

Division of Licensing and Protection
103 South Main Street
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

February 9, 2015

Ms. Meagan Buckley, Administrator
Burlington Health & Rehab
300 Pearl Street
Burlington, VT 05401-8531

Dear Ms. Buckley:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **January 27, 2015**. 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

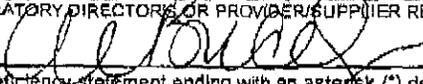
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 01/29/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES NO PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475014	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/27/2015
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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
F 000	INITIAL COMMENTS	F 000		
F 309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to ensure that each resident receives the necessary care and services to maintain the highest practicable physical well-being for 2 of 3 sampled residents, (Resident #1 and #2), regarding proper monitoring after falls. The findings include the following:</p> <p>1. Per record review on 1/26/15, Resident #1 had two unwitnessed falls dated 9/24/14 and 10/28/14. Per facility policy dated 10/2010 neurological assessment is to be completed after any unwitnessed falls. Neurological evaluation is to be completed every 15 minutes for 1 hour, every 30 minutes for 4 hours, every hour for 2 hours and every shift for 72 hours unless specified by the Medical Doctor. There is no evidence in the medical record that neurological</p>	F 309	<p>The following constitutes the facility's response to the findings of the Department of Licensing and Protection and does not constitute an admission of guilt or agreement of the facts alleged or conclusions set forth in the summary statement of deficiencies.</p> <p>F309</p> <ol style="list-style-type: none"> 1. There were no negative outcomes to any resident related to this alleged deficient practice. 2. Neither resident reside at center 3. All residents that have a fall resulting in resident hitting their head or any un-witnessed fall are potentially affected by this alleged deficient practice. 4. Education to nursing staff regarding completing neurological evaluation "NVS" per policy. 5. Random weekly audits to be completed by DNS/Designee. 6. DNS or Designee shall report out to QAA committee monthly x3 at this time frequency of further surveillance shall be determined by committee. 7. Corrective actions shall be complete by 02/06/2015 <p>F309 POC accepted 2/6/15 mBeAmandra/Amc</p>	

LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Executive Director	(X6) DATE 2/5/2015
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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.

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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 01/27/2015
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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 309	<p>Continued From page 1</p> <p>signs were completed post falls, nor is there evidence that MD specified otherwise.</p> <p>2. Per record review on 1/27/15, Resident #2, had an unwitnessed fall on 5/24/14. Per facility policy dated 10/2010 neurological assessment is to be completed after an unwitnessed falls. Neurological evaluation is to be completed every 15 minutes for 1 hour, every 30 minutes for 4 hours, every hour for 2 hours and every shift for 72 hours unless specified by the Medical Doctor. Per record review neurological evaluation did not begin until approximately 4 hours post fall.</p> <p>Per interview with the Director of Nurses (DNS) on 1/26/15, confirmation was made that neurological assessments were not completed as per policy.</p>	F 309		