STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475014	A. Building B. Wing	12/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Burlington Health & Rehab	300 Pearl Street Burlington, VT 05401

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0557 Level of Harm - Actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. 43524 Based on observation, interview, and record review, it was determined that the facility failed to ensure residents are treated with respect and dignity for 1 resident. (Resident #1). Findings include: Observation of Resident #1 on 12/20/21 at 12:15 PM revealed she/he was sitting in a wheelchair, leaning to the far left side, with the left side of her/his head resting on her/his left shoulder. The resident was wearing a pair of black shorts, a white shirt, and white mid shin high socks. She/he had a white towel wrapped around her/his waist, above the umbilicus and her/his mid and lower abdomen were exposed. The bottom of a colostomy bag was noted below the towel that was wrapped around the resident. The white towel was noted to have some light brown to yellow substance and particles covering much of the exposed surface. Under the resident in her/his wheelchair was a large white pad with writing on the underside, that covered the seat of the wheelchair and draped down in front of the wheelchair to approximately 2 inches above the front wheels of the wheelchair. Along the right side of this pad, from the seat of the wheelchair down to the bottom of the pad where it hung to approximately 2 inches above the front wheels of the wheelchair was a strip approximately 2 inches wide, where more of the light brown to yellow substance and particles were noted. The residents hands were noted to have this light brown and yellow substance on both her/his hands as well as on the right leg of her/his shorts at the thigh area. Introductions were made and the resident stated, I asked over an hour ago for someone to come in and help me, as you can see I am covered in feces. This is my life, everyday and they don't seem to care. I sit like this for hours until someone decides I am deserving of their help. S/he went on to say, I use to be able to care for myself, but my vision is so bad all I can see are shadows. When asked about the substance noted on the towel, her/his shorts, her/his hands and the pad s/he were sitting on, s/he stated this is all feces, they do not use the right supplies for my colostomy. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0557 Level of Harm - Actual harm Residents Affected - Few	During this interaction with this resident a person who identified themselves as the residents therapist, came into the residents room and greeted the resident. This person stated, this is unacceptable, I've suggested s/he call and file a complaint. S/he is on a hunger strike and I'm very concerned about her/his nutrition. The surveyor asked the resident why s/he was on a hunger strike and the resident stated, Because the staff here don't listen to me, they don't really seem to care about me and I worry about those that can't speak for themselves, I feel like doing this hunger strike, well, it might bring awareness to how we are treated. I came here because I wanted to but I didn't know the care was going to be so bad. It's not right for old people like me to be left sitting in feces for hours and then to be told we are difficult, argumentative, and hard to care for because we speak out. I am speaking out for all the residents here, because we pay good money and should get good care. This surveyor stated that they would bring to the staffs attention the residents current situation. The resident asked that this surveyor come back while the staff provide the care I want you to see for yourself the chemical burns I have on my skin from being left in my own feces for hours at a time. Interview on 12/20/21 at approximately 12:45 PM with the LPN who was assigned to this resident, s/he explained that they were aware of the residents needs but it takes 2 staff members to clean this resident up. S/he pointed to the LNA that was assigned to this resident and stated, s/he has been busy providing care to other residents while I've been busy passing medications to the residents and I have several Covid positive patients on my side so I have to put gloves on, mask, face shield, and a gown before I go into the room, then I provide the care and have to ungarb to go to the next residents room and then do the same thing with putting on new gloves, masks, face shield and gown. The surveyor asked her/him to come and see the resident to which the LPN put her/his arms out to the side and said, What? Do you want me to go clean [pronoun omitted] up now? The nurse and surveyor arrived in the residents room at approximately 12:55 PM, the nurse confirmed that the resident was covered in his/her own feces and that the colostomy bag must have let loose, s/he stated, yup, this is a typical day for [pronoun omitted]. The nurse explained that the process of cleaning the resident up after this type of situation is quite time consuming so s/he is usually assisted once everyone else has received their care for the morning. The nurse stated s/he would gather the supplies, get the assigned LNA and they would come back and get her/him cleaned up. Interview with the DON on 12/20/21 at approximately 1:10 PM who agreed to go to the unit with the surveyor and see the resident. Upon approaching the residents room with the DON, the resident was out in her/his wheelchair in the hallway just outside of her/his room. The assigned LPN and LNA met us with the resident, who had not been cleaned up at this point. The DON greeted the resident who stated to the DON, This is new, all this attention all of a sudden, too bad it took a visit from the state to get the care I need. The DON acknowledged the residents condition and that s/he had feces on her/his clothes, hands, down the front of the pad s/he was sitting on in the wheelchair and the towel wrapped around the residents waist that was also covered in feces. The DON stated s/he was not aware of this being a frequent occurrence. (continued on next page)

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F 0557 Level of Harm - Actual harm Residents Affected - Few	The LPN requested the resident to come into her/his room so s/he could change the resident's catheter and ostomy and get h/him cleaned up and in some clean clothes. The resident asked the LPN to please use the ostomy supplies that were in the box at the end of her/his bed. The LPN brought out into the hallway, 5 different ostomy bags and supplies and asked the resident which one s/he wanted to use. The resident explained to the LPN which supplies work the best but s/he was not sure if there were any left. The resident explained that the supplies s/he had at home are the ones that s/he had used for a long time and they work very well. The resident stated that a while ago a staff member went to the residents home and brought back one box of the supplies the resident used prior to her/his admission to this facility. The resident asked why the facility couldn't just order the supplies that worked and stated, I told them if my insurance wouldn't cover them then I would pay for them and they still use whatever they want. The resident stated that the facility uses whatever they happen to have available instead of the proven supplies that really work. At 1:45 PM the resident was in her/his bed and the LPN pulled the front of the residents incontinence brief forward which revealed a large amount of dried feces on the residents lower abdomen. The LNA brought to the residents bedside a basin of warm soapy water. The LPN attempted to wash the feces off with a warm wet wash cloth with soap and the resident cried out and stated, Oh my god that hurts so bad, please, what are you doing? The LPN explained, I just tried washing the feces off but it is dried in place. I will need to soak your tummy for a bit to clean it all off. The LPN put the washcloth in the basin and then pulled it out and squeezed the water onto the residents abdomen. S/he then patted and wiped the residents abdomen until the abdomen was clean exposing red, raw skin. The LPN then lifted the bottom of the residents shirt up above the colostomy bag and then lifted the bottom of the colostomy bag where s/he noted red, raw skin where the bottom of the colostomy bag was. [NAME] tape that was discolored with a brownish yellow substance, was noted around where the opening of the ostomy bag was. The LPN stated s/he was going to remove the entire ostomy device and replace with all new as well as changing the residents catheter. At 2:15 PM the LPN and LNA were still working to get the resident cleaned up. On four occasions during this time while care was being provided by the LPN, s/he said, I know that hurts baby, I'm sorry. On 12/20/21 at approximately 2:30 PM an interview with the Regional Director of Clinical Services regarding the interviews that took place earlier, specific to the observations that were made of this resident at 12:15 PM and an hour and a half later, at 1:45 PM staff had started to provide care to the resident. S/he stated that this resident does refuse care at times and most recently was found in a similar way by the Administrator. S/he stated that the Administrator offered to get staff to come clean her/him up and s/he stated they wanted to eat their breakfast first. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0557 Level of Harm - Actual harm Residents Affected - Few	A review of the residents MAR (Medication Administration Record) revealed that the resident had not had any behaviors for the month of the November 2021 and December of 2021 and there was no documentation to support that the resident refused care or services. Review of the last 30 days of nurses notes revealed resident refused a shower on 11/16/21 stating, I'm not in the mood for it and its too cold.; a nursing note dated 12/14/21 reveals, Patient became agitated and verbally aggressive during meal pass this evening . Patient proceeded to move down to dining room to yell and be verbally aggressive with staff .Patient returned to room agitated, unable to redirect.; and on 12/20/21 at 08:21 a Behavior Note was entered stating, This writer spoke to [proper name omitted] on or about 12/16/21 about [pronoun omitted] taking over the day room with all of [pronoun omitted] gadgets and IT type equipment .Also on Saturday 12/18/21 when this writer was serving breakfast I noticed [proper name omitted] to be soiled from his colostomy bag. I told [pronoun omitted] I would get an LNA to help. [Pronoun omitted] refused saying [proper name omitted] wanted to eat breakfast first. After [pronoun omitted] finished breakfast [pronoun omitted] consented to and received care., this was signed by the facility Administrator. There were no other notes or documentations available to support frequent refusals of care. There is a PA's (Physician Assistant) note dated 12/20/2021 at 10:17 AM, Review of Systems which does not include any skin assessment or documentation specific to the residents complaints about her/his skin having chemical burns. A previous assessment completed on 12/02/2021 at 04:22 PM by the PA did include an assessment of the residents integumentary (skin) system and reveals the resident had a rash, there were no recommendations made specific to this rash and no treatment for this rash listed in the current doctors orders.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 43524 Based on observation, interview, and record review it was revealed that the facility failed to provide treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for 1 residents in a survey sample of 3. (Resident #1) 1.) Per record revew, a physician's order for Resident #1 read, Compression stockings to BLE [bilateral lower extremities] for edema management. Apply in the AM Remove in the PM one time a day and remove per schedule. Review of Resident #1's comprehensive person-centered care plan, revealed the following current care plan: The resident has fluid overload or potential fluid volume overload r/t [related to] BLE [Bilateral Lower Edema]. The goal specific to this care plan was as follows: The resident will remain free of s/sx [signs and symptoms] of fluid overload through review date as evidenced by decrease in or absence of edema, anxiety, agitation, restlessness, confusion, changes in mood or behavior, nausea/vomiting, dypsnea, congestion, orthopnea, easily fatigued, jugular distentions. One of the interventions to this goal read, Compression stockings to BLE, apply in AM remove in PM. The date this goal was initiated was on 10/18/21 and the target date is documented as 02/22/22. Observation of Resident #1 in her/his room on 12/20/21 at 12:15 PM, revealed that s/he was wearing black shorts, a white shirt, and white socks and she/he was not wearing compression stockings. Interview on 12/20/21 at approximately 1:30 PM with Resident #1's assigned LNA (Licensed Nurses Aide) who confirmed the resident was not wearing her/his compression stockings. The LNA explained that a couple of days earlier, when s/he was providing care to the resident and the resident had a pair of black compression stockings on. The LNA removed these compression stockings and sent them to the laundry because they were covered in feces. The LNA stated to his/her knowledge the resident only had the one pair of compression stockings and the black ones have not yet come back from the laundry. Interview on 12/20/21 at approximately 12:16 PM with the LPN (Licensed Practical Nurse) who was assigned to this resident, s/he confirmed that Resident #1 was not wearing compression stockings as ordered. 2.) Per record review, Resident #1 had a current care plan that read, The resident will be able to express thoughts/feelings regarding current situation through next review. This goal was initiated on 05/17/2021 and was revised on 12/20/2021 with a target date of 02/22/2022. One of the interventions read, Stop sign across room door to deter other residents from entering room, 15 minutes [sic] check to provide for safety. Date initiated was 12/19/2021. Observation on 12/20/21 at 12:15 revealed a cloth stop sign was hung on the left side of the residents room doorway and on the right side of the doorway was a piece of velcro that the sign was noted to attach to. The cloth sign was hanging on the left side of the door and was not across the door. (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	Interview with Resident #1, who stated that the cloth stop sign was put up to stop the lady with dementia from coming into my room - she comes in and drinks the coffee off my table, she goes through my things, and when I tell staff they do nothing about it. Time spent with the resident was from 12:15 PM to 1:00 PM and at no time did the staff come to put the cloth stop sign up and across the residents doorway and at no time during that 45 minutes did a staff member come and check in on the resident to meet the goal of 15 minute checks to provide safety. Interview with the assigned LNA who explained that the cloth sign should be across the residents doorway as some of the residents with dementia tend to wander into his room and this is upsetting to him. The LNA was not aware of 15 minute checks to provide safety. 3.) Per record review, Resident #1 had a current care plan that read, Alteration in musculoskeletal status r/t [related to] Quadriplegia with an initiation date of 05/17/2021, there was no revision date. The goal read, The resident will remain free of complications through review date, the target date was documented as 02/22/2022. One of the interventions read, Anticipate and meet needs. Be sure call light is within reach and respond promptly to all requests for assistance. Observation of Resident #1 on 12/20/21 at 12:15 PM revealed s/he was sitting in a wheelchair, leaning to the far left side, with the left side of her/his head resting on her/his left shoulder. The resident was wearing a pair of black shorts, a white shirt, and white mid shin high socks. S/he had a white towel wrapped around her/his waist, above the umbilicus and her/his mid and lower abdomen were exposed. The bottom of a colostomy bag was noted below the towel that was wrapped around the resident. The white towel was noted to have some light brown to yellow substance and particles covering much of the exposed surface. Under the resident in her/his wheelchair was a large white pad with writing on the underside, that covered the seat of the wheelchair and draped down in front of the wheelchair to approximately 2 inches above the front wheels of the wheelchair. Along the right side of this pad, from the seat of the wheelchair down to the bottom of the pad where it hung to approximately 2 inches above the front wheels of the wheelchair was a strip approximately 2 inches wide, where more of the light brown to yellow substance and particles were noted. The residents hands were noted to have this light brown and yellow substance on both her/his hands as well as on the right leg of her/his shorts. Introductions were made and the resident stated, I asked over an hour ago for someone to come in and help me, as you can see I am covered in feces. This is my life, everyday and they don't seem to care. I sit like this for hours until someone decides I am deserving of their help. She/he went on to say, I use to be able to care for myself, but my vision is so bad all I can see are shadows. When asked about the substance noted on the towel, her/his shorts, her/his hands and the pad they were sitting on, she/he stated this is all feces, they do not use the right supplies for my colostomy. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Actual harm Residents Affected - Few	During this interaction with this resident a person who identified themselves as the residents therapist, came into the room and greeted the resident. This person stated, this is unexceptable, I've suggested he call and file a complaint. S/he is on a hunger strike and I'm very concerned about his nutrition. The surveyor asked the resident why s/he was on a hunger strike and the resident stated, Because the staff here don't listen to me, they don't really seem to care about me and I worry about those that can't speak for themselves, I feel like doing this hunger strike, well, it might bring awareness to how we are treated. I came here because I wanted to but I didn't know the care was going to be so bad. It's not right for old people like me to be left sitting in feces for hours and then to be told we are difficult, argumentative, and hard to care for because we speak out. I am speaking out for all the residents here, because we pay good money and should get good care. This surveyor explained that they would bring to the staffs attention the residents current situation. The resident asked that this surveyor come back while the staff provide the care I want you to see for yourself the chemical burns I have on my skin from being left in my own feces for hours at a time. Interview on 12/20/21 at approximately 12:45 PM with the LPN who was assigned to this resident, s/he explained that they were aware of the residents needs but it takes 2 staff members to clean this resident up. S/he pointed to the LNA that was assigned to this resident and stated, she/he has been busy providing care to other residents while I've been busy passing medications to the residents and I have several Covid positive patients on my side so I have to put gloves on, mask, face shield, and a gown before I go into the room, then I provide the care and have to ungarb to go to the next residents room and then do the same thing with putting on new gloves, masks, face shield and gown. The surveyor asked her/him to come and see the resident to which the LPN put her/his arms out to the side and said, What? Do you want me to go clean him/her up now? The nurse and surveyor arrived in the residents room at approximately 12:55 PM, the nurse confirmed that the resident was covered in her/his own feces and referred to the colostomy stating that it must have let loose and, yup, this is a typical day. The nurse explained that the process of cleaning the resident up after this type of situation is quite time consuming so he is usually done once everyone has received their care for the morning. The nurse stated she would gather the supplies and she/he and the assigned LNA would come back and get her/him cleaned up. Interview with the DON on 12/20/21 at approximately 1:10 PM who agreed to go to the unit and see the resident. Upon approaching the residents room with the DON, the resident was out in her/his wheelchair in the hallway just outside of her/his room. The assigned LPN and LNA met us with the resident, who had not been cleaned up at this point. The DON greeted the resident who stated to the DON, This is new, all this attention all of a sudden, too bad it took a visit from the state to get the care I need. The DON acknowledged the residents condition and that she/he had feces on her/his clothes, hands, down the front of the pad she/he was sitting on in the wheelchair and the towel wrapped around the resident that was also covered in feces. The DON stated she/he was not aware of this being a frequent occurance. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Actual harm Residents Affected - Few	The LPN requested the resident to come into her/his room so she/he could change the residents catheter and ostomy. The resident asked the LPN to please use the ostomy supplies that were in the box at the end of her/his bed. The LPN brought out into the hallway, 5 different ostomy bags and supplies and asked the resident which one she/he wanted to use. The resident explained to the LPN which supplies work the best but she/he was not sure if there were any left. The resident explained that the supplies she/he had at home are the ones that she/he has used for a long time and they work very well. The resident stated that a while ago a staff member went to the residents home and brought back one box of the supplies the resident used prior to her/his admission to this facility. The resident asked why the facility couldn't just order the supplies that worked and stated, I told them if my insurance wouldn't cover them then I would pay for them and they still use whatever they want. The resident stated that the facility uses whatever they happen to have available instead of the proven supplies that really work. At 1:45 PM the resident was in her/his bed and the LPN pulled the front of the residents incontinence brief forward which revealed a large amount of dried feces on the residents lower abdomen. The LNA brought to the residents bedside a basin of warm soapy water. The LPN attempted to wash the feces off with a warm wet wash cloth with soap and the resident cried out and stated, Oh my god that hurts so bad, please, what are you doing? The LPN explained, I just tried washing the feces off but it is dried in place. I will need to soak your tummy for a bit to clean it all off. The LPN put the washcloth in the basin and then pulled it out and squeezed the water onto the residents abdomen. S/he then patted and wiped the residents abdomen until the abdomen was clean exposing red, raw skin. The LPN then lifted the bottom of the residents shirt up above the colostomy bag and then lifted the bottom of the colostomy bag where she/he noted red, raw skin where the bottom of the colostomy bag was. [NAME] tape that was discolored with a brownish yellow substance, was noted around where the opening of the ostomy bag is. The LPN stated s/he was going to remove the entire ostomy device and replace with all new as well as changing the resident catheter and clothes. At 2:15 PM the LPN and LNA were still working to get the resident cleaned up. An interview on 12/20/21 at proximately 2:30 PM with the Regional Director of Clinical Services regarding the observation and interviews that took place earlier in the day specific to observations made of this resident at 12:15 PM and an hour and a half later, at 1:45 PM staff had started to provide care to the resident. S/he did explain that this resident does refuse care at times and most recently was found in a similar way by the Administrator. S/he stated that the Administrator offered to get staff to come clean her/him up and she/he stated they wanted to eat their breakfast first. Review of Resident #1's medical record revealed an active order that read, Complete Weekly Skin Review every day shift every Mon. The following Weekly Skin Review were noted 11/06/2021 at 21:46 revealed redness and pre-existing skin tears. A note states, Skin tear to L [left] shin, tx is place, scattered small open areas surrounding stoma, tx in place.; 11/15/2021 at 13:30 that reports the same areas and the same note; 11/22/2021 at 13:35 that reports the same areas with a note that states, Stoma site present on abdomen, tx in place. L shin wound tx in place.; 11/29/2021 at 13:35 revealed Skin Tears pre-existing and a note that states, skin tear in healing stages; 12/06/2021 at 13:35 revealed Skin Tears pre-existing and Open Area. A note stated, Left shin skin tear Stoma to right abdomen; and 12/13/2021 at 14:21 revealed Skin Tears pre-exisiting and Open Area. A note stated, Skin tear to L shin, tx in place, scattered small open areas surrounding stoma, tx in place. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Actual harm Residents Affected - Few	A review of the residents MAR (Medication Administration Record) revealed that the resident had not had any behaviors for the month of the November 2021 and December of 2021 and there was no documentation to support that the resident refused care or services. Review of the last 30 days of nurses notes revealed resident refused a shower on 11/16/21 stating, I'm not in the mood for it and its too cold.; a nursing note dated 12/14/21 reveals, Patient became agitated and verbally aggressive during meal pass this evening . Patient proceeded to move down to dining room to yell and be verbally aggressive with staff .Patient returned to room agitated, unable to redirect.; and on 12/20/21 at 08:21 a Behavior Note was entered stating, This writer spoke to [proper name omitted] on or about 12/16/21 about [pronoun omitted] taking over the day room with all of [pronoun omitted] gadgets and IT type equipment Also on Saturday 12/18/21 when this writer was serving breakfast I noticed [proper name omitted] to be soiled from his colostomy bag. I told [pronoun omitted] I would get an LNA to help. [Pronoun omitted] refused saying [proper name omitted] wanted to eat breakfast first. After [pronoun omitted] finished breakfast [pronoun omitted] consented to and received care., this was signed by the facility Administrator. There were no other notes or documentations available to support frequent refusals of care. There is a PA's (Physician Assistant) note dated 12/20/2021 at 10:17 AM, Review of Systems does not include any skin assessment or documentation specific to the residents complaints about her/his skin having chemical burns. A previous assessment completed on 12/02/2021 at 04:22 PM by the PA did include an assessment of the residents integumentary (skin) system and reveals the resident had a rash, there were no recommendations made specific to this rash.