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 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

Man Cota PN

Licensing Chief



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

PRINTED: 04/17/2018 FORM APPROVED OMB NO. 0938-0391

	TO TOTT MILETOTIVE	- WHILDION NO OLIVIOLO	·		ON DIVIC	. 0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPL A. BUILDING	E CONSTRUCTION		E SURVEY MPLETED
n .		475003	B. WING		04/	04/2018
NAME OF	PROVIDER OR SUPPLIER		5	TREET ADDRESS, CITY, STATE, ZIP CODE	1 047	V4/2010
KINDRE	TRANSITIONAL CA	RE & REHAB BIRCHWOOD TER		3 STARR FARM RD BURLINGTON, VT 05408		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 000	was conducted by	onsite recertification survey the Division of Licensing and	F 000	This Plan of Correction is the center's credicallegation of compliance. Preparation and/or execution of this plan of does not constitute admission or agreement	f correction	
F 645 SS=E	deficiencies were in survey: PASARR Screenin CFR(s): 483.20(k)(dentified as the result of the g for MD & ID (1)-(3)	F 645	provider of the truth of the facts alleged or set forth in the statement of deficiencies. The correction is prepared and/or executed sole	conclusions ne plan of ly because	The second secon
	individuals with a n with intellectual dis §483.20(k)(1) A nu or after January 1, (i) Mental disorder (i) of this section, u authority has deter	rsing facility must not admit, on 1989, any new residents with: as defined in paragraph (k)(3) inless the State mental health mined, based on an		Residents #4, #5, #10, #36, #53, #5 #84 PASAAR screens were comple submitted to the State of Vermont. House audit completed on PASAAI completion to ensure no other reside affected by this practice.	ted and R screen ents were	5/1/18
	performed by a per State mental health (A) That, because condition of the ind the level of service and (B) If the individual services, whether t specialized service (ii) Intellectual disa (k)(3)(ii) of this sec intellectual disabilit	bility, as defined in paragraph tion, unless the State y or developmental disability		The Social Service department staff educated via conference call on 4/3/Nicole Marabella, State of Vermo PASSR Coordinator, on PASAAR requirements per CMS regulations. secondary on-sight in-service will b conducted on May 18 th . Social Service Director or designee complete random audits monthly on PASAAR completion for residents. results of these audits will be review the QAPI committee monthly until	A e will The yed with	A CONTINUE C
ia .	(A) That, because a condition of the ind the level of service and(B) If the individual	mined prior to admission- of the physical and mental ividual, the individual requires s provided by a nursing facility, requires such level of he individual requires		consecutive months of compliance i obtained. Social Service Director is responsib overall compliance. Moss for accords 1/24/18 missage.	s le for	L

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE

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.

(X6) DATE

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

PRINTED: 04/17/2018 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3)	DATE SURVEY COMPLETED
		475003	B. WING				04/04/2018
	PROVIDER OR SUPPLIER D TRANSITIONAL CA	RE & REHAB BIRCHWOOD TER		43 S	EET ADDRESS, CITY, STATE, ZIP CODE TARR FARM RD RLINGTON, VT 05408		0470472016
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 645	Continued From pa						
1 040			F	545			
â I	specialized service	s for intellectual disability.					
	section-	eptions. For purposes of this		.0			
	(i)The preadmissio	n screening program under					
	paragraph(k)(1) of	this section need not provide	i .	į			1
	to a pursing facility	in the case of the readmission of an individual who, after		1			4
	being admitted to the	he nursing facility, was	it	3			
	transferred for care	e in a hospital.		3			
	(ii) The State may	choose not to apply the					
	preadmission scree	ening program under					
	paragraph (k)(1) of	this section to the admission		1	2		
	to a nursing facility (A) Who is admitted	d to the facility directly from a	ĺ				
	hospital after receiv	ving acute inpatient care at the	vi	4			
	hospital,						
	(B) Who requires n	ursing facility services for the		1			
	condition for which	the individual received care in		i			i
	the hospital, and	ng physician has certified,					1
	before admission to	the facility that the individual					12
	is likely to require le facility services.	ess than 30 days of nursing					,
	§483.20(k)(3) Defir section-	nition. For purposes of this					T
1	- Control of the cont	considered to have a mental					
	disorder if the indiv	idual has a serious mental					
	disorder defined in	483.102(b)(1).					
	(II) An individual is	considered to have an					
	intellectual disability	y if the individual has an y as defined in §483.102(b)(3)					80
	or is a person with	a related condition as					
	described in 435.10	010 of this chapter.					
		NT is not met as evidenced					
	by:						
	facility foiled to see	rviews and record reviews, the					

CENTE	RS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES		W/		<u>u</u>	American Company	FOR	D: 04/17/2018 MAPPROVED D: 0938-0391
AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		ONSTRUCTION			(X3) D/	ATE SURVEY OMPLETED
		475003	B. WING	45-1-1-000000000000000000000000000000000					
NAME OF	PROVIDER OR SUPPLIER	According to the second		STRE	ET ADDRESS, C	ITY STATE	ZIP CODE	1 04	4/04/2018
KINDRE		RE & REHAB BIRCHWOOD TER	3	43 S	TARR FARM RE)	211 3002		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDE (EACH COR CROSS-REFE	RECTIVE AC		LDBE	(X5) COMPLETION DATE
F 645	Continued From pa	ge 2	F 6	A E	AV(1)	ė,		300000	
		eening And Resident Review)	,	45					9
	was conducted for t	3 applicable Residents							
	(Residents #84, #54	4, #53, #5, #36, #10, #4, and		1					
	#83) who were adm	litted with a 30 day exemption							
	Findings include:	their expected 30 day stay.							*
	1. Per record review	w, Resident #84 had a		*	2)				
=	PASARR dated 1/25	5/16, for which the exemption		all or many parties					
	was marked for an a	anticipated stay of less than					8		
	30 days. There is n	o evidence of a complete							
	exceeded Resident	leted after the 30 days was # 84 has diagnosis of a		1					
	psychotic disorder	On 04/03/18 at 10:04 AM, the		1					
	Social Services Dire	ctor confirmed that the		B					
	PASARR was not do	one after the initial 30 day							
	period.	***							
2	PASARR screening	v, Resident # 5 has a dated 10/12/05. Part A							
,	checked "yes" by the	e physician identifies that the		1					
	resident is being add	mitted to the facility for less							1
	than 30 days. There	is no evidence of further							7
	Screening after the 3	30 days exemption. Resident							Î
	Bipolar Disease and	cluding, but not limited to, Delirium. On 04/03/18 at	A T	i					d
	10:04 AM, the Socia	Services Director confirmed							The Control of the Co
	that the PASARR sc	reening has not been							*
	updated since the in	itial 30 day period.				19			
	3. Per record review	w, Resident # 10 has a							
	PASARR screening	dated 2/12/16 Part A		ě.					
	checked "yes" by the	physician identifies that the							
	than 30 days. Thorn	nitted to the facility for less							
	screening after the 3	is no evidence of further 0 days exemption. Resident							n I
	#10 has diagnoses in	acluding but not limited to							
	Borderline Personali	ty Disorder and					5		8
	Anxiety/Depressive [Disorder. On 04/03/18 at							ľ

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 04/17/2018 FORM APPROVED OMB NO. 0938-0391

		& MEDICAID SERVICES				OMB NO	0.0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		ONSTRUCTION		TE SURVEY MPLETED
		475003	B. WING	CONTRACTOR OF THE CONTRACTOR O	to Notificial English and Annual Property of the Control of the Co		10410040
NAME OF	PROVIDER OR SUPPLIER	V		STRE	ET ADDRESS, CITY, STATE, ZIP CODE	1 04	/04/2018
KINDRE	D TRANSITIONAL CA	RE & REHAB BIRCHWOOD TER			TARR FARM RD		
MINDIAL	- TRANSITIONAL CA	RE & REHAB BIRCHWOOD TER		BUR	RLINGTON, VT 05408		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LDBE	(X5) COMPLETION DATE
F 645	Continued From pa	ige 3	F 6	, ,	* (
		creening has not been		-10			\$
	updated since the in	nitial 30 day period.		į	2		
		202					Ī
	4. Per record revie	w, Resident # 36 has a					
	PASARR screening	dated 2/7/17. Part A was					
920 F.	Social Worker and	e screening was signed by the identifies that the resident is					
	being admitted to the	ne facility for less than 30					r.
	days. There is no e	evidence of further screening		*			
	after the 30 days wa	as exceeded. Resident #36			₹ =		
	has diagnoses inclu	uding, but not limited to					1
	Psychosis, Dement	ia and Major Depressive					
	Services Director of	8/18 at 10:04 AM, the Social onfirmed that the PASARR		ŧ			-
	screening has not h	peen updated since the initial					
	30 day period.	been aposted since the fillial		1			
					:: :		
	Per record review	w, Resident # 53 has a					
	PASARR screening	dated 2/6/17. Part A checked					į.
	'yes". The screening	ng was signed by the Social		į.			ř.
	admitted to the facil	es that the resident is being lity for less than 30 days.		- 1			
	There is no evidence	se of further screening after					
	the 30 days was ex	ceeded. Resident #53 has		ŧ			
	diagnoses including	, but not limited to.					
	Schizo-Affect Disord	der, Anxiety and Major					
	the Social Services	er. On 04/03/18 at 10:04 AM, Director confirmed that the					
	PASARR screening	has not been updated since					ř.
	the initial 30 day per	riod.					ħ
	6. Per record review	w, Resident # 54 has a					
	PASARR screening	dated 11/3/16. Part A					
	checked "yes". The	screening was signed by the				3	
	physician and the S	ocial Worker identifying that				2	
	less than 30 days	admitted to the facility for					
	further screening at	There is no evidence of ter the 30 days was		8			
	exceeded. Residen	nt #54 has diagnoses					

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 04/17/2018 FORM APPROVED OMB NO. 0938-0391

		& MEDICAID SERVICES			MB NO. 0938-039
STATEMENT OF DE AND PLAN OF COR	FICIENCIES RECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	8-11	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		475003	B. WING		
NAME OF PROVID	ER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	04/04/2018
KINDRED TRA		RE & REHAB BIRCHWOOD TER	100000	43 STARR FARM RD BURLINGTON, VT 05408	
(X4) ID PREFIX (TAG R	EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BF COMPLETION
	inued From pa		F 64	5	
Disor Deprethe S PASA the in 7. Per 30-da dated Resid after comp chang Social 4/4/10 was d	der, Severe Passive Disorder ocial Services ARR screening of the services are medical received exemption Fit 4/12/17. Who dent #4 would out the 30 days had bette a Level 1 ge to long termil Services con Brat 9:17 AM, to	nited to, Schizo-Affect sychotic Behaviors and Major r. On 04/03/18 at 10:04 AM, Director confirmed that the has not been updated since riod. ord review Resident #4 had a ASARR from the hospital, en it was determined that remain in long term care, and d lapsed, the facility failed to PASARR screening for the care status. The Director of firmed during an interview on hat no PASARR screening rethe 30-day exemption		This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of codoes not constitute admission or agreement by provider of the truth of the facts alleged or conset forth in the statement of deficiencies. The procession is prepared and/or executed solely but it is required by the provisions of federal and see F 804	orrection the clusions olan of
8. Per 30-da dated Resid after to comp chang Socia 04/03. was condocumed from the comp change Socia Comp change Co	r medical record by exemption P 3/15/16. Whilent #4 would record whe 30 days have the 30 days have the a Level 1 If the services confused after the services at 10:05 Allompleted at 10:05 Allomple	(1) (1) (1) (1) (1) (1) (1) (1) (1) (1)	F 804	Temperature logs were immediately implemented. All residents have the potential to be a by this practice. Education on beverage temperatures a documentation on temperature logs we provided by the Director of Food Services of the complete random weekly to ensure bettemperatures and documentation is beit completed per policy. The results of the audits will be reviewed with the QAPI committee monthly until 3 consecutive months of compliance is obtained. The Food Services Director is responsi	nd as ices to 4/19/18. ee will verage ng hese

overall compliance.

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 04/17/2018 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING COMPLETED 475003 B. WING NAME OF PROVIDER OR SUPPLIER 04/04/2018 STREET ADDRESS, CITY, STATE, ZIP CODE KINDRED TRANSITIONAL CARE & REHAB BIRCHWOOD TER 43 STARR FARM RD BURLINGTON, VT 05408 SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (X5) COMPLETION DATE (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 804 Continued From page 5 F 804 §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that beverages were served at a safe and appetizing temperatures. Findings include: 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.

STATEMENT	12 15OLATED DE RERORS WHICH CALIER	DEPENDENCE :		"A" FOI
NO HARM W	OF ISOLATED DEFICIENCIES WHICH CAUSE 2TH ONLY A POTENTIAL FOR MINIMAL HARM	PROVIDER #	MULTIPLE CONSTRUCTION A. BUILDING	DATE SURVEY
FOR SNESAN	ND NFs		A. BOILDING	COMPLETE
	4.	475003	B. WING	4/4/2018
	covider or supplier D'TRANSITIONAL CARE & REHAB BIRCH	43 STARR FARM		
ID		BURLINGTON.	VI	
PREFIX TAG	SUMMARY STATEMENT OF DEFICIEN	CIES		
F 641	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect to the accurate and continuous accurate and continuous accurate and continuous accurate and continuous accurate accurate and continuous accurate a	idenced by: offirmed by staff intered on for 2 of 24 samp on #10, the MDS as ated 1/4/18, indical	erview, the facility failed to ensure acted residents, Residents #10 and #93 seessment (a mandated assessment to tes Resident #10 has an active diseas	ol used to . se of Viral
	that the resident does not meet the active diagnosis should not have been included 2. Medical record review for Resident # indicating that the resident received an at Coordinator confirmed on 4/2/18 at 3:56 classified as an anti-platelet medication.	on the assessment.	imum Data Set (MDS) assessment di	refore the atted 3/15/18
	diagnosis should not have been included 2. Medical record review for Resident # indicating that the resident received an at Coordinator confirmed on 4/2/18 at 3:56	on the assessment.	imum Data Set (MDS) assessment di	refore the atted 3/15/18
	diagnosis should not have been included 2. Medical record review for Resident # indicating that the resident received an at Coordinator confirmed on 4/2/18 at 3:56	on the assessment.	imum Data Set (MDS) assessment di	refore the atted 3/15/18
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	diagnosis should not have been included 2. Medical record review for Resident # indicating that the resident received an at Coordinator confirmed on 4/2/18 at 3:56	on the assessment. 93 identified a Min nticoagulant medica PM that an error w	imum Data Set (MDS) assessment di	efore the ated 3/15/18
	diagnosis should not have been included 2. Medical record review for Resident # indicating that the resident received an at Coordinator confirmed on 4/2/18 at 3:56	on the assessment. 93 identified a Min nticoagulant medica PM that an error w	imum Data Set (MDS) assessment dation for 7 of the last 7 days. The Mass made and in fact resident is on Pl	efore the ated 3/15/18
	diagnosis should not have been included 2. Medical record review for Resident # indicating that the resident received an at Coordinator confirmed on 4/2/18 at 3:56	on the assessment. 93 identified a Min nticoagulant medica PM that an error w	imum Data Set (MDS) assessment dation for 7 of the last 7 days. The Mass made and in fact resident is on Pl	efore the ated 3/15/18
	diagnosis should not have been included 2. Medical record review for Resident # indicating that the resident received an at Coordinator confirmed on 4/2/18 at 3:56	on the assessment. 93 identified a Min nticoagulant medica PM that an error w	imum Data Set (MDS) assessment dation for 7 of the last 7 days. The Mass made and in fact resident is on Pl	efore the ated 3/15/18
	diagnosis should not have been included 2. Medical record review for Resident # indicating that the resident received an at Coordinator confirmed on 4/2/18 at 3:56	on the assessment. 93 identified a Min nticoagulant medica PM that an error w	imum Data Set (MDS) assessment dation for 7 of the last 7 days. The Mass made and in fact resident is on Pl	efore the ated 3/15/18
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Any deficitney statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safegoards 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 of not a plan of correction are disclosable 14 days following the date these documents are made as aliable to the facility. It deficiencies are ened, an approved plan of

The above isolated deficiencies pase no actual harm to the residents

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 04/17/2018 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING COMPLETED 475003 8. WING NAME OF PROVIDER OR SUPPLIER 04/04/2018 STREET ADDRESS, CITY, STATE, ZIP CODE KINDRED TRANSITIONAL CARE & REHAB BIRCHWOOD TER 43 STARR FARM RD BURLINGTON, VT 05408 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL ID (X5) COMPLETION DATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) E 000 Initial Comments E 000 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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 grogram participation.