



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) 241-2345
To Report Adult Abuse: (800) 564-1612
Fax (802) 241-2358

February 10, 2011

Ursula Margazano, Administrator
Burlington Health & Rehab
300 Pearl Street
Burlington, VT 05401

Provider ID #:475014

Dear Ms. Margazano:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **November 30, 2010**.

Follow-up may occur to verify that substantial compliance has been achieved and maintained.

Sincerely,

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

Pamela M. Cota, RN
Licensing Chief

PC:jl

Enclosure



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

RECEIVED
Division of
FEB 0 4 11

PRINTED: 01/25/2011
FORM APPROVE:
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475014	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	Licensing and Protection	(X3) DATE SURVEY COMPLETED C 11/30/2010
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NAME OF PROVIDER OR SUPPLIER BURLINGTON HEALTH & REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 300 PEARL STREET BURLINGTON, VT 05401
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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	F 000		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES An unannounced on-site complaint investigation was conducted by the Division of Licensing and Protection on 11/30/10. There was a regulatory violation. The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview the facility failed to use an assistance device correctly to prevent an accident for 1 applicable resident. (Resident #1) Findings include: Per interview on 11/30/10 at 12:15 PM, the Speech Language Pathologist (SLP) stated that on 11/15/10, Resident #1 requested both legs to be elevated. While the resident was in the wheelchair, the SLP lifted the resident's legs onto the bed and did not use the wheel chair leg rests. The resident tipped backwards in the wheelchair and fell, requiring transport to the emergency room for sutures. Per interview on 12/02/10 at 9:30 AM, a family member stated the incident effected [the resident] as s/he had a hard time sleeping after the incident and was afraid. During an interview on 11/30/10 at 1:10 PM, the Physical Therapist stated "the practice of putting the legs up on the bed while in the wheelchair is not	F 323	The facility maintains that it ensures that the resident environment remains free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. How the corrective action(s) will be accomplished for those residents found to be affected by the alleged deficient practice? : Resident # 1 had no negative outcome and was discharged home as per plan. DNS, Therapy, Nurse Mnger, &/or Designee How will the facility identify other residents having the potential to be affected by the same deficient practice? : Any resident using an assistive device is potentially affected by this alleged deficient practice. What measures will be put into place or systematic changes made to ensure that the deficient practice will not recur? : Nursing and therapy staff will be re-educated re: use of assistive devices. DNS, SDC, Rehab Director, &/or designee	12/30/10 11/19/10 On-going 12/30/10 On-going

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Michelle Magano* TITLE: *Administrator* (X6) DATE: *2/3/11*

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

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

PRINTED: 01/25/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475014	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2010
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NAME OF PROVIDER OR SUPPLIER BURLINGTON HEALTH & REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 300 PEARL STREET BURLINGTON, VT 05401
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F 323 Continued From page 1
safe...staff should know that legs are not supposed to be elevated [up on the bed] while someone is in a wheelchair, there should be leg supports or be put back into bed," and confirmed that the assistive device was not used correctly to prevent an accident.

F 323

How will the facility monitor its corrective actions to ensure that the deficient practice will not recur? :
Ten random audits will be conducted per week for 4 weeks, to ensure compliance with use of any assistive devices. Corrective actions will be reported with f/u review at Action Team and QA Meetings with changes made as appropriate.
DNS, ADNS, &/or designee

12/30/10
On-going

F323 POC Accepted 2/10/11. pmetarn