



AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING
Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury VT 05671-2306
<http://www.dail.vermont.gov>
Voice/TTY (802) 241-2345
To Report Adult Abuse: (800) 564-1612
Fax (802) 241-2358

December 9, 2010

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

Dear Mr. Daly:

Enclosed is a copy of your acceptable plans of correction for the complaint investigation conducted on November 23, 2010. 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,

A handwritten signature in black ink, appearing to read "Pamela M. Cota". The signature is written in a cursive, flowing style.

Pamela M. Cota, RN
Licensing Chief



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

RECEIVED
Division of

PRINTED: 11/29/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475003	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ Licensing and Protection B. WING _____	(X3) DATE SURVEY COMPLETED C 11/23/2010
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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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(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	F 000	<i>This Plan of Correction is the center's credible allegation of compliance.</i>	
F 312 SS=D	<p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS</p> <p>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide necessary services to maintain good grooming and personal hygiene for 1 of 7 residents in the sample (Resident #1). Findings include:</p> <p>Per observation on 11/23/10 at 12:30 PM, Resident #1's fingernails were long and had a buildup of a brownish substance under the nails. The Resident has a history of scratching his/herself and is being treated for itchy skin. Per record review on 11/23/10 at 12:46 PM, the Resident is dependent on staff for personal hygiene, including nail care. On 11/23/10 at 12:50 PM, the Unit Manager confirmed that Resident #1's fingernails were long and dirty and that the Resident was dependent on staff for grooming and personal hygiene.</p>	F 312	<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 312 Resident #1 fingernails were cleaned and trimmed on 11/23/10</p> <p>The DNS, or her designee, will assess each resident for appropriate grooming. The DNS or her designee will provide individual in-service and or counseling to staff members identified as not providing necessary care to residents identified through the assessment process.</p> <p>The DNS or her designee will in-service nursing staff on providing nail care.</p> <p>The DNS or her designee will conduct weekly rounds to assure that care is provided.</p> <p>The DNS, or her designee, will monitor through observation that appropriate grooming is provided. Results of these observations will be brought to the monthly Performance Improvement Committee at least monthly for 3 months or until 100% compliance achieved. The DNS is responsible for overall compliance.</p> <p>F312 POC Accepted 12/9/10 R-Tremblay RN / Pincoturn</p>	12/10/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 12/3/10
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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.