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 27, 2018

Ms. Alecia Dimario, Administrator
Kindred Transitional Care & Rehab Birchwood Terrace
43 Starr Farm Rd
Burlington, VT 05408-1321

Dear Ms. Dimario:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **April 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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 475003 | A. BUILDING _____ B. WING _____ | 04/04/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| KINDRED TRANSITIONAL CARE & REHAB BIRCHWOOD TER | 43 STARR FARM RD BURLINGTON, VT 05408 |

| (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 |
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| F 000 | INITIAL COMMENTS<br><br>An unannounced onsite recertification survey was conducted by the Division of Licensing and Protection on 4/2-4/2018. The following regulatory deficiencies were identified as the result of the survey: | F 000 | *This Plan of Correction is the center's credible allegation of compliance.*<br><br>*Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* | |
| F 645 SS=E | PASARR Screening for MD & ID<br>CFR(s): 483.20(k)(1)-(3)<br><br>§483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability.<br><br>§483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with:<br>(i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission,<br>(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and<br>(B) If the individual requires such level of services, whether the individual requires specialized services; or<br>(ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission-<br>(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility, and<br>(B) If the individual requires such level of services, whether the individual requires | F 645 | F 645<br><br>Residents #4, #5, #10, #36, #53, #54, #83, #84 PASAAR screens were completed and submitted to the State of Vermont.<br><br>House audit completed on PASAAR screen completion to ensure no other residents were affected by this practice.<br><br>The Social Service department staff were educated via conference call on 4/3/18 by Nicole Marabella , State of Vermont PASSR Coordinator, on PASAAR requirements per CMS regulations. A secondary on-sight in-service will be conducted on May 18th.<br><br>Social Service Director or designee will complete random audits monthly on PASAAR completion for residents. The results of these audits will be reviewed with the QAPI committee monthly until 3 consecutive months of compliance is obtained.<br><br>Social Service Director is responsible for overall compliance.<br><br>F645 PoC accepted 4/24/18 mtriggins RN/ PMC | 5/1/18 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Gillian DiLara — TITLE: Executive Director — (X6) DATE: 4/23/18

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 645 | Continued From page 1<br>specialized services for intellectual disability.<br><br>§483.20(k)(2) Exceptions. For purposes of this section-<br>(i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.<br>(ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual-<br>(A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,<br>(B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and<br>(C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services.<br><br>§483.20(k)(3) Definition. For purposes of this section-<br>(i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1).<br>(ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interviews and record reviews, the facility failed to assure that a PASARR | F 645 | | |

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| F 645 | Continued From page 2 | F 645 | | |

(Pre-Admission Screening And Resident Review) was conducted for 8 applicable Residents (Residents #84, #54, #53, #5, #36, #10, #4, and #83) who were admitted with a 30 day exemption and have exceeded their expected 30 day stay. Findings include:

1. Per record review, Resident #84 had a PASARR dated 1/25/16, for which the exemption was marked for an anticipated stay of less than 30 days. There is no evidence of a complete PASARR was completed after the 30 days was exceeded. Resident # 84 has diagnosis of a psychotic disorder. On 04/03/18 at 10:04 AM, the Social Services Director confirmed that the PASARR was not done after the initial 30 day period.

2. Per record review, Resident # 5 has a PASARR screening dated 10/12/05. Part A checked "yes" by the physician identifies that the resident is being admitted to the facility for less than 30 days. There is no evidence of further screening after the 30 days exemption. Resident #5 has diagnoses including, but not limited to, Bipolar Disease and Delirium. On 04/03/18 at 10:04 AM, the Social Services Director confirmed that the PASARR screening has not been updated since the initial 30 day period.

3. Per record review, Resident # 10 has a PASARR screening dated 2/12/16. Part A checked "yes" by the physician identifies that the resident is being admitted to the facility for less than 30 days. There is no evidence of further screening after the 30 days exemption. Resident #10 has diagnoses including, but not limited to, Borderline Personality Disorder and Anxiety/Depressive Disorder. On 04/03/18 at 10:04 AM, the Social Services Director confirmed

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| F 645 | Continued From page 3 | F 645 | | |

that the PASARR screening has not been updated since the initial 30 day period.

4. Per record review, Resident # 36 has a PASARR screening dated 2/7/17. Part A was checked "yes". The screening was signed by the Social Worker and identifies that the resident is being admitted to the facility for less than 30 days. There is no evidence of further screening after the 30 days was exceeded. Resident #36 has diagnoses including, but not limited to Psychosis, Dementia and Major Depressive Disorder. On 04/03/18 at 10:04 AM, the Social Services Director confirmed that the PASARR screening has not been updated since the initial 30 day period.

5. Per record review, Resident # 53 has a PASARR screening dated 2/6/17. Part A checked "yes". The screening was signed by the Social Worker and identifies that the resident is being admitted to the facility for less than 30 days. There is no evidence of further screening after the 30 days was exceeded. Resident #53 has diagnoses including, but not limited to, Schizo-Affect Disorder, Anxiety and Major Depressive Disorder. On 04/03/18 at 10:04 AM, the Social Services Director confirmed that the PASARR screening has not been updated since the initial 30 day period.

6. Per record review, Resident # 54 has a PASARR screening dated 11/3/16. Part A checked "yes". The screening was signed by the physician and the Social Worker identifying that the resident is being admitted to the facility for less than 30 days. There is no evidence of further screening after the 30 days was exceeded. Resident #54 has diagnoses

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| F 645 | Continued From page 4<br>including, but not limited to, Schizo-Affect Disorder, Severe Psychotic Behaviors and Major Depressive Disorder. On 04/03/18 at 10:04 AM, the Social Services Director confirmed that the PASARR screening has not been updated since the initial 30 day period.<br>7. Per medical record review Resident #4 had a 30-day exemption PASARR from the hospital, dated 4/12/17. When it was determined that Resident #4 would remain in long term care, and after the 30 days had lapsed, the facility failed to complete a Level 1 PASARR screening for the change to long term care status. The Director of Social Services confirmed during an interview on 4/4/18 at 9:17 AM, that no PASARR screening was completed after the 30-day exemption document lapsed.<br><br>8. Per medical record review Resident #93 had a 30-day exemption PASSAR from the hospital, dated 3/15/16. When it was determined that Resident #4 would remain in long term care, and after the 30 days had lapsed, the facility failed to complete a Level 1 PASARR screening for the change to long term care status. The Director of Social Services confirmed during an interview on 04/03/18 at 10:05 AM, that no PASARR screening was completed after the 30-day exemption document lapsed. | F 645 | *This Plan of Correction is the center's credible allegation of compliance.*<br><br>*Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* | |
| F 804<br>SS=F | Nutritive Value/Appear, Palatable/Prefer Temp<br>CFR(s): 483.60(d)(1)(2)<br><br>§483.60(d) Food and drink<br>Each resident receives and the facility provides-<br><br>§483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; | F 804 | Temperature logs were immediately implemented.<br><br>All residents have the potential to be affected by this practice.<br><br>Education on beverage temperatures and documentation on temperature logs was provided by the Director of Food Services to dietary staff to ensure compliance on 4/19/18.<br><br>The Food Services Director or designee will complete random weekly to ensure beverage temperatures and documentation is being completed per policy. The results of these audits will be reviewed with the QAPI committee monthly until 3 consecutive months of compliance is obtained.<br><br>The Food Services Director is responsible for overall compliance. | 5/1/18 |



F804 POC accepted 4/24/18 MHiggins RN/AMC

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| F 804 | Continued From page 5<br>§483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview and record review, the facility failed to ensure that beverages were served at a safe and appetizing temperatures. Findings include:<br><br>Per review of facility food temperature logs from 12/1/17 - 3/31/18, of the 363 meals served, hot beverage temperatures were checked only 58 times and cold beverage temperatures were checked only 68 times. This was confirmed by the Executive chef on 4/3/18 at 9:30 A.M. | F 804 | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

AH
"A" FORM

| STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs | PROVIDER # 475003 | MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | DATE SURVEY COMPLETE 4/4/2018 |
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| KINDRED TRANSITIONAL CARE & REHAB BIRCH | 43 STARR FARM RD BURLINGTON, VT |

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES |
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| F 641 | Accuracy of Assessments<br>CFR(s): 483.20(g)<br><br>§483.20(g) Accuracy of Assessments.<br>The assessment must accurately reflect the resident's status.<br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review and confirmed by staff interview, the facility failed to ensure accurate Minimum Data Set (MDS) documentation for 2 of 24 sampled residents, Residents #10 and #93. The findings include the following:<br><br>1. Per medical record review for Resident #10, the MDS assessment (a mandated assessment tool used to evaluate and screen for resident needs) dated 1/4/18, indicates Resident #10 has an active disease of Viral Hepatitis. Interview with the MDS Coordinator Registered Nurse confirms on 4/2/18 at approximately 1 PM, that the resident does not meet the active diagnosis definition for the assessment purposes. Therefore the diagnosis should not have been included on the assessment.<br><br>2. Medical record review for Resident #93 identified a Minimum Data Set (MDS) assessment dated 3/15/18 indicating that the resident received an anticoagulant medication for 7 of the last 7 days. The MDS Coordinator confirmed on 4/2/18 at 3:56 PM that an error was made and in fact resident is on Plavix, which is classified as an anti-platelet medication. |

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The above isolated deficiencies pose no actual harm to the residents

031099

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| E 000 | Initial Comments<br><br>An emergency preparedness review was conducted by the Division of Licensing & Protection during the recertification survey on 4/2-4/2018. There were no regulatory deficiencies identified as a result of the emergency preparedness review. | E 000 | | |

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

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