

2567 Re Survey Addendum

F725

1. A quote has been obtained and work is being scheduled to supplement the call bell system to have lights outside resident rooms so all appropriate staff can be aware and answer resident requests for assistance. Anticipated date of completion by vendor is anticipated to be 8 weeks.

2. A communication board will be added to each patient unit to be used to identify events of the day, staff working and other information patients and staff deem appropriate for communication. The boards will not contain resident specific information per HIPPA regulations.

3. Staff will receive education regarding communication to elicited patient choices/preferences regarding care.

4. Staffing schedules have been reviewed and primary assignments have been identified based on census and acuity to assure staffing coverage on all units.

F850 The center will provide 40 hours of a qualified social services utilizing a qualified social worker from sister centers.

Recruitment efforts are ongoing until a qualified social worker is secured for the center.

Continued coverage will be monitored by the Center Executive Director.

POC ongoing 12.26.18
MB SL

Genesis

Date: December 18, 2018

To: Ms. Pamela Cota, RN

Re: Burlington Health & Rehab Center
Plan of Correction,
Credible Allegation of Compliance, and
Request for Re-survey

Dear Ms. Cota:

On December 4, 2018 surveyors from Division of Licensing and Protection completed an inspection at Burlington Health Care & Rehab Center. As a result of the inspection, the surveyors alleged that the Facility was not in substantial compliance with certain Medicare and Medicaid certification requirements. Enclosed you will find the Statement of Deficiencies (HCFA-2567) with the Facility's Plan of Correction for the alleged deficiencies. Preparation of the Plan of Correction does not constitute an admission by the Facility of the validity of the cited deficiencies or of the facts alleged to support the citation of the deficiencies.

Please also consider this letter and the Plan of Correction to be the Facility's credible allegation of compliance. The facility will achieve [or has achieved] substantial compliance with the applicable certification requirements on or before January 4, 2019. Please notify me immediately if you do not find the Plan of Correction acceptable.

This letter is also our request for a re-survey, if one is necessary, to verify that the Facility achieved substantial compliance with the applicable requirements as of the dates set forth in the Plan of Correction and credible allegation of compliance.

Thank you for your assistance with this matter. Please call me if you have any questions.

Yours truly,

Jessica Jennings, RN
Administrator

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