



**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

October 5, 2010

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

Dear Ms. Margazano:

Enclosed is a copy of your acceptable plans of correction for the complaint investigation conducted on September 15, 2010. 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,

A handwritten signature in cursive script that reads "Pamela M. Cota".

Pamela M. Cota, RN  
Licensing Chief



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

RECEIVED  
Division of

PRINTED: 09/17/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>475014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	OCT 04 10 Licensing and Protection	(X3) DATE SURVEY COMPLETED  C <b>09/15/2010</b>
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NAME OF PROVIDER OR SUPPLIER  <b>BURLINGTON HEALTH &amp; REHAB</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>300 PEARL STREET BURLINGTON, VT 05401</b>
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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	<p><b>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 on the summary statement of deficiencies.</b></p> <p>The facility maintains that it provides for the residents' right to participate in planning care and treatment or changes in care and treatment.</p> <p><b>How the corrective action(s) will be accomplished for those residents found to be affected by the alleged deficient practice? :</b> Resident # 1 suffered no negative outcomes from this alleged deficient practice. Resident # 1 care plans revised to reflect current individual level of care. Seen by physician and psychology. <b>DNS, SDC, Nurse Mnger, &amp;/or Designee</b></p>	9/15/10
F 280 SS=D	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>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.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, interview and record review, the facility failed to revise the plan of care to reflect changes in status for 1 applicable Resident (Resident #1). Findings include:  Per record review on 9/15/10 at 10:48 A.M., staff did not update the care plan to reflect Resident</p>	F 280		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Wesley M. Mergerson* TITLE *Administrator* (X6) DATE *10/1/10*

A deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that certain 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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NAME OF PROVIDER OR SUPPLIER  <b>BURLINGTON HEALTH &amp; REHAB</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>300 PEARL STREET</b> <b>BURLINGTON, VT 05401</b>	
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F 280	Continued From page 1 #1's verbalizations of suicidal ideation. Per nursing notes of 8/6/10 and 8/14/10, Resident #1 stated to staff that she/he "didn't want to live anymore" and "I just want to die, I'm just going to keep not eating". Per interview with the Unit Manager (UM) at 11:15 A.M. on 9/15/10, the UM confirmed that the care plan had not been revised to reflect Resident #1's suicidal ideation.	F 280	<b>How will the facility identify other residents having the potential to be affected by the same deficient practice? :</b> All residents who verbal suicidal ideation are potentially affected by this alleged deficient practice. Reports of suicidal ideation will be noted on the 24 hour report for discussion in Concurrent Review	On-going
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS  The services provided or arranged by the facility must meet professional standards of quality.  This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, facility staff failed to meet professional standards of quality for 1 applicable resident (Resident #1). Findings include:  Per record review on 9/15/10 at 10:48 A.M., staff failed to notify the physician or initiate suicide precautions for Resident #1. The Resident made suicidal statements on 8/6/10, 8/14/10 and 9/3/10. Per facility policy, staff is to notify the Resident's physician of current threat of suicide, initiate 1:1 observation and place the Resident on close supervision with appropriate documentation on every shift. During an 11:15 A.M. interview on 9/15/10, the Unit Manager confirmed that the physician was not notified after the 8/6/10 and 8/14/10 suicidal statements and that the Resident was not placed on 1:1 supervision or close observation per facility policy.	F 281	<b>What measures will be put into place or systematic changes made to ensure that the deficient practice will not recur? :</b> Nurses will be re-educated re: care plan revisions re: verbalization of suicidal ideation. <b>DNS, SDC, &amp;/or designee</b>  <b>How will the facility monitor its corrective actions to ensure that the deficient practice will not recur? :</b> Any resident who verbalizes suicidal ideation will have care plan audited for accuracy and adherence to care plan revision. Verbalization of suicidal ideation will be reported in Clinical Concurrent Review with f/u review at Action Team and QA Meetings with changes made as appropriate. <b>DNS, ADNS, &amp;/or designee</b>  <i>F280 POC Accepted 10/4/10 R.Tremblay RN P.McIntyre RN</i>	

<p><b>F281</b></p>	<p>The facility maintains that services that are provided or arranged by the facility meet professional standards.</p> <p><b>How the corrective action(s) will be accomplished for those residents found to be affected by the alleged deficient practice? :</b></p> <p>Resident # 1 suffered no negative outcomes from this alleged deficient practice. Resident #1 – Care Plan has been clarified and updated to reflect current care needs. Seen by physician and psychology.</p> <p style="text-align: right;"><b>DNS, Nurse Mnger, &amp;/or Designee</b></p> <p><b>How will the facility identify other residents having the potential to be affected by the same deficient practice? :</b></p> <p>All residents who verbal suicidal ideation are potentially affected by this alleged deficient practice. Reports of suicidal ideation will be noted on the 24 hour report for discussion in Concurrent Review</p> <p><b>What measures will be put into place or systematic changes made to ensure that the deficient practice will not recur? :</b></p> <p>Nurses will be re-educated re: Policy &amp; Procedure re: Suicide Threats / Precautions.</p> <p style="text-align: right;"><b>DNS, SDC, Rehab Director &amp;/or designee</b></p>	<p>9/15/10</p> <p>On-going</p> <p>10/5/10 On-going</p>
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	<p><b>How will the facility monitor its corrective actions to ensure that the deficient practice will not recur? :</b>  Residents who verbalize suicidal ideation will have chart audited for adherence to Suicide Threats / Precautions Policy &amp; Procedure.  Verbalization of suicidal ideation will be reported in Clinical Concurrent Review with f/u review then reported at Action Team and QA Meetings with changes made as appropriate.</p> <p><b>DNS, ADNS &amp;/or designee</b></p> <p><i>FAB POC Accepted 10/4/10</i>  <i>R.Tremblay RN / J.McCoturn</i></p>	<p><b>10/5/10</b></p>