

Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury, VT 05671-2306
<http://www.dail.vermont.gov>
Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
Fax (802) 871-3318

April 8, 2013

Mr. Daniel Daly, Administrator
Kindred Transitional Care & Rehab Birchwood Ter
43 Starr Farm Rd
Burlington, VT 05408-1321

Dear Mr. Daly:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **March 13, 2013**. 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

PC:jl



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

APR 03 2013

PRINTED: 03/26/2013
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 03/13/2013
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE & REHAB BIRCHWOOD TER			STREET ADDRESS, CITY, STATE, ZIP CODE 43 STARR FARM RD BURLINGTON, VT 05408	
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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 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, staff failed to assure an interdisciplinary team determined a resident was appropriate to self-administer drugs for 1 of 26 residents in the stage 2 sample (Resident #2). Findings include: Per observation of a medication pass on 3/13/13 at 8:35 AM, Resident #2 was given medications by a nurse to self-administer. Per record review on 3/13/13 at 8:55 AM, there was no physician order for self-administration of medications. Additionally, there was no nursing assessment to determine if the resident was appropriate to self-administer medications. Per interview with the Unit Manager (UM) on 3/13/13 at 9:03 AM, residents should be assessed for self-administration of medications and a physicians's order is required. The UM confirmed that there is no physician order or nursing assessment for self-administration of medications.	F 176	<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 176 Resident #2 was assessed for self-administration of medications. An audit will be conducted to ensure that any resident/patient who chooses to self administer medications has been assessed to determine if the resident/patient is appropriate to self administer medications. Interdisciplinary staff member will receive re-education regarding Self Administration of Medications policy. Nursing management staff will conduct monthly audits x3 months to ensure compliance. Audit results will be reported to the Performance Improvement Committee monthly x3 months. The DNS is responsible for overall compliance. <i>R176 POC accepted 4/5/13 mcluhanr/ame</i>	April 13, 2013

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



TITLE

Administrator

(X6) DATE

4/2/13

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.

PM

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F 223 SS=D	<p>483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION</p> <p>The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.</p> <p>This REQUIREMENT is not met as evidenced by: Based upon staff interview and record review, the facility failed to assure that 1 of 4 residents in the applicable sample (Resident #40) remained free from verbal, physical and mental abuse by anyone, including other residents. Findings include: 1. Per 3/13/13 review of progress notes dated 3/7/13, at approximately 3:00 AM, Resident #40 (in his/her electric wheelchair) came up to Resident #88 and started talking in a loud voice. Resident #88 struck out at Resident #40, hitting him/her on the upper chest. Resident #40 attempted to kick Resident #88, but Resident #88 moved and walked back to his/her room. Resident #40 was assessed; no injuries were found by the nurse at that time. At 3:30 AM on 3/7/13, Resident #40 was administered morphine 40mg for complaint of pain. On 3/8/13, the nursing progress note documented that Resident #40 complained of upper chest pain at 1:30 PM and received morphine 40mg. The doctor's order for as needed morphine was available for use related to Resident #40's condition of chronic pain, and was not a specific order related to the incident.</p>	F 223	<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 223 Resident to resident altercation between resident #40 and #88 was investigated by the survey team during the center's annual survey. A report to APS was made March 29, 2013.</p> <p>Staff continues to implement care plan interventions to address target behaviors for both resident #40 and #88.</p> <p>Staff will be re-educated regarding specific behavioral interventions for current residents presenting with behavioral issues.</p> <p>Behavioral care plans will continue to be reviewed by the interdisciplinary team during routine scheduled care conferences and as needed.</p> <p>Nursing management will continue to audit the effectiveness of behavioral care plan interventions during daily interactions with residents and staff. Ad Hoc interdisciplinary behavioral care plan conferences will be conducted on an as needed basis. Audit results will be reported to the Performance Improvement Committee monthly x3 months. The ED is responsible for overall compliance.</p>	April 13, 2013

F223 POC accepted 4/13/13
mcullivanRW / Pmc

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F 223	<p>Continued From page 2</p> <p>Per record review on 3/13/13, Resident #40 has care plans for behavior problems, physical abuse and socially inappropriate and intrusive behaviors. Review of care plans for Resident #88 from 10/11/12 to present included plans for target behaviors of yelling at other residents, hitting and swinging at staff, angry outbursts, irritability with surroundings and altercations with other residents.</p> <p>Per 3/13/13 10:16 AM interview with the facility's Assistant Director of Nursing Services (ADNS), the ADNS confirmed knowledge of the 3/7/13 incident between Resident #40 and Resident #88.</p> <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the</p>	F 223	<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>	
F 225 SS=D		F 225	<p>Resident to resident altercation between resident #40 and #88 was investigated by the survey team during the center's annual survey. A report to APS was made March 29, 2013</p> <p>Interdisciplinary staff will be re-educated regarding the process for reporting a resident to resident altercation and/or abuse to Licensing and Protection and APS.</p> <p>Nursing management will monitor compliance with reporting process daily x3 months.</p> <p>Findings will be reported to the Performance Improvement Committee monthly x3 months.</p> <p>The ED is responsible for overall compliance.</p>	April 13, 2013

*F225 POC accepted 4/15/13
mCulhanRNJ/PMC*

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F 225	<p>Continued From page 3 State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based upon staff interview and record review, the facility failed to report witnessed abuse of 1 of 4 residents in the applicable sample (Resident #40) to the State Survey and Certification agency (DLP), according to their facility policy and as required by the Federal regulation. Findings include:</p> <p>1. Per 3/13/13 review of progress notes dated 3/7/13, at approximately 3:00 AM Resident #40 (in his/her electric wheelchair) came up to Resident #88 and started talking in a loud voice. Resident #88 struck out at Resident #40 hitting him/her on the upper chest. Resident #40 attempted to kick Resident #88, but moved away and walked back to his/her room. Resident #40 was assessed; no injuries were found by the nurse at that time. At 3:30 AM Resident #40 was administered Morphine 40 mg for pain. On</p>	F 225		

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F 225	Continued From page 4 3/8/13, the nursing progress note documented that Resident #40 complained of upper chest pain at 1:30 PM and received Morphine 40 mg. [The doctor's order for as needed morphine was available for use related to Resident #40's condition of chronic pain, and was not a specific order related to the incident.] Per 3/13/13 9:20 AM interview, the B wing unit nurse manager confirmed that the facility policy is to report resident to resident incidents to the Director of Nursing Services (DNS) or the Assistant Director of Nursing Services (ADNS) who then make the decision to report to APS or the state Survey and Certification agency. Per 3/13/13 10:16 AM interview, the ADNS confirmed knowledge of the 3/7/13 incident between Resident #40 and Resident #88 and acknowledged that the facility did not report the incident to either APS or the state Survey and Certification agency.	F 225	<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 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial	F 250	The Director of Social Services has reviewed resident #80's care plan as relates to plans for return to the community and has updated resident #80's progress notes to clarify plans related to making appropriate referrals and/or arrangements/options to meet the psychosocial well-being for resident #80. The Director of Social Services has been re-educated regarding need to document progress with referrals to community services that were offered, tried, refused, revised and coordination of care needed pre-discharge to meet each resident's psychosocial well being. Social Services will update each resident's care plan and progress notes quarterly and as needed as relates to return to community plans/progress. Nursing management will monitor compliance with this process during scheduled quarterly care plan reviews. Finding will be reported to the Performance Improvement Committee monthly x6 months. The ED is responsible for overall compliance.	April 13, 2013

F250 POC accepted 4/15/13
mcullivanRN jame

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F 250	<p>Continued From page 5</p> <p>well-being of one of two applicable residents in the sample (Resident #80). The findings include:</p> <p>1. Per record review on the morning of 03/12/13 Resident #80 was admitted in November 2012 for rehabilitation after a hospitalization for seizure like activity, dizziness and weakness, and remains in the facility. The MDS (minimum data set) assessment on admission, dated 11/08/12 and the 01/21/13 quarterly assessment shows, in section "Q0300 -expects to be discharged to the community" and Q0400- "active discharge plan occurring for the resident to return to community" and section Q0600- "referral has been made to the local contact Agency -YES".</p> <p>The care plan dated 11/19/13 states "[resident] wishes to discharge back to the community with [family], presently there is no home to discharge back [family] are at a hotel, goals would like to discharge to [family] home when [s/he] gets one, will need to be no more than 1 assist [with]interventions..., establish a pre-discharge plan with resident and [family] and evaluate progress and revise plan as needed evaluate [resident] motivation to return to the community prepare and give [family] contact numbers for all community referrals".</p> <p>Per the 11/22/12 evaluation note by a social service worker (SSW), it states in care plan decision "[resident] really doesn't understand all of the implications of [family's] homelessness [s/he] believes that when [family] gets an apartment [resident] will move back in with [family] that appears to be the [family] plan as well". Per a SSW noted dated 12/14/12 at 4:12</p>	F 250		

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F 250	Continued From page 6 P.M. states "[s/he] did have VNA services in the home who said the home was clean and the resident cared for, medicaid application form and instruction given." Per the Progress note by Social Service dated 01/30/13 during the MDS quarterly assessment. it states "hopes to discharge home with [family] when they finally get an apartment". Per interview at 2:26 P.M. on 03/12/13, the SSW stated "well the [family] has many community services in place and is working with them. I think I gave [family] the COTS [community outreach temp shelter] number. I don't think that it will work out, personally speaking...". The SSW confirmed that there is no documentation regarding evaluating the progress of [family] getting an apartment, what referrals to community services that were offered/tired/refused/revised, any coordination of care and what is the pre-discharge plan, or if not feasible, what revisions are needed to meet this resident's well being. The SSW confirmed their is no evidence of making referrals, arrangements or finding options to meet the psychosocial well-being for this resident.	F 250			
F 280 SS=D	Also see F280. 483.20(d)(3), 483.10(k)(2) RIGHT TO 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	F 280			

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F 280	Continued From page 7 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 record review and staff interview, the facility failed to revise care plans to reflect the current status for 2 of 26 residents in the Stage 2 Sample. (Residents #80 and #128) The finding include: 1. Per record review Resident #80's care plan does not accurately reflect the potential for home discharge. The Admission care plan dated 11/19/12 states "[resident] wishes to discharge back to the community with [family], presently there is no home to discharge back [family] are at a hotel, goals would like to discharge to [family] home when [s/he] gets one, will need to be no more than 1 assist [with] interventions... establish a pre-discharge plan with resident and [family] and evaluate progress and revise plan as needed evaluate [resident] motivation to return to the community prepare and give [family] contact numbers for all community referrals".	F 280	<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 The Director of Social Services has reviewed resident #80's care plan as it relates to plans for return to the community and has updated resident #80's progress notes to clarify plans related to making appropriate referrals and/or arrangements/options to meet the psychosocial well-being for resident #80. Resident #128's care plan has been reviewed and revised to reflect current fall status. Social Services will update each resident's care plan and progress notes quarterly and as needed as relates to return to community plans/progress. Social Services has been re-educated regarding need to document progress with referrals to community services that were offered, tried, refused, revised and coordination of care needed pre-discharge to meet each resident's psychosocial well being. Nursing staff will be re-educated regarding need to revise care plans after a Post Fall Assessment is completed. Nursing Management will monitor compliance with this process during scheduled quarterly care plan reviews and following review of Post Fall Assessments. Results of these audits will be brought to the	April 13, 2013	

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F 280	<p>Continued From page 8</p> <p>Per the 11/22/12 evaluation note by social service worker (SSW) states in care plan decision "[resident] really doesn't understand all of the implications of [family's] homelessness [s/he] believes that when [family] gets an apartment [resident] will move back in with [family] that appears to be the [family] plan as well". The Progress note by SSW dated 01/30/13 during the MDS quarterly assessment states "hopes to discharge home with [family] when they finally get an apartment".</p> <p>Per interview at 2:26 P.M. on 03/12/13 the SSW stated " I don't think that it will work out, personally speaking...". The SSW confirmed that there is no documentation regarding evaluating the progress of the family and what is the pre-discharge plan, if not feasible, what revisions are needed to meet this resident's well being. Per interview on 03/12/13 at 4:54 P.M the Unit Manager and SSW confirmed the care plan needs to revised to accurately reflect the resident's status.</p> <p>Also see F250</p> <p>2. Per medical record review on 03/13/2013 at 10:04 am, Resident #128 was readmitted to the facility in October 2012 following an episode of of urosepsis that required hospitalization. Since her/his 1st admission in 2010 s/he has always been coded as being a falls risk individual. Two</p>	F 280	<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>Performance Improvement Committee monthly x6 months. The ED is responsible for overall compliance.</p> <p><i>F280 POC accepted 4/15/13 McLihan RN/pmc</i></p>	

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F 280	Continued From page 9 falls are recorded in the medical record, 02/06/2013 and 02/15/2013 which resulted in no injuries. Both falls have documented follow-up assessments and interventions. There has been no revision to the care plan to indicate these recent falls or what additional interventions were put in place after these 2 falls to reduce the risk for future falls. The Unit Manager confirms during interview on 03/13/2013 at 11:10 am that the care plan has not been revised to reflect the current falls and that the expectation is for staff to revise a care plan after the 'post assessment' documentation is completed.	F 280	<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 282 SS=D	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, interview and record review, the facility failed to assure services were provided in accordance to the care plan for 2 of 26 residents in the applicable sample. (Resident #247 & #125) Findings include: 1. Per interview and record review Resident #247 did not have services provided according to the care plan for monitoring edema and communicating with the dialysis unit. Per interview on 03/11/13 at 2:09 PM, the resident stated that "the bruising was from falls at home	F 282	Resident #247's care plan related to hemodialysis has been reviewed by the nurses assigned to this resident's care. Nursing staff will be re-educated regarding need to monitor and document any negative findings related to areas addressed in hemodialysis care plans. Nursing staff will be re-educated regarding use of Dialysis communication book. A new Smoking Assessment has been completed for resident #125 to include documentation of educating resident #125 on safe smoking practices and offering a smoking cessation program. Current residents who smoke will have a new Smoking Assessment completed to include documentation of education on safe smoking practices and offering a smoking cessation program. Nursing management will monitor follow-up documentation to Dialysis Center recommendations weekly x 3 months. Nursing Management will monitor compliance with Safe Smoking policy monthly x 3 months.	April 13, 2013	

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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE & REHAB BIRCHWOOD TER	STREET ADDRESS, CITY, STATE, ZIP CODE 43 STARR FARM RD BURLINGTON, VT 05408
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F 282	<p>Continued From page 10 and my legs ache and they are swollen". Per observation at that time there was edema bilaterally to the lower legs. The resident was admitted on 03/08/13 with, among other medical issues, renal failure and hemodialysis treatment.</p> <p>Per record review of the care plan dated 03/11/13 related to hemodialysis, it states "access site dressing and flushes done at [hemodialysis] center, check Band-Aid for at least 4 hrs after treatment or longer, check communication log record on return for any reports, collaborate with dietician at dialysis center about weights outcomes nutrition and counseling, communicate and send dialysis communication record with [resident] to every dialysis appointment for any reports, communicate with [hemodialysis] center...monitor /document for peripheral edema and ascities notify MD if identified...".</p> <p>Per review of the nursing notes from admission on 03/08/13 until 03/12/13 there is no documentation that staff were monitoring for edema. Per review of the Communication book dated 03/12/13 with an entry from the dialysis unit, it states "edema ++ both legs (likely also contributing to nausea and feeling 'full' wt's 64.1 Kg vital signs and medications... resident is to get an extra treatment on Wed, 03/13/13."</p> <p>Per interview on 03/13/13 at 9:30 A.M. the staff nurse stated that the resident receives hemodialysis on Tuesdays, Thursday and Saturdays. The nurse also stated "We didn't have a communication book so until that happens we just pass papers back and forth, or we write progress notes". S/he confirmed that there was no communication book available for the</p>	F 282	<p><i>This Plan of Correction is the center's creative 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>Findings will be reported to the Performance Improvement Committee monthly x 3 months. The DNS is responsible for overall compliance.</p> <p><i>F282 POC accepted 4/5/13 McLinhannan / PMC</i></p>	
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F 282	<p>Continued From page 11</p> <p>03/09/13 dialysis session, there was no documentation for monitoring for edema nor progress note regarding treatment. Per interview the Unit manager on 03/13/12 at 10:00 A.M. confirmed care and services were not provided according to the written care plan.</p> <p>2. Per direct observation on 03/12/2013 at 10:22 AM, Resident #125 was observed to be wearing a pair of brown pants that were noted to have numerous cigarette burns in them specific to the lap area.</p> <p>Per record review Resident #125 was admitted to the facility on 1/4/11. It was noted on admission that Resident #125 was a an active smoker. Per review of the comprehensive assessment (MDS) dated 1/30/13, it indicated that Resident #125 was alert and oriented and able to make decisions independently. The assessment indicated that Resident #125 had no physical limitations in upper body movement, was independent in most activities of daily living.</p> <p>Review of the facility smoking assessment indicated that Resident #125 was assessed to be</p>	F 282			

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F 282	<p>Continued From page 12 able to smoke independently with no need for protective equipment.</p> <p>Per review of the residents written plan of care, the care plan titled "smoking" and last reviewed and revised on 11/23/12, the written plan of care indicated that the facility will review the facility smoking policy with resident/and or family, educate the resident on safe smoking practices and offer resident a cessation program.</p> <p>Per review of the medical record there was no evidence that the facility reviewed the facility smoking policy with resident/and or family, there was no evidence that the facility educated Resident #125 on safe smoking practices and there was no evidence that the facility offered Resident #125 a cessation program as indicated in the written plan of care.</p> <p>Per review of the facility policy titled "Smoking" the policy indicates in the documentation guidelines that the facility must document in the resident's medical record education of family/legal responsible party and patient on the facility's Smoking Policy.</p> <p>Per interview with the Unit Manger (UM), Administrator and Corporate Nursing Director at 2:46 PM, the UM confirmed that Resident #125 was an active smoker who was able to smoke independently and able to make his/her own decisions. The UM indicated that Resident #125 was not in need of any safety equipment when he/she smoked. The UM confirmed after review of the medical record and backfiled records that there was no documentation to provide that indicated that since admission on 1/4/11,</p>	F 282		
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F 282	Continued From page 13 Resident #125 had reviewed the facility smoking policy with a facility staff member staff, there was no evidence that the facility educated Resident #125 on safe smoking practices and there was no evidence that the facility offered Resident #125 a cessation program as indicated in the written plan of care.	F 282	<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 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to provide necessary treatment and services to promote healing of pressure sores and prevent new sores from developing for 1 of 3 applicable residents in the sample (Resident #206). Findings include: 1. Resident #206 was admitted on 02/06/13, went to the hospital on 03/06/13 and returned on 03/07/13 with diagnoses of debility, falls, weakness, pancytopenia, hypercalemia, anemia, diverticulosis, hypothyroidism, rheumatoid arthritis and other medial issues.	F 314	F 314 Resident #206's skin was reassessed on 3/13/13 to ensure appropriate documentation and treatment in place. Current residents with pressure ulcers have been reassessed to ensure proper documentation and treatment are in place. Licensed nurses will be re-educated regarding the following: -Accurate completion of the skin assessment forms -Need to initiate appropriate, timely treatment per center's Wound Management Protocol -Updating skin care plan to reflect current status -Strategies to prevent development of pressure ulcers. Residents/patients with pressure ulcers will be monitored by nursing management and the Dietician weekly to ensure documentation reflects necessary treatment and services promote healing. The Pressure Ulcer Logs will be audited weekly by nursing management. Findings will be reported to the Performance	April 13, 2013

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F 314	<p>Continued From page 14</p> <p>Per review of the nursing assessments of the skin on 02/06/13, it notes a "skin tear on coccyx, 1 cm [centimeter]". On 02/07/13 "non-pressure right buttock, referral to wound nurse for treatment [TX] recommendations". The 02/08/13 assessment states "no changes- referral to wound nurse for TX recommendation regarding right buttocks area". On 02/13/13, the weekly skin check notes the area on the right buttock, however, no description is noted as to size, color, type.</p> <p>The 02/20/13 assessment states "-at hospital until 2000 [8:00 P.M.] refused skin check". On 02/27/13 - 'rashy area [on chest]".</p> <p>A nursing re-admit assessment on 03/07/13 states "pink blanchable coccyx, cavilon [skin treatment] in place." Also noted on 03/07/13 - "open stage 2 coccyx 1.3 cm x 0.5 x 0.1".</p> <p>Per review of the Patient/Nursing Evaluation Part 1- on 02/06/13 does not identify a pressure ulcer, but an open area in gluteal fold area and measurements as 0.5 cm round above the anus. Per the initial MDS assessment of 02/14/13 does not identify any stage 1 pressure ulcers, only a skin tear. However does identify the resident for 'at risk' of developing pressure ulcer and "will proceed to treat, monitor and report and changes in the area on buttocks".</p> <p>Per review of the non-pressure log book and the pressure ulcer log book there are no entries that identify this resident's skin condition. A care plan was implemented on 03/07/13 noted to "cleanse with Normal Saline pat dry, spray entire area with Cavilon no sting barrier, spray cover with comfeel change Q5 days and PRN".</p>	F 314	<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>Improvement Committee monthly x6 months. The DNS is responsible for overall compliance.</p> <p><i>F314 POC accepted 4/15/13 McLihanRN/PMC</i></p>

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F 314	Continued From page 15	F 314	<i>This Plan of Correction is the center's credible allegation of compliance.</i>	
F 365 SS=D	<p>483.35(d)(3) FOOD IN FORM TO MEET INDIVIDUAL NEEDS</p> <p>Each resident receives and the facility provides food prepared in a form designed to meet individual needs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to prepare food in a form to meet individual needs for 1 of 26 in sample. (Resident #188) Findings include:</p> <p>1. Per Interview on 03/11/13 at 11:59 A.M. in the main dining area, Resident #188 stated to the nurse surveyor "I could pick up my water with my spoon...the coffee was thick...I picked up my coffee and couldn't put in my sugar, the cereal you could pick up the whole thing". Upon further conversation the resident indicated that this has happened for the last couple of days and confirmed that this might have to do with a 'swallowing problem'.</p> <p>Per record record review the physician orders</p>	F 365	<p>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.</p> <p>F 365</p> <p>Thickened liquids order for resident # 188 was reviewed by nursing and the Food Service Supervisor on 3/11/13</p> <p>Current residents with physician's orders for thickened liquids has been reviewed.</p> <p>Licensed nurses, LNA's and Activity staff will be re-educated regarding process for thickening liquids to consistency ordered by the physician.</p> <p>Nursing Management will maintain and keep a thickened liquids profile in the main dining room on each unit. Staff will be educated regarding need to reference this profile for the residents with physician's orders for thickened liquids.</p> <p>Nursing Management will conduct random weekly audits x 3 months to ensure compliance with this program.</p> <p>Findings will be reported to the Performance Improvement Committee monthly x3 months The DNS is responsible for overall compliance.</p>	April 13, 2013

F365 POC accepted 4/5/13
McLuhan RN/PMC

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F 365	<p>Continued From page 16</p> <p>and dietician recommendations are for mechanical soft diet and nectar thick fluids (fluids thickened to the consistency of nectar). Per observation at 12:11 P.M. a LNA (Licensed Nursing Assistant) poured plain water into the resident's glass and the resident stated "that's better" [regarding clear regular water].</p> <p>Per interview at that time the nurse surveyor asked the LNA if the resident's fluid needed to have a thickener added, as the resident just indicated to the nurse surveyor about possible thickened fluids. The LNA stated "oh I usually don't work here" and then asked another LNA who confirmed that thickener should be added. The LNA then stated "We usually know but sometimes if we see them coughing then we know that they should be on thick-it". S/he also stated that it would be good to have some sort of list to know when someone's diet gets changed but that it states on the meal ticket the diet they are on, however, the meal ticket was not out from the kitchen at this time. The LNA added 2 teaspoons (tsp) of thickener in 3/4 glass of water.</p> <p>Per interview at 12:24 P.M. the SLP (speech therapist) confirmed "I put [resident] on nectar thick last week because of a history of Aspiration pneumonia" and indicated that the small glass filled to the top is 8 ounces (oz.) and when filled to the to the ridge which is about 3/4 is 6 oz, small glasses are 4 oz.</p> <p>When the meal tray was served at 12:34 P.M. the milk was of nectar consistency but the cranberry juice was normal consistency. It was observed that the cranberry juice was being thickened by the LNA pouring half of the white powder from a</p>	F 365		

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F 365	Continued From page 17 small plastic 'solo' medicine cup into the cranberry juice [4 oz]. The LNA stated "the milk is already thickened, it came out that way" and confirmed only half of the 'solo' cup was used to thicken the cranberry juice. Per interview at 1:00 P.M. the FSS (food service supervisor) stated that per Sysco Instant Food Thickener Suggested Usage Chart shows for 4 oz of cranberry juice and water use 1 Tablespoon (Tbs) and for 8 oz use 2 Tbs. The FSS confirmed that the small plastic 'solo' med cup when filled is 1 Tbs. The FSS stated "water is already thickened" and "I am surprised [thick-it was added] because we have it already thickened, it is our policy as this is less chance of error and the only thing that has to be mixed is coffee/tea...milk, juice, water are all pre-mix in containers". The FSS confirmed that for 6 oz of water "should have 1 and 1/2 Tbs" and that the observed 2 tsp was incorrect, as well as half of the 'solo' cup added to the cranberry juice.	F 365	<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 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	F 371	<u>F 371</u> The kitchen dry storage room, shelving in the walk-in refrigerator and window ledges in the dishwashing room were cleaned on 3/11/13. The kitchen will be thoroughly cleaned. The "Nutritional Services Quick Rounds" monitoring form will be completed daily by the nutritional services department and weekly by the Executive Director to ensure food is stored, prepared and distributed under sanitary conditions. The Registered Dietician will report findings of the "Nutritional Services Quick Rounds" to the Performance Improvement Committee monthly x 6 months. The ED is responsible for overall compliance.	April 13, 20

F371 POC accepted 4/15/13
mcaihanRN/pmc

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F 371	Continued From page 18 by: Based on observation and staff interview, the facility failed to store prepare and distribute food under sanitary conditions. Findings include: Per observation during the initial kitchen tour on 3/11/13 at 10:40 AM, the following unsanitary conditions were observed: 1. Two ceiling corners in the dry storage room had spider webs, living spiders and dust in them. 2. The shelving in the walk-in refrigerator was heavily soiled with dust and debris. 3. A window ledge in the dishwashing room situated over the clean dish area was soiled with dust and a dead insect carcass. The above observations were confirmed by the Food Services Manager at the time of the observations.	F 371	<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 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.	F 441	F 441 The (2) unlabeled urinals and (1) unlabeled urinary collection hat were removed from rooms 303 and 309 on 3/11/13 A sign alerting visitors that there were specific directions needed before entering the room of resident #243 was posted on 3/11/13. Licensed nurses and LNA's will be re-educated regarding need to ensure appropriate signage is placed on the door of resident/patients requiring contact or droplet precautions. Licensed nurses and LNA's will also be reeducated regarding proper labeling and storage of urinals and urinary collection hats. Nursing management and or the Infection Control Nurse will conduct random daily audits to ensure compliance. The infection control nurse will report findings to the Performance Improvement Committee monthly x3. The DNS is responsible for overall compliance.	April 13, 2013

*F441 POC accepted 4/5/13
McLinn RN/PMC*

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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 441	Continued From page 19 (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain a sanitary environment to help prevent the development and transmission of infection. Findings include: Per observation on 3/11/13 at 4:30 PM two rooms housing two male residents each had unlabeled urinals containing small amounts of urine on the top of the toilets (rooms 303, 309). Additionally, room 309 also had an unlabeled urinary collection hat on the bathroom floor. The above observations were confirmed by the Unit Manager (UM) on 3/11/13 at 4:55 PM. Per interview with the Unit Manager on 3/13/13 at 9:38 AM, h/she	F 441			

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

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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE & REHAB BIRCHWOOD TER	STREET ADDRESS, CITY, STATE, ZIP CODE 43 STARR FARM RD BURLINGTON, VT 05408
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F 441	<p>Continued From page 20</p> <p>stated it is his/her expectation that urinals and collection devices are to be labeled with the resident's name and stored when not in use.</p> <p>2. Per direct observation on 3/11/13 at 9:30 AM, Room 229 was observed to have a red infection control bag on the door containing supplies, it was noted that there was no notification on the door that alerted visitors that there specific directions needed before entering the room.</p> <p>Per review of the medical record of Resident #243, the record indicated that Resident #243 had an active diagnosis of Methicillian-resistant Staphylococcus aureus (MRSA).</p> <p>Per review of the facility policy titled Transmission Based Precautions, it indicates that all residents on droplet precautions need to have a sign posted that indicates "See the nurses before entering the room".</p> <p>Per interview with a Licensed Nursing Assistant indicated that Resident #243 was on special precautions and that all people entering room should have a mask on.</p> <p>Per interview with the facility Infection Control Nurse on 3/11/13, he/she confirmed that Resident #243 was on droplet precautions for MRSA in the sputum and was on special droplet precautions requiring staff and visits to wear a mask when entering the room. The Infection Control RN confirmed that the facility policy</p>	F 441		
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F 441	Continued From page 21 indicated that a sign would be placed on the door to indicate all visitors see nurse before entering room. The Infection Control RN indicated that there was no notification on the entrance to Resident #243 indicating that all visitors need to see nurse before entering and without the sign on the room visitors would not know they had to see the nurse for directions for precautions needed before entering the room, placing anyone who entered at risk of contracting or carrying the infection.	F 441		