

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

May 1, 2014

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 **April 9, 2014**. 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

RECEIVED
Division of DMB NO. 0838-0391

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 APR 28 14 Licensing and Protection 04/09/2014
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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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(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

The Division of Licensing and Protection conducted an unannounced onsite annual recertification survey on April 7 - 9, 2014. The following regulatory deficiencies were cited as a result.

F 272 483.20(b)(1) COMPREHENSIVE ASSESSMENTS

The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.

- A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following:
- Identification and demographic information;
 - Customary routine;
 - Cognitive patterns;
 - Communication;
 - Vision;
 - Mood and behavior patterns;
 - Psychosocial well-being;
 - Physical functioning and structural problems;
 - Continence;
 - Disease diagnosis and health conditions;
 - Dental and nutritional status;
 - Skin conditions;
 - Activity pursuit;
 - Medications;
 - Special treatments and procedures;
 - Discharge potential;
 - Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum

F 000 This Plan of Correction is the center's credible allegation of compliance.

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 272

F 272 May 5, 2014

A modification was made to MDS to reflect resident #94 broken denture.

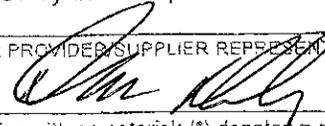
All residents have the potential to be affected by the deficient practice.

Nurses responsible for conducting accurate assessments will be re-educated on the importance of comprehensive, accurate assessments.

The MDS coordinator through record review will randomly audit MDS assessments for accuracy focusing on section L.

Results of these audits will be brought to the Performance Improvement committee for 3 months or until 100% achieved. The DNS is responsible for overall compliance.

F 272 POC accepted
Shirley R. Tremblay RW/SP

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X8) DATE 4/25/14
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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.

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

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OMB NO. 0938-0391

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F 272

Continued From page 1
Data Set (MDS); and
Documentation of participation in assessment.

F 272

This REQUIREMENT is not met as evidenced by:
Based on record review, observation and interviews the facility failed to conduct an accurate assessment for 1 of 24 residents in the Stage 2 sample. (Resident #94) Findings include:

Per record review, the Admission Minimum Data Set (MDS) dated 01/09/14 and the MDS dated 03/24/14 for Resident #94 did not identify broken or loosely fitting dentures. Per review, Section L [dental/oral health] is marked "No" for broken or loosely fitting full or partial dentures [cracked, cracked, unclean or loose]. During an interview with Resident #94 on 04/07/14 at 3:59 PM, the Resident stated "I have this broken tooth which is sharp and see this stuff on the upper denture, it has been repaired several times but it is not going to last." S/he also stated that "the dentures fit OK but I can tell there are getting loose". Per observation at that time, the resident's denture had a broken tooth on the lower front center and gray material in between the upper front teeth. The resident identified the gray material as a type of bonding glue. Per interview on 04/09/14 at 11:42 AM the MDS coordinator confirmed the MDS' were inaccurate.

Also see F411.

modification to MDS

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F 280 SS=G 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 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 staff interview and record review, the facility failed to revise the care plan for 1 of 24 residents reviewed in the stage 2 sample (Resident #176) related to his/her increased risk for pressure ulcer development. Findings include:

Per 4/9/14 record review, Resident #176 was re-admitted to the facility on 3/3/14 on the hospice program, after a stay at a respite facility. Per review of the Admission examination form dated 3/3/14, Resident #176 was identified as having a Braden Scale score of 11, identifying him/her as at high risk for the development of a

F 280

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

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F 280

May 5, 2014

Resident # 176 care plan has been revised to reflect current status.

All residents have the potential to be affected by the deficient practice.

RN and LPN will be re-educated on the need to document in the resident's care plan interventions and approaches to managing pressure ulcers or potential pressure ulcers based on assessment.

Care plans of residents that have a high risk of developing pressure ulcers (Braden Scale) will be reviewed during clinical rounds by the nursing management team DNS/Nurse Manager/designee. Emphasis will be placed on newly admitted residents. Care plans will be audited for completeness and accuracy.

Results of these audits will be brought to the monthly Performance Improvement Committee for 3 months or until 100% compliance achieved.

The DNS is responsible for overall compliance.

F280 POC accepted 5/11/14 R. Tremblay/SP

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F 280 Continued From page 3

pressure ulcer (The Braden Scale is a tool used to predict pressure ulcer risk). Issues identified on the 3/3/14 Braden Scale included that the resident had very limited sensory perception, meaning that s/he responds only to painful stimuli or cannot communicate discomfort except by moaning or restlessness or has sensory impairment. Skin was identified as "very moist." The resident was chair fast and mobility was checked as "very limited." Nutrition was identified as "very poor." Friction and shear were checked as a "potential problem." The resident also was identified as having an altered mental status, dementia, terminal illness, recent weight loss, and was taking antipsychotic, anti-anxiety, and narcotic medications.

Per record review on 4/9/14, Resident #176's care plan related to being "at risk for potential skin impairments" was developed on 6/24/13 during a prior admission (at a time when the resident was identified as "...currently independent with all aspects of his mobility including bed mobility"). The care plan was not revised on his 3/3/14 readmission to reflect the resident's significant change in status and higher pressure ulcer risk until 3/20/14, 9 days after s/he had already developed a pressure ulcer on his/her left heel and 17 days after his/her re-admission. On 4/9/14 at 8:40 AM, the unit manager of the B wing, where the resident was transferred on 3/14/14, confirmed the above information.

F 282
SS=D Refer also to F314.
483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN

F 280

F 282

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F 282

Continued From page 4

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 record review and interviews the facility failed to implement the plan of care and provide consistent services for 1 of 3 residents in the sample. (Resident #7) Findings include:

Per the initial staff interview on 04/07/14 the Unit Manager stated that Resident #7 had an unwitnessed fall on 03/08/14 as well as on 03/09/14. Per review of the resident's chart and incident reports, the resident had falls on 02/27/14, 03/08/14 and 03/09/14. Per review of the care plan notes that staff are to monitor and to follow the guide and fall risk intervention tool. Per the Fall policy notes that residents are to be monitored every 15 minutes x 1 hour, then every 30 minutes for 1 hour then every 2 hours for 2 hours then every 4 hours until no longer necessary or in 72 hours if stable. Per review of the neurological record dated 02/27/14 - 03/02/14, the first hour checks (starting at 2:00 PM) were recorded, however the next hour was not documented, nor are there nursing notes, regarding the vital signs, pupils, level of consciousness, speech or motor response. The next neurological check was noted at (9:00 PM) six hours after, missing the 30 minute checks and several 2 hour checks. Thereafter the checks were every four hours.

Per review of the neurological record dated 03/09/14 - 03/12/14 starting at 10:45 PM, a gap of

F 282

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F 282

Resident #7 sustained no ill effects from deficient practice.

All residents have the potential to be affected by the deficient practice.

RN's and LPN's will be re-educated on the policy for obtaining neuro-vital signs.

The DNS or her designee will monitor for compliance through periodic review of resident's record. Emphasis will be placed on residents that have fallen.

Results of these audits will be brought to the monthly Performance Improvement Committee meeting for 3 months or until 100% compliance achieved.

The DNS is responsible for overall compliance.

May 5, 2014

F282 POC accepted 5/1/14
R. Tremblay EW/SP

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F 282 Continued From page 5
45 minutes between 11:00 PM and 11:45 PM was noted. Additionally, a gap of seven hours from 12:30 AM to 8:00 AM was also noted, missing a 30 minute and two 2 hour checks. The Unit Manager on 04/09/14 at 10:25 AM confirmed the above missing information and that staff did not follow the plan of care for neurological checks after the falls.

F 282
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F 314 SS-G 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES

F 314
May 5, 2014

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.

F 314
Resident # 176 pressure ulcer was healed 3/26/14.

Current residents with pressure ulcers have been reassessed to ensure proper documentation and treatment are in place.

This REQUIREMENT is not met as evidenced by:
Based on record review, observation and staff interview, the facility failed to ensure that a resident who enters the facility without a pressure ulcer does not develop a pressure ulcer unless the individuals' clinical condition demonstrates that it was unavoidable for 1 of 3 applicable residents in the stage two survey sample (Resident #176). The findings include:

RN and LPN will be re-educated regarding the following:
-accurate completion of the skin assessment
-need to initiate appropriate, timely treatment per facility's Wound Management Protocol
-updating skin care plan to reflect current status
-Strategies to prevent development of pressure ulcers.

Per 4/9/14 record review, Resident # 176 was re-admitted to the facility on 3/3/14 on the hospice program, after a stay at a respite facility. Per review of the Admission examination form dated 3/3/14, Resident #176 did not have any

Residents that are at risk for developing pressure ulcers will be monitored by nursing management to ensure that necessary interventions are put in place.

Findings will be reported to the monthly Performance Improvement Committee for 3 months or until 100% compliance achieved.

F 314 POC accepted 5/1/14
R. Tremblay, ew / sp

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F 314 Continued From page 6
skin integrity issues upon admission. On the same exam, s/he was identified as having a Braden Scale score of 11, identifying him/her as at "high risk" for the development of a pressure ulcer. (The Braden Scale is a tool used to predict pressure score risk).

F 314

Issues identified on the 3/3/14 Braden Scale included that the resident had very limited sensory perception, meaning that s/he responds only to painful stimuli or cannot communicate discomfort except by moaning or restlessness or has sensory impairment. Skin was identified as "very moist." The resident was chair fast and mobility was checked as "very limited." Nutrition was identified as "very poor." Friction and shear were checked as a "potential problem." The resident also was identified as having an altered mental status, dementia, terminal illness, recent weight loss, and was taking antipsychotic, anti-anxiety, and narcotic medications.

Per 4/9/14 review of the resident's medical record, Resident #176 developed a pressure ulcer on 3/11/14. Per review of the nursing progress note, on 3/11/14, the wound nurse reported that there was a 4 x 3.5 cm raised clear fluid filled blister on the residents left heel, lateral aspect. On the right heel, there was an area of bright pink/red blanching skin. The resident was identified as at risk for skin breakdown and an alternating air mattress was placed on the bed. New orders were obtained to off load heels, wear blue boots (heel protective devices) and to use pillows and/or heel ramps. Per review of the Weekly pressure ulcer report dated 3/11/14, the resident was identified as having a Stage II pressure ulcer (Ulcers are staged from I-IV with Stage I being the least serious).

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F 314	Continued From page 7 On 4/9/14 at 10:00 AM, the C wing unit manager (UM), confirmed that the resident was identified as at high risk for the development of a pressure sore on admission by his/her Braden score and that no preventative measures (air mattress, heel protectors, skin protective sprays, etc.) were implemented until a pressure ulcer was identified on the resident's left heel on 3/11/14. S/he stated s/he was uncertain if the resident was flagged for high risk on the facility's electronic health record "dashboard," (a tool used to prompt staff about residents' medical risks/needs so action can be taken).	F 314	<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 411 SS=D	Refer also to F280. 483.55(a) ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS 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 record review, observation and	F 411	Arrangements are being made to have resident #94 denture repaired. Unit Managers will assess residents for the need for dental services. Residents and or responsible parties will be notified re: need for external dental services. Nursing staff will be re-educated on the process of residents requiring dental services. Random audits of residents will be done monthly to ensure that any residents in need of dental services has had follow-up. Results of these audits will be brought to the monthly Performance Improvement Committee. Changes will be made as necessary. The DNS is responsible for overall compliance. F 411 POC accepted 5/1/14 RTremblay/afp	May 5, 2014

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F 411 Continued From page 8
Interviews the facility failed to provide, refer, obtain or assist 1 of 3 residents in the sample regarding dental services. (Resident #94)
Findings include:

Per interview and observation on 04/07/14 at 3:59 PM, Resident #94 stated that s/he would like to have the broken lower denture repaired and the upper dentures as well. S/he stated "I have this broken tooth which is sharp and see this stuff [gray bonding material between upper teeth] it has been repaired several times but it is not going to last. S/he also stated that "the dentures fit OK but I can tell this is getting loose". The resident acknowledged that it has been this way for several months. Per review of the admission care plan dated 02/24/14 for dental/oral health, it states to report to the physician, signs and symptoms of oral/dental problems needing attention.
There is no evidence via documentation that since February's admission, that either Unit attempted to have Resident #94's dentures repaired, made a referral, or made a plan to assist the resident to get them fixed. Per interview at 11:40 AM on 04/09/14, the Unit Manager stated the resident was transferred from another unit on 03/06/14 but no information regarding broken dentures was brought to [unit manager's] attention and confirmed dental services or referrals were not provided at this time.

F 411

F9999 Also see F272.
FINAL OBSERVATIONS

F9999

Vermont State Licensing and Operating Rules for

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F9999 Continued From page 9
Nursing Homes

5.3 Accuracy of Assessments
(b) Each assessment must be conducted or coordinated by a registered nurse (RN) who signs and certifies the completion of the assessment.

This REQUIREMENT is NOT MET as evidenced by:
Based on record review and interviews an assessment was not conducted by the RN for 1 applicable resident. (Resident #94) Findings include:

Per record review, Resident # 94's assessment dated 02/07/14 was completed, signed and dated by the LPN [licensed practical nurse]. Part two and three contained information regarding oral/mouth status, other body systems and activities of daily living. Part one [demographics] was initiated by the RN on the evening shift. However, there is no evidence that the RN reviewed and/or certified the LPN's assessment, who worked on the next shift. Per interview on 04/09/14 at 11:40 AM the Unit Manager confirmed the RN did not sign/certify the completion of the assessment by the LPN.

See also F272.

F9999

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

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.

9999 May 5, 2014

Resident #94 assessment was reviewed for completion by an RN.

All residents have the potential to be affected by the deficient practice.

Part I, II and III of resident evaluations done by LPN's will be reviewed by an RN. Licensed staff will be educated as to this practice.

Random audits of resident record will be done by the management team to assure compliance.

Results of these audits will be brought to monthly Performance Improvement Committee meeting for 3 months or until 100% compliance achieved.

The DNS is responsible for overall compliance.

F9999 POC accepted 5/1/14
R Tremblay, RW / SP