



VERMONT

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) 871-3317  
To Report Adult Abuse: (800) 564-1612  
Fax (802) 871-3318

April 8, 2013

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

Provider #: 475003

Dear Mr. Daly:

The Division of Licensing and Protection conducted an onsite complaint investigation on **April 4, 2013**. The purpose of the investigation was to determine if your facility was in compliance with Federal participation requirements of the Medicare/Medicaid Program. The investigation was completed on **April 4, 2013** and there were no regulatory violations related to the complaint allegations.

Sincerely,

A handwritten signature in black ink that reads "Pamela M. Cota RN". The signature is written in a cursive, flowing style.

Pamela M. Cota, RN  
Licensing Chief

PC:jl

Enclosure



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

PRINTED: 04/08/2013  
FORM APPROVED  
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>475003</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br><b>C</b><br><b>04/04/2013</b> |
|--|---|--|---|

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|--|---|
| NAME OF PROVIDER OR SUPPLIER<br><br><b>KINDRED TRANSITIONAL CARE &amp; REHAB BIRCHWOOD TER</b> | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>43 STARR FARM RD</b><br><b>BURLINGTON, VT 05408</b> |
|--|---|

| (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<br><br>An unannounced on-site investigation was conducted on 04/04/13 by the Division of Licensing and Protection for 2 complaints. There were no regulatory findings. | F 000 |  |  |
|-------|---|-------|--|--|

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|---|-------|-----------|
| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|-------|-----------|

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 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.