

April 15, 2010

Daniel Daly, Administrator
Birchwood Terrace Healthcare
43 Starr Farm Rd
Burlington, VT 05401

Provider #: 475003

Dear Mr. Daly:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **March 31, 2010**. Please post this document in a prominent place in your facility.

We will 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,



Suzanne Leavitt, RN, MS
Licensing Chief

Enclosure



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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475003	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/31/2010
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NAME OF PROVIDER OR SUPPLIER BIRCHWOOD TERRACE HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 43 STARR FARM RD BURLINGTON, VT 05401
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F 000	INITIAL COMMENTS	F 000		
F 279 SS=D	<p>The Division of Licensing and Protection conducted an unannounced onsite annual recertification survey 3/29/10 - 3/31/10.</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe 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 §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to develop a comprehensive care plan for one resident (#58). Findings include:</p> <p>Per record review on 3/30/10 at 4:32 PM, there was no care plan for Resident #58 who was admitted in late March, 2010, with an indwelling</p>	F 279	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>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.</i></p> <p>F 279</p> <p>Resident #58 was care planned for indwelling catheter. Catheter was d/c on 3/30/10.</p> <p>Current residents with catheters will be reviewed for care plan. Care plans will be developed for any resident without a care plan.</p> <p>The Staff Development Coordinator or her designee will educate staff on the care plan process for catheter use.</p> <p>Audits (record review) of residents with indwelling catheters will be conducted weekly times 3 months to ensure a plan of care is in place.</p> <p>Results of these audits will be reported to the monthly Performance Improvement Committee and changes will be done as needed. The DNS is responsible for overall compliance.</p> <p><i>OC audit 4-15-10</i></p>	May 1, 2010
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE		(X6) DATE
		Administrator		9/15/10

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 279	Continued From page 1 Foley catheter in place. During a 4:57 PM interview on 3/30/10, the Unit Manager confirmed that there was no care plan to address the resident's Foley catheter and stated that all residents with Foley catheters should have a care plan addressing the use of the catheter.	F 279	<i>This Plan of Correction is the center's credible allegation of compliance.</i>	
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review the facility failed to follow proper sanitation and food handling practices. Findings include: 1. Per observation on 3/30/10 at 11:10 AM, a Dietary Aide was asked to test the Low Temperature Dish washing system for chlorine level. The test strip indicated a zero level of chlorine. The test was repeated twice and the readings were both zero. All readings were confirmed at the time of observation by the Dietary Manager and the Dietician. Chlorine levels should be 50 - 100 ppm per facility policy. The " Low Temperature Dish machine: Temperature & Sanitizer Log " indicated that testing had not been done at 8 AM on 3/31/10 after the breakfast service per facility policy.	F 371	<i>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.</i> F 371 Eco Lab was contacted immediately on 3/30/10 regarding the chlorine level testing 0. The dishwasher was fixed the same day prior to the next meal. The C wing refrigerator was repaired on April 1, 2010 and there have been no further temperatures out of range. A and B wing refrigerators were checked for temperatures out of range. Both had no temperatures out of range. Dietary staff will be educated on the following: -Documentation of dishwasher chlorine levels 3x/day and the need to notify the Food Service Manager when results are out of range. -Notifying the Food Service Manager when the Refrigerator/Freezer temperatures are out of range. -Documentation of chemical sanitizer level of the pot sink 3x/day. Nursing staff will be educated to notify Maintenance when the unit refrigerators are out or temperature range. The Sanitizer log for the pot sink and dishwasher and the temperature log for the refrigerator/freezer have been changed to include a supervisor signature validation that	May 1, 2010

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F 371	<p>Continued From page 2</p> <p>2. Per record review on 3/31/10 at 12:30 PM the " Low Temperature Dish machine Temperature & Sanitizer Test Log " for January, February, and March showed that dietary staff failed to document the required three times a day testing of the dishwasher sanitizing system per facility policy on 24 separate days. The missing test documentation was confirmed by the Dietary Manager at 12:33 P.M. on 3/31/10..</p> <p>3. Per record review on 3/29/10 at 10:35 AM the March Walk-In Freezer Temperature Log noted the freezer to have documented out-of-range temperatures (temperature higher/warmer than 0 degrees Fahrenheit) on 5 out of 29 morning readings. Out-of-range readings for March were confirmed by the Dietary Manager and the Maintenance Supervisor at 10:50 AM. Record Review of Walk-in Freezer temperature logs for January and February documented out-of-range temperatures on 4 out of 31 mornings and 2 out of 28 mornings respectively, and was confirmed by the Dietary Manager on 3/31/10 at 12:35 PM.</p> <p>4. Per record review and interview on 3/31/10 at 7:35 AM with Unit Manager, the C Wing Refrigerator had out-of-range readings (higher/warmer than 38 degrees Fahrenheit) recorded on 11 out of 31 days in March. Refrigerator/Freezer Temperature Log March readings confirmed with Unit Manager at 7:35 A.M. on 3/31/10.</p> <p>5. On 3/29/10 at 10:55 AM a record review of the Pot and Pan Sink Sanitizer Log for March showed that dietary staff failed to document the required three times a day testing per facility policy of the chemical sanitizer in the pot and pan sink on 6</p>	F 371	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>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.</i></p> <p>test results are with range or if out of range, follow up has been completed.</p> <p>Random audits will be done 3x/week by the Executive Director or his designee for 1 month then weekly for 3 month to ensure sanitizing results and refrigerator/freezer temperatures are within range and if not in range that appropriate follow-up was taken.</p> <p>Results of the these audits will be brought to the monthly Performance Improvement Committee meeting and changes will be made as appropriate. The Executive Director is responsible for overall compliance.</p> <p><i>Acc Audit 4-15-10</i> <i>R. F. Rubin</i></p>	
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PRINTED: 04/07/2010
FORM APPROVED
OMB NO. 0938-0391

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F 371 Continued From page 3
separate days in March. The missing test documentation was confirmed by the Dietary Manager at 10:55 AM on 3/29/10.

F 411 483.55(a) ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS
SS=D

The facility must assist residents in obtaining routine and 24-hour emergency dental care.

A facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine and emergency dental services to meet the needs of each resident; may charge a Medicare resident an additional amount for routine and emergency dental services; must if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and promptly refer residents with lost or damaged dentures to a dentist.

This REQUIREMENT is not met as evidenced by:
Based on observation, family and staff interview, and record review, the facility failed to assist in obtaining routine dental care for one resident (#82). Findings include:

Per family interview on 3/30/10 at 10:15 AM, and confirmed by interview with Unit Manager on 3/31/10 at 10:40 AM, Resident #82 has not had routine dental services in the past 2 years. Per observation on 3/31/10 at 10:34 AM and confirmed by the Licensed Nursing Assistant (LNA) providing care, Resident #82 has bleeding in the oral cavity when her teeth are brushed.

F 514: 483.75(l)(1)-RES
SS=B RECORDS-COMplete/ACCURATE/ACCESSIB

F 371
This Plan of Correction is the center's credible allegation of compliance.

F 411
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 411
Resident #82 was assessed for dental services by the attending M.D. and a treatment was ordered for the bleeding gums. The responsible party was notified regarding dental consult and declined external dental services due to resident's declining condition.

Unit managers will assess residents for the need of dental services. Residents and or responsible parties will be notified re: need for external dental services.

The Staff Development Coordinator or her designee will educate nursing staff on the process of residents requiring dental services.

Random audits of residents will be done monthly to ensure that any resident in need of dental services has had follow-up.

Results of these audits will be brought to monthly Performance Improvement Ctm. Changes will be made as necessary. The DNS is responsible for overall compliance.

F 514
*Receipt 4-15-10
R. [Signature]*

May 1, 2010

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F 514	<p>Continued From page 4 LE</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based upon staff interview and record review, the Facility failed to maintain accurate, complete, and organized clinical information about each resident that is readily accessible for resident care for three residents in the applicable sample. (Residents #115, #142, and #147). Findings include: 1. Per Record Review on 3/31/10, Resident #142 was on every 15 minute suicide precaution checks per nursing measure initiated on 3/8/10. On 3/29/10, there was no evidence that staff on the day, evening, and night shifts documented on the Resident Observation Checklist that every 15 minute suicide precaution checks were conducted for Resident #142. On 3/31/10, at 9:36 AM, the Charge Nurse confirmed that on 3/29/10 every 15 minute suicide precaution checks for Resident #142 were not documented by all three shifts on the Resident Observation Checklist.</p> <p>2. Per record review during the three days of</p>	F 514	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>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.</i></p> <p>F 514 Nursing staff caring for resident #142 will be educated on the importance of documenting 15-minute checks for suicide precautions. There were no other missing entries for the 15-minute check suicide precaution. Resident # 115 was re-weighed and weighs 140 lbs. Resident # 147 was re-weighed and weighs 179 lbs. The RCS system was updated with the accurate weight.</p> <p>No other residents are currently on 15 minute checks for suicide precautions. Resident weights will be reviewed for accuracy. Residents will be re-weighed as needed for inaccurate weights and RCS system will be updated with the accurate weight. A new process has been initiated which requires the weights and the date obtained. Nursing staff will be educated regarding the new process.</p> <p>The SDC or her designee will educate nursing staff on the accurate documentation of 15 minute check suicide precautions. The Charge Nurse or her designee is responsible to file the completed 15-minute check forms in the medical record.</p> <p>The Nurse Manager or her designee will</p>	May 1, 2010.
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F 514	<p>Continued From page 5</p> <p>survey, the Resident Care System (RCS) failed to have current accurate records with accepted standards for Residents #115 & #147. Per record review on 3/29/10 the RCS weights for Resident # 115 was recorded as 120 lbs. and for Resident #147 was recorded as 160 lbs. Per record review on 3/30/10 in the morning, Resident # 147's weight showed a hand written weight of 170 lbs. Per interview, at this time, the Dietician stated that the 160 weight "must have been recorded wrong" and was suppose to be 170 and Resident# 115 should be 141 lbs.. However, the Dietician was unable to show evidence by either the worksheet nor documentation. Per interview on 3/31/10 at 9:30 A.M., the RCS data entry person confirmed that the weights given to the surveyors on the first day of survey (03/29/10) was accurate and current at that time and was not aware of changes. Per interview the Dietician on 03/31/10 at 11:30 A.M. confirmed that an entry into the system can be changed after it is initially recorded without the date and time being recorded from the computers internal clock at the time of a new entry or by whom, thereby not following accepted practice of assuring accurate clinical records by dating and signing.</p>	F 514	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>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.</i></p> <p>audit the medical record 3x/week of any resident on suicide precaution 15-minute check to ensure documentation is complete. The Nurse Manager or her designee will do random audits of weight documentation weekly for 3 months to ensure accuracy and compliance.</p> <p>Results of these audits will be reviewed at the monthly Performance Improvement Committee meeting and changes will be made as necessary. The DNS is responsible for overall compliance.</p> <p><i>Doc signed 4-15-10</i> <i>R. F. Kelly</i></p>	
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