

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

October 3, 2016

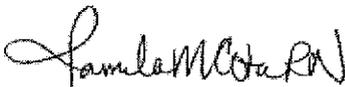
Ms. Alecia Dimario,
Kindred Transitional Care & Rehab Birchwood Ter
43 Starr Farm Rd
Burlington, VT 05408-1321

Dear Ms. Dimario:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **August 30, 2016**. 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

PRINTED: 09/14/2016
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 _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/30/2016
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIDNAL CARE & REHAB BIRCHWOOD TER			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
F 000	INITIAL COMMENTS An unannounced on site investigation of four (4) self reports was conducted by the Division of Licensing and Protection on 8/29 and 8/30/16. The findings include the following: F 280 483.20(d)(3), 483.10(k)(2) RIGHT TO SS=D PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, record review and confirmed by staff interview the facility failed to ensure that the comprehensive care plan was updated to reflect the current needs of 1 of 6 sampled residents. For Resident #4, the findings include the following:	F 000	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <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 280		F 280	Resident #4 care plan was updated to reflect current care needs. Residents on 15 minute checks have the potential to be affected by the alleged deficient practice. Nursing staff have been educated on the policy of updating resident care plans to reflect current care needs. The DNS/designee will do random audits of resident care plans to assure compliance at the weekly care plan review meetings. Results of these audits will be brought to the monthly Quality Improvement meeting for 3 months to ensure compliance. The DNS is responsible for overall compliance. F280 POC accepted 9/29/16 MBeckman/RL/PMU	9/26/16	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Alissa D. Mann* TITLE *Executive Director* (X6) DATE *9/19/16*

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.

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

PRINTED: 09/14/2016
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 _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/30/2016
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE & REHAB BIRCHWOOD TER			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
F 280	Continued From page 1 Per review of the medical record, Resident #4 was admitted on 11/8/13 with diagnosis to include Dementia with Behavioral Disturbances, Major Depressive Disorder and Alzheimer's Disease. Per review of the resident's Interdisciplinary Care Plan (ICP), a focus identifies verbal aggression towards others and documents actual altercations residents on 6/8/16 and 8/14/16. Interventions in managing the resident are multiple, but do not include the 15 minute checks that began on 8/14/16 per nurses notes. Confirmation was made at 8:55 AM by the Unit Manager that the care plan does not include the 15 minute checks. Therefore the care plan has not been updated to reflect the resident's current needs.	F 280			
F 282	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview the facility failed to provide necessary supervision by qualified persons in accordance with the written plan of care for 2 of 6 sampled residents (Resident #1 and #6). The findings include the following: 1. Per medical record review, Resident #1 was admitted on 6/8/16 with diagnosis to include Alzheimer's Disease, Dementia with Behavioral	F 282	Resident #1 is receiving 1 on 1. Resident #6 15 minute checks have been discontinued. All residents on 15 minute checks have the potential to be affected by the alleged deficient practice. Staff have been re-educated on the policy to document 15 minute checks using the "monitoring tool". Nurse managers/charge nurses will review 15 minute monitoring tool every shift to assure accurate documentation of intervention. The DNS/designee will do random audits of "monitoring tool" to assure compliance. Results of these audits will be brought to the monthly Quality Improvement Committee for 3 months to ensure compliance. The DNS is responsible for overall compliance.	9/26/16	
			F882 POC accepted 9/29/16 mberhanden/pme		

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

PRINTED: 09/14/2016
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 _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/30/2016
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE & REHAB BIRCHWOOD TER		STREET ADDRESS, CITY, STATE, ZIP CODE 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)

F 282 Continued From page 2

F 282

Disturbances, Irritable Bowel Syndrome and Hypertension. Per review of the nurses notes, Resident #1 has been involved in numerous resident to resident altercations. Documentation identifies that the resident is intrusive into other's rooms, not always redirectable with episodic acts of aggression.

Per review of the resident's Interdisciplinary Care Plan (ICP), a focus identifies a potential for resident to resident altercations related to Dementia with lack of safety awareness, constant intrusive wandering, inability to adequately interpret the actions of others and the effects of his/her own actions, inability to interpret needs of others. Documented actual incidents occurred on 6/12/16, 6/26/16, 7/6/16 and 8/14/16. Interventions in managing the behaviors identified are multiple and include 15 minute safety checks.

Per observation by the nurse surveyor that began on 8/29/16 at 11:20 AM two (2) female residents sit outside Resident #1's room by the exit door. Residents ambulate freely up and down the hall.

The following activity took place:

11:50 AM Charge Nurse and Licensed Nurse Aide (LNA) observe the resident to be asleep. Thirty (30) minutes since the surveyor's observation began and no knowledge when the resident was actually last seen by the nursing staff.

12:25 PM Licensed Practical Nurse (LPN) enters the resident's room. Thirty five (35) minutes since the last staff observation.

12:48 PM LPN brings the resident lunch. Surveyor restarts observation on 8/29/16 at 2 PM. 2:19 PM LPN enters the resident's room and shares with the surveyor that s/he ate very little

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

PRINTED: 09/14/2016
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 _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/30/2016
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE & REHAB BIRCHWOOD TER			STREET ADDRESS, CITY, STATE, ZIP CODE 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
F 282	Continued From page 3 lunch, but drank all fluids offered. Nineteen (19) minutes since the surveyor's observation began. No knowledge as to when the last staff observation occurred prior to 2 PM. 2:32 PM LPN checks on resident. 2:42 PM LPN checks on resident. 3:16 PM agitated female resident enters Resident #1's room and exits immediately. She is exit seeking, ambulating at a fast past and enters other resident rooms along the corridor. 3:20 PM LPN checks on the resident. Thirty-eight (38) minutes since the last staff observation. LPN confirms at 3:20 PM that s/he has not checked on this resident every 15 minutes as directed by the care plan. Per review of the "Resident Monitoring Tool", it is a form used to identify that safety checks have been completed, the time the observation was conducted, the location of activity and initials of who completed the check. Nurses notes have numerous entries identifying that the 15 minute checks are ongoing beginning on 6/19/16, however the "Monitoring Tool" has not been consistently completed. The following entries evidence incomplete documentation of the actual observation. They are as follows: 6/21/16 from 12 AM through 6:30 AM, 6/28/16 from 11:30 PM through 11:45 PM, 7/31/16 from 5 PM through 6:15 PM, 8/2/16 from 11:30 PM through 11:45 PM, 8/8/16 from 11:30 PM through 11:45 PM, no documentation can be located for a 24 hour period for 8/10/16, 8/15/15 from 11:30 PM through 11:45 PM, no documentation can be located for a 24 hour period for 8/16/16, 8/22/16 from 11:15 AM through 2:30 PM and 8/26/16 from 11:30 AM through 3 PM.	F 282		

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

PRINTED: 09/14/2016
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 _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/30/2016
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE & REHAB BIRCHWOOD TER			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
F 282	Continued From page 4 Per interview with the Director of Nurses at 9:50 AM confirmation was made that the safety checks for Resident #1 are inconsistently documented. 2. Per medical record review, Resident #6 was admitted on 10/29/14 with diagnosis to include Dementia with Behavioral Disturbances, Falls, Hypertension, COPD, Anemia, Alcohol and Nicotine Dependence and Cognitive Communication Deficit. Per review of the resident's Interdisciplinary Care Plan (ICP), the resident has a focus for potential of resident to resident altercations related to cognitive and communication deficits, progressive Dementia and a wandering history resulting in altercations with other residents. Multiple interventions to manage resident to resident altercations are listed and include 15 minute safety checks. Nurses notes have numerous entries identifying that the 15 minute checks are ongoing. However the "Monitoring Tool" has not been consistently completed. The following entries evidence incomplete documentation of the actual observation. They are as follows: 7/14/16 from 9:30 PM through 10:30 PM, 8/14/16 from 7 AM through 2:45 PM, 8/15/16 from 7 AM through 7:15 PM and 8/27/16 from 3:30 PM through 10:30 PM. Per interview with the Unit Manager at 11:30 AM confirmation was made that the safety checks for Resident #6 are inconsistently documented.	F 282			
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives	F 323			

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

PRINTED: 09/14/2016
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 _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/30/2016
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE & REHAB BIRCHWOOD TER		STREET ADDRESS, CITY, STATE, ZIP CODE 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	PRDVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	<p>Continued From page 5</p> <p>adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and confirmed by staff interview the facility failed to ensure that each resident receives adequate supervision to prevent accidents and deter an opportunity for a resident to resident altercation for 3 of 6 sampled residents. For Residents #1, #4 and #6 the findings include the following:</p> <p>1. Per medical record review, Resident #1 was admitted on 6/8/16 with diagnosis to include Alzheimer's Disease, Dementia with Behavioral Disturbances, Irritable Bowel Syndrome and Hypertension. Per review of the nurses notes, Resident #1 has been involved in numerous resident to resident altercations. Documentation identifies that the resident is intrusive into other's rooms, not always redirectable with episodic acts of aggression.</p> <p>Per review of the resident's Interdisciplinary Care Plan (ICP), a focus identifies a potential for resident to resident altercations related to Dementia with lack of safety awareness, constant intrusive wandering, inability to adequately interpret the actions of others and the effects of his/her own actions, inability to interpret needs of others. Documented actual incidents occurred on 6/12/16, 6/26/16, 7/6/16 and 8/14/16. Interventions in managing the behaviors identified are multiple and include 15 minute safety checks.</p>	F 323	<p>F 323</p> <p>Resident #1 is receiving 1 on 1. Residents #6 and #4 15 minute checks have been discontinued.</p> <p>All residents on 15 minute checks have the potential to be affected by the alleged deficient practice.</p> <p>Staff have been re-educated on the policy and procedure for 15 minute checks.</p> <p>Nurse managers/charge nurses will review 15 minute monitoring tool every shift to assure accurate documentation of intervention.</p> <p>The DNS/designee will do random observations of resident's on 15 minute checks to assure compliance. Results of these audits will be brought to the monthly Quality Improvement Committee for 3 months to ensure compliance.</p> <p>The DNS is responsible for overall compliance.</p> <p>F323 POC accepted 9/29/16 M.Bertrand RN/PMU</p>	9/26/16

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

PRINTED: 09/14/2016
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 _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/30/2016
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE & REHAB BIRCHWOOD TER		STREET ADDRESS, CITY, STATE, ZIP CODE 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
F 323	<p>Continued From page 6</p> <p>Per observation by the nurse surveyor that began on 8/29/16 at 11:20 AM two (2) female residents sit outside Resident #1's room by the exit door. Residents ambulate freely up and down the hall.</p> <p>The following activity took place: 11:50 AM Charge Nurse and Licensed Nurse Aide (LNA) observe the resident to be asleep. Thirty (30) minutes since the surveyor's observation began and no knowledge when the resident was actually last seen by the nursing staff. 12:25 PM Licensed Practical Nurse (LPN) enters the resident's room. Thirty five (35) minutes since the last staff observation. 12:48 PM LPN brings the resident lunch. Surveyor restarts observation on 8/29/16 at 2 PM. 2:19 PM LPN enters the resident's room and shares with the surveyor that s/he ate very little lunch, but drank all fluids offered. Nineteen (19) minutes since the surveyor's observation began. No knowledge as to when the last staff observation occurred prior to 2 PM. 2:32 PM LPN checks on resident. 2:42 PM LPN checks on resident. 3:16 PM agitated female resident enters Resident #1's room and exits immediately. She is exit seeking, ambulating at a fast past and enters other resident rooms along the corridor. 3:20 PM LPN checks on the resident. Thirty-eight (38) minutes since the last staff observation.</p> <p>LPN confirms at 3:20 PM that s/he has not checked on this resident every 15 minutes as directed by the care plan.</p> <p>Per review of the "Resident Monitoring Tool", it is a form used to identify that safety checks have been completed, the time the observation was</p>	F 323		

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

PRINTED: 09/14/2016
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 _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/30/2016
--	--	--	---

NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE & REHAB BIRCHWOOD TER	STREET ADDRESS, CITY, STATE, ZIP CODE 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
--------------------	--	---------------	---	----------------------

F 323 Continued From page 7

F 323;

conducted, the location of activity and initials of who completed the check. Nurses notes have numerous entries identifying that the 15 minute checks are ongoing beginning on 6/19/16, however the "Monitoring Tool" has not been consistently completed. The following entries evidence incomplete documentation of the actual observation. They are as follows: 6/21/16 from 12 AM through 6:30 AM, 6/28/16 from 11:30 PM through 11:45 PM, 7/31/16 from 5 PM through 6:15 PM, 8/2/16 from 11:30 PM through 11:45 PM, 8/8/16 from 11:30 PM through 11:45 PM, no documentation can be located for a 24 hour period for 8/10/16, 8/15/15 from 11:30 PM through 11:45 PM, no documentation can be located for a 24 hour period for 8/16/16, 8/22/16 from 11:15 AM through 2:30 PM and 8/26/16 from 11:30 AM through 3 PM.

Per interview with the Director of Nurses at 9:50 AM confirmation was made that the safety checks for Resident #1 are inconsistently documented.

2. Per medical record review, Resident #6 was admitted on 10/29/14 with diagnosis to include Dementia with Behavioral Disturbances, Falls, Hypertension, COPD, Anemia, Alcohol and Nicotine Dependence and Cognitive Communication Deficit. Per review of the resident's Interdisciplinary Care Plan (ICP), the resident has a focus for potential of resident to resident altercations related to cognitive and communication deficits, progressive Dementia and a wandering history resulting in altercations with other residents. Multiple interventions to manage resident to resident altercations are listed and include 15 minute safety checks.

Nurses notes have numerous entries identifying

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

PRINTED: 09/14/2016
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 _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/30/2016
--	--	--	---

NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE & REHAB BIRCHWOOD TER	STREET ADDRESS, CITY, STATE, ZIP CODE 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
--------------------	--	---------------	---	----------------------

F 323 Continued From page 8 F 323

that the 15 minute checks are ongoing. However the "Monitoring Tool" has not been consistently completed. The following entries evidence incomplete documentation of the actual observation. They are as follows: 7/14/16 from 9:30 PM through 10:30 PM, 8/14/16 from 7 AM through 2:45 PM, 8/15/16 from 7 AM through 7:15 PM and 8/27/16 from 3:30 PM through 10:30 PM.

Per interview with the Unit Manager at 11:30 AM confirmation was made that the safety checks for Resident #6 are inconsistently documented.

3. Per medical record review, Resident #4 was admitted on 11/8/13 with diagnosis to include Dementia with Behavioral Disturbances, Major Depressive Disorder, Hypertension, COPD, Alzheimer's Disease and Glaucoma.

Per review of the resident's Interdisciplinary Care Plan (ICP), Resident #4 has a focus for Resident to Resident altercations, verbal aggression towards others, inability to interpret the environment and other residents. Documented actual incidents on 6/8/16 and 8/14/16. Multiple interventions to manage resident to resident altercations are listed.

Per review of the nurses notes, 15 minute safety checks that were initiated on 8/14/16 to ensure the location and safety of Resident #4. Those checks are still in place and are identified in the nurses notes.

Nurses notes have numerous entries identifying that the 15 minute checks are ongoing. However, the "Monitoring Tool" has not been consistently completed. The following entries evidence incomplete documentation of the actual

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

PRINTED: 09/14/2016
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 _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/30/2016
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE & REHAB BIRCHWOOD TER		STREET ADDRESS, CITY, STATE, ZIP CODE 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
F 323	Continued From page 9 observation. They are as follows: 8/15/16 from 11:30 PM through 11:45 PM, 8/22/16 from 6 AM through 2:30 PM and 8/24/16 from 1:30 PM through 3 PM. Per interview with the Unit Manager at 8:55 AM confirmation was made that the safety checks for Resident #4 are inconsistently documented on the Resident Monitoring Tool and can not ensure that safety checks are being conducted every 15 minutes for safety.	F 323		