

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

May 18, 2016

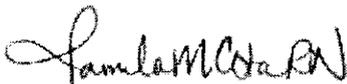
Ms. Alecia Dimario,
Kindred Transitional Care & Rehab Birchwood Terrace
43 Starr Farm Rd
Burlington, VT 05408-1321

Dear Ms. Dimario:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on April 27, 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: 05/05/2016
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 04/27/2016
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 000	INITIAL COMMENTS The Division of Licensing and Protection conducted an unannounced onsite annual recertification survey on 4/25/16 - 4/27/16. The following regulatory violations were cited as a result.	F 000	<i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the alleged facts or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of federal and state law require it.</i>	
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to provide housekeeping and maintenance services to maintain a sanitary, orderly and comfortable interior in resident rooms and bathing areas on A, B and C units. The findings include the following: Per environmental tour on 4/26/16 in the presence of the Nursing Home Administrator and the Maintenance Director the following were observed: B Wing: 20 Resident Rooms with built in closets and bureaus were found to have rough edges, chipped and peeling paint and missing knobs. Walls are noted to have peeling paint, sheet rock with gouges and cove base sloughing from the walls. Waste paper baskets were found without plastic bag enclosures, therefore the baskets themselves were found to be heavily soiled with accumulated dried materials. Oxygen concentrators in use were found to have	F 253	May 26, 2016 Walls and closets with noted holes and gouges were patched and painted. Oxygen concentrators and wastebaskets were immediately assessed and cleaned as needed. The Director of Nursing/or Designee will re-educate staff regarding the facilities procedures related to equipment use and linen handling. The Director of Nursing/or Designee will conduct monthly rounds to assess procedures are being maintained. All results will be reported to the QAPI meeting for 3 months to ensure compliance. The Director of Maintenance and ED/ or Designee will complete monthly rounds and identify any areas of needed repair. Work orders will be established so that repairs can be tracked for completion. The Director of Maintenance and ED/ or Designee will work with the Corporate Office to develop a systematic plan for refurbishment and repairs in patient rooms and shower rooms.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Alma D. Maro* TITLE *Executive Director* (X6) DATE *5/13/16*

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.

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F 253	Continued From page 1 accumulated dust, debris and dried on spills. C Wing: 10 Resident Rooms with built in closets and bureaus were found to have rough edges, chipped and peeling paint and missing knobs. Walls are noted to have peeling paint, sheet rock with gouges and cove base sloughing from the walls. Waste paper baskets were found without plastic bag enclosures, therefore baskets themselves were found to be heavily soiled with dried accumulated materials. Oxygen concentrators in use were found to have accumulated dust, debris and dried on spills. Special Care Unit: 5 Resident Rooms with built in closets and bureaus were found to have rough edges and chipped and peeling paint. Walls are noted to have peeling paint and cove base sloughing from the walls. Waste paper baskets were found without plastic bag enclosures, therefore baskets themselves were found to be heavily soiled with dried accumulated materials. B and C Wing Bathing/Shower Rooms: Both were found to have cracked tiles on the walls located towards the floor. C Wing shower room was found to have dirty soiled laundry resting on the floor and on the towel racks. Privacy curtains were noted to be soiled as well. Confirmation was made at the end of the tour that the resident rooms, and shower rooms are in need of cosmetic repairs. Also confirmed that waste paper baskets and oxygen concentrators need cleaning.	F 253	The results of rounds and repairs will be reviewed with the QAPI committee monthly x 3 months to ensure compliance. The ED is responsible for overall compliance. <i>F253 POC accepted 5/17/16 RTremblay RN/PMC</i>		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS	F 279	F 279 Resident # 94 care plan has been developed for alteration in skin integrity. House audits have been completed on residents with potential/actual skin integrity issues to ensure that care plans have been developed. The SDC/designee completed re-education on developing care plans for residents with potential/actual skin integrity issues. The DNS/designee will complete random care plan audits on resident's with potential/actual skin integrity impairments monthly x 90 days. The results of these audits will be reviewed at the monthly QAPI meeting for 3 months to ensure compliance. The DNS is responsible for overall compliance. <i>F279 POC accepted 5/17/16 RTremblay RN/PMC</i>	May 26, 2016	

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F 279	<p>Continued From page 2</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to assure that a plan of care was developed for 1 resident (R #94) in a stage 2 sample of 31. Findings include: Per record review, Resident #94 has a pressure area on the Left 4th toe. In reviews of the MDS (Minimum Data Set - a comprehensive assessment tool), Nursing Assessments, and weekly skin checks since his/her first admission on 12/15/15, the resident is coded not to have a pressure ulcer. The resident was absent from the facility from 1/5/16 to 3/17/16 when s/he returned with no pressure ulcers. The resident was</p>	F 279			

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F 279	Continued From page 3 discharged to the hospital on 4/8/16 for fever and altered mental status. R #94 was readmitted on 4/11/16 and the Nursing Admission Assessment Skin inspection notes a pressure area which is staged as Unstageable on the L 4th Toe. The Admission assessment MDS notes the Unstageable pressure ulcer on the 4th toe. In a review of the record although the care plan does have an initiated Problem of Impaired Skin Integrity there are no prevention or care interventions found in the plan of care. Per interview on 4/27/16 at 1:40 PM, the Charge Nurse on the Unit confirmed that there was no care plan with interventions developed for a new pressure area discovered on 4/11/18.	F 279			
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure 1 of 4 applicable residents in the stage 2 sample of 31 (Resident #154) received the necessary care to maintain the highest practicable well being. Findings include: Per record review, Resident #154 had an	F 309	F 309 Resident # 154 no longer resides at the facility. All residents with un-witnessed falls have the potential to be affected. The SDC/designee has re-educated the licensed nurses on the facility fall policy/procedure with emphasis on NVS for un-witnessed falls. The DNS/designee will complete post fall audits on residents monthly x 90 days. The results of these audits will be reviewed at the monthly QAPI committee to ensure compliance. The DNS is responsible for overall compliance.	May 26, 2016	
			F309 POC accepted 5/17/16 RTremblay/RW/PMC		

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F 309	Continued From page 4 unwitnessed fall on 3/30/16. There is no evidence that staff performed Neurological Vital Signs (NVS) after the unwitnessed fall. Facility policy states that if the fall is unwitnessed monitor NVS every 15 minutes for 1 hour, then every 30 minutes for 1 hour, then every hour for 2 hours. On 4/27/16 at 12:25 PM, the Director of Nurses (DNS) confirmed that NVS should have been done after the unwitnessed fall and that they have not been done.	F 309			
F 353 SS=D	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by:	F 353	F 353 Resident # 28 needs are being met per care plan. All residents have the potential to be affected. The DNS/designee has been actively recruiting for licensed nurses and licensed nursing assistants. Current strategies include utilizing local as well as multiple other state recruitment options. The facility has contracted with temporary staffing agencies to provide direct care for the facility. The facility has an active Recruitment and Retention committee. The ED/designee will audit staffing weekly. Results of audits will be reviewed at the monthly QAPI committee for 3 months to ensure compliance. The ED is responsible for overall compliance. <i>F353 POC accepted 5/17/16 RITremedy/PAL/pnd</i>	May 26, 2016	

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F 353	Continued From page 5 Based on staff and resident interviews and record review, the facility failed to assure that there was sufficient staff to assure the highest well-being of each resident and assure the provision of care according to the resident's plans of care. Findings include: 1). Per resident interview on 4/26/16, Resident #28 stated during the resident interview that s/he has requested to use his/her bedside commode during the night shift and has been told that they are too busy to assist him/her to the bedside commode and that s/he must use the bedpan although that is not his/her preferred method of elimination. S/he states that s/he has told staff that s/he cannot comfortably use the bedpan. As a result s/he states that s/he has "held" his/her urine all night long to avoid using the bedpan. S/he states that one night recently s/he had held his/her urine as long as s/he could but that s/he finally had to request the bedpan. S/he relates that s/he waited so long that s/he had "overflowed" the bedpan and that his/her clothing and bedding were wet. In an interview on 4/26/16 at 2:30 PM the Director of Nurses (DNS) stated that the facility is aware that they are understaffed despite many efforts to recruit both Nurses and Licensed Nurses Aides (LNAs).	F 353			
F 371 SS=E	483.35(i) FOOD PROCURE, STDRE/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	F 371			

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F 371	Continued From page 6 under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and confirmed by staff interview the facility failed to ensure that food in the nourishment kitchens on A, B and C Wings are stored under sanitary conditions. The findings include the following: Per tour on 4/26/16 of the kitchenettes on all 3 Units in the presence of the Registered Dietician (RD) the following was observed: 1. Dementia unit kitchen cabinet was found to have 2 multi-serving bags of partially used potato chips and a multi-serving bag of partially used vanilla wafers unsealed nor dated as to the day any of the food products were opened. 2. B Wing cabinet drawer was found to store multiple souffle cups containing a white powder. There is no identification as to the contents in the souffle cups or the date when the powder was put in use. The cups are marked 2 T. 3. C Wing refrigerator was found to have multiple residents' personal food items (fried chicken-cherry peppers) in disposable containers with the following dates: 3/27/16, 4/23/16 and 4/25/16. 3 Styrofoam containers labeled jelly dated 4/23/16. The refrigerator is heavily soiled with a dried sticky substance making it difficult to open and close the lower drawers. Confirmation	F 371	F 371 Food in the nourishment room/refrigerator that was not dated, unsealed was discarded immediately. The refrigerators in the nourishment rooms were all cleaned and placed on a cleaning schedule. All residents have the potential to be affected. The SDC/designee has re-educated the staff on food storage/cleaning guidelines per policy. The Culinary/Hospitality Manager/designee will complete regular audits of nourishment rooms for 1 month and then weekly audits for 60 days. Results of these audits will be reviewed at the monthly QAPI meeting to ensure compliance. The ED is responsible for overall compliance. <i>F371 POC accepted 5/17/16 RTremblay/PW/PM</i>	May 26, 2016	

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F 371	Continued From page 7 is made by both the Unit Manager and the RD that the refrigerator is very dirty and needs cleaning. They also confirm that the food should of been discarded as per the date on the containers. The RD also confirmed the findings on the Dementia Unit and B Wing and voiced that the foods need to be stored and labeled properly.	F 371			
F 514 SS=D	483.75(l)(1) RES RECORDS-COMplete/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to maintain complete and accurate clinical records in accordance with acceptable professional standards of practice for 1 of 31 residents in the sampled group. For Resident #77, the findings include the following: Per medical record review Resident #77 was admitted on 2/20/16 with diagnoses to include	F 514	F 514 Resident # 77 physician has been notified regarding skin tear. Appropriate documentation was completed in the medical record. The LPN involved was re-educated on the policy related to contact of physician and the need for appropriate documentation. House audit of resident's care plans with potential/actual skin integrity issues has been completed to ensure no other residents are affected by this practice. The SDC/designee has re-educated licensed nurses on MD notification and documentation requirements. The DNS/designee will complete random audits on documentation on residents with skin integrity issues monthly x 90 days. The results of these audits will be reviewed at the monthly QAPI committee x3 months to ensure compliance. The DNS is responsible for overall compliance. <i>F514 POC accepted 5/17/16 R Tremblay RN/pml</i>	May 26, 2016	

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F 514	Continued From page 8 Type 2 Diabetes, amputation, Chronic Ulcer of the right foot with partial amputation of multiple toes, End Stage Renal Disease with dependency on Renal Dialysis and Chronic Obstructive Pulmonary Disease. Per review of the Dialysis Communication Record for Resident #77 dated 4/25/16, evidences documentation from the Dialysis Registered Nurse (RN) ["Resident #77 must have bumped his toe between your facility and ours-2nd toe stump with skin tear, bleeding. Area cleaned and antibiotic ointment applied please follow up thanks."] Per observation Licensed Practical Nurse (LPN) evaluated Resident #77's 2nd toe stump on 4/25/16 at approximately 4:15 PM at the facility. The wound was treated and dressed. Per observation of the medical record on 4/26/15 there is no evidence that the physician was notified of the newly acquired wound nor is there evidence that wound care was conducted. Confirmation is made by the Unit Manager that there is no documentation or notification to the physician regarding Resident #77's newly acquired wound or treatment there of. Per interview with the LPN on 4/27/16 regarding the lack of communication to the physician regarding the newly acquired wound and the lack of documentation pertaining to the wound, confirmation was made by the LPN stating ["I just did not do it"].	F 514			
F9999	FINAL OBSERVATIONS 7.13 Nursing Services The facility must have sufficient nursing staff to	F9999			

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F9999	Continued From page 9 provide nursing and related services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care or as specified by the licensing agency. (d) Staffing Levels. The facility shall maintain staffing levels adequate to met resident needs. (1) At a minimum, nursing facilities must provide: (i) no fewer than 3 hours of direct care per resident per day, on a weekly average, including nursing care, personal care and restorative nursing care, but not including administration or supervision of staff; and of the three hours of direct care, no fewer than 2 hours per resident per day must be assigned to provide standard LNA care (such as personal care, assistance with ambulation, feeding, etc.) performed by LNAs or equivalent staff and not including meal preparation, physical therapy or the activities program. This requirement is NOT MET as evidenced by: Based on record review and Resident and Staff interviews, the facility failed to assure that there was sufficient staff to assure the highest well-being and care according to the resident's plans of care. Findings include: 1. In a review of the facility staffing patterns for February, March and April of 2016 it is found that the facility failed to meet the state regulatory requirement for 2 hours per day per resident of direct (LNA) care on 10 days in February, 9 days in March, and 6 of 23 reported days in April. Additionally the Total number of care hours of 3 hours per day per resident were not met on 8 days in February, 9 days in March, and 5 of 23	F9999	9999 Resident # 28 needs are being met per care plan. All residents have the potential to be affected. The DNS/designee has been actively recruiting for licensed nurses and licensed nursing assistants. Current strategies include utilizing local as well as multiple other state recruitment options. The facility has contracted with temporary staffing agencies to provide direct care for the facility. The facility has an active Recruitment and Retention committee. The ED/designee will audit staffing weekly. Results of audits will be reviewed at the monthly QAPI committee for 3 months to ensure compliance. The ED is responsible for overall compliance.	May 26, 2016	

F9999 POC accepted 5/17/16 RTremblay/RWjmc

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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 04/27/2016
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	
F9999	Continued From page 10 reported days in April. In an interview on 4/26/16 at 2:30 PM the Director of Nurses (DNS) stated that the facility is aware that they are understaffed despite many efforts to recruit bot Nurses and Licensed Nurses Aides 2. Also see F353.	F9999			