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	09/21/2022

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

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F 0555 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to choose his or her attending physician. 46135 Based on resident and staff interviews, the facility failed to allow 1 of 31 sampled residents to choose his/her attending physician. Findings include: During a confidential interview on 9/19/22 at 10:55 AM, a resident stated that s/he was told by the facility that s/he cannot have his/her own doctor while s/he is in the facility. The resident, while crying, said things are hard enough being here. I want my regular doctor, but I was told I can only have the nursing home's doctor. During an interview on 9/20/22 at 12:45 PM, the Admission Licensed Nurse Assistant stated that s/he didn't know residents could have their own provider and confirmed that the facility does not give residents the choice to choose their own provider.

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.

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

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F 0645 Level of Harm - Potential for minimal harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45667 Based on interviews and record review the facility failed to ensure two residents (#5 and #58) of the survey sample of 31 individuals were screened for a mental disorder or intellectual disability prior to admission through completion of a PASARR (a PASARR is Preadmission Screening for Individuals with a Mental Disorder (MD) and Individuals with Intellectual Disability (ID) which is to be completed prior to admission so that an individual identified with MD or ID receive care and services in the most integrated setting appropriate to their needs). Findings include: 1. Facility failed to complete a PASARR for Resident #5. Resident #5 was admitted to the facility on [DATE] with diagnoses including schizophrenia, major depressive disorder, and cerebral infarct (a type of stroke blocking blood vessels to the brain). Review of a record filed as updated PASARR signed 8/16/21 in resident #5's medical record revealed PASARR Part C Intellectual Disability or Related Condition was incomplete. This section contains 5 questions that must be answered. If response to any question in part C is a yes, a level II Developmental Disabilities PASARR is required. The following questions in part C were left without a response: Question 1- Does this individual have a diagnosis of intellectual/developmental disability? Question 2-Does this individual have a related condition (e.g. cerebral palsy, epilepsy, brain injury) resulting in significant impairment in intellectual functioning and adaptive behavior. The Director of Social Services was interviewed on 9/20/22 at approximately 2:00 PM and confirmed these questions should have been answered and that the form is incomplete. 46135 2. Per record review, Resident #58 was admitted to the facility on [DATE] with diagnoses including anxiety disorder, major depressive disorder, unspecified psychosis not due to a substance or known physiological condition, and cognitive communication deficit. Review of Resident #58's PASARR signed 7/20/22 revealed two areas in which further action was to be taken by the nursing facility. Part A of Resident #58's PASARR is checked yes indicating that they are likely to require less than 30 days in the facility and would therefore qualify for an exception for the remainder of the screening, unless the individual's stay exceeds 30 days, in which the admitting nursing home is to complete and submit the form in full. Part C of resident #58's PASARR indicates that there is presenting evidence that this individual may have an intellectual/developmental disability or related condition, signaling a Level II Developmental Disabilities PASARR is required. There was no evidence in Resident #58's medical record that a PASARR Level I or PASARR Level II was completed after the 7/20/22 PASARR was submitted to the facility. Per interview on 9/20/22 at 12:01 PM, the Director of Social Services stated that Resident #58's 7/20/22 PASSAR was incorrect. S/he could not produce PASARR Level I or PASARR Level II follow ups to Resident #58's 7/20/22 PASARR or documentation in his record stating why it was not needed.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46135 Based on observation, resident and staff interview, and record review, the facility failed to develop and/or implement a comprehensive care plan for 4 of 31 sampled residents (Residents #5, #16, #54, and #59). Findings include: 1. Review of the medical record for Resident #54 reveals the resident was readmitted to the facility on [DATE] with diagnoses that include end stage renal disease (ESRD) and dysphagia (difficulty swallowing). Resident #54's care plan focus The resident needs dialysis (hemo) [related to] renal failure, [history] of renal calculus [kidney stone], absence of kidney, [history] of hydronephrosis [a condition of excess urine accumulation in kidney(s) that causes swelling of kidneys], updated 3/14/22, reveals the following interventions: monitor intake and output, and Obtain . weight per protocol. Resident #54's care plan focus Resident may be nutritionally at risk related to dysphagia, ESRD on HD [hemodialysis], updated 7/22/22, reveals the following interventions: record and monitor intakes, and record and monitor weights. The last weight documented in the Resident #54's record was on 6/1/2022 and there was no evidence that intake and output was being monitored and recorded consistently. Per interview with a Licensed Practical Nurse (LPN) and Licensed Nurse Aide (LNA) on 09/21/22 at 9:33 AM, the LPN stated that weights are done at the dialysis facility but could not find consistent documentation of weights from the dialysis facility. The LNA stated that they do not monitor Resident #54's intakes or outputs because it does not come up on the LNA assignment. Per interview on 9/20/22 at 4:01 PM, the Assistant Director of Nursing could not find weights, intakes, or outputs for Resident #54 and confirmed that the care plan was not being followed. 45667 2. The facility failed to develop a care plan for impaired swallow for Resident #5. Resident #5 was admitted to the facility on [DATE] with diagnoses including schizophrenia, major depressive disorder, and cerebral infarct (a type of stroke blocking blood vessels to the brain). Record review reveals MDS assessment Section K completed 7/6/22 indicates resident has swallowing disorder. Resident #5 has a physicians order written 7/7/22 for regular/liberalized diet, dysphagia puree texture, thin consistency, staff assist and supervision with all meals, single bites and sips. Resident #5's care plan was reviewed and noted not to contain an entry for impaired swallowing to include the ordered specific textures and viscosity of fluids or direction for assistance and supervision with all meals. A nurses note from 8/6/22 states resident ate an unknown amount of popcorn which was on the kitchen counter. On 8/31/22 a nurses note states Resident #5 ate a handful of staff members trail mix left at the nurses' station. On 9/20/22 at approximately 11:00 AM, the Speech Language Pathologist stated the resident has a significant history of aspiration (entry of materials such as food or drink into portions of the respiratory system), is at high risk for choking, and this problem should be on the care plan. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Facility failed to develop a care plan for an actual wound for Resident #16. Resident #16 was admitted to the facility on [DATE] with diagnoses including major depressive disorder, osteoarthritis, polyneuropathy, spinal stenosis lumbar region and general muscle weakness. There is no care plan in place to address resident #16's current wound. Record review revealed a Physicians order written 8/12/22 to apply Triad paste every shift and as needed to the left buttock wound. A skin assessment on 9/8/22 identified a pressure ulcer stage I, facility acquired, 4.1 cm x 3.0 cm (centimeter). The care plan was reviewed and noted to contain a problem for risk for skin impairment but no mention of a current wound. The Assistant Director of Nursing was interviewed on 9/20/22 and he/she confirmed this actual problem should be on the care plan. 4. Facility failed to implement the care plan regarding positioning for Resident #59. Resident #59 was admitted to the facility on [DATE] with diagnoses including unspecified dementia, cognitive communication deficit, muscle weakness, and osteoarthritis. On 9/19/22 at 10:55 AM the resident was observed lying in his/her bed on his/her back without any supportive devices. Above the residents bed were two signs. One was representative of a clock face with every two hours colored indicating how the resident should be positioned. The turn clock indicated the resident should he positioned on his/her left side between 10:00 AM and 12:00 PM. The second sign said keep heels floated using pillows, heels off of pillow every time (every time underlined) signed therapy. At 11:00 AM the Unit Manager confirmed the resident should have been turned and should have both heels elevated. On 09/20/22 at 9:00 AM Resident #59 was found with both heels on bed, no extra pillow or heels up device in bed. The LPN confirmed the resident has his/her heels on the bed without the support device and was not familiar with the resident having or needing foam boots. A record review revealed an order from the Physician written 1/27/22: Ensure patient's heels are floated OFF of the bed at all times and is wearing her foam protector boots (when not in wheelchair) every day and evening shift AND as needed. The care plan was reviewed and noted to contain the problem: Potential for pressure ulcer development with interventions to include; off load heels for pressure reduction while in bed using heels up pillow, assist with turning and repositioning approximately every two hours and as needed. On 09/20/22 at approximately 10:00 AM the Unit Manager confirmed the care plan was not being followed as written.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45667 Based on observations, interviews, and record review, the facility failed to ensure that one applicable resident was offered sufficient fluid intake to maintain proper hydration and health. Findings include: Facility failed to maintain proper hydration for Resident #10. Review of Resident #10's medical record reveals the resident was admitted to the facility on [DATE] with diagnoses that included chronic systolic (congestive) heart failure. A fluid restriction was ordered (a fluid restriction is used to avoid overloading the heart in persons with heart failure). The physicians order dated 5/3/21 stated: Fluid restriction 1500 cc: Dietary 960cc, 7-3 shift 220cc, 3-11 shift 220cc, 11-7 shift 100cc. Resident #10's care plan contained the same breakdown of allotted amounts of fluids per shift. On 09/19/22 a LNA (Licensed Nursing Assistant) was observed providing Resident #10 a cup of ice, when asked about the fluid restriction, the LNA denied awareness of a restriction. Review of the record of fluids provided by shift for the past between 09/01/22-09/20/22 reveals the allotted amount of fluids was exceeded nine times during the day shift, ten times during the evening shift, and eighteen times during the night shift. During an interview with the Unit Manager conducted 9/20/22 at approximately 1:00 PM, he/she confirmed the resident should not be given fluids in excess of the ordered amounts and that the care plan was not being followed.

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46135 Based on interview and record review, the facility failed to ensure pain medication was administered per physician order for 1 of 31 sampled residents (Resident #368). Findings include: Per record review, Resident #368 was admitted to the facility on [DATE] for pain management and therapy following back surgery. Resident #368 had an order for HYDROmorphone HCl Tablet 2 MG Give 1 tablet by mouth every 3 hours as needed for Pain -Start Date- 09/12/2022 [Dilaudid, used to treat severe pain]. Per interview on 09/19/22 at 01:09 PM, Resident #368 stated that s/he didn't have his/her pain medication for almost 15 hours after admission. S/he said s/he was admitted to the facility around 5 PM in the evening and his/her pain was okay at first but became increasingly worse after arrival. S/he informed the nurse repeatedly of his/her pain. S/he was finally offered Tylenol and Robaxin [methocarbamol; a muscle relaxant] around 2:00 AM which didn't help manage the pain completely. S/he stated the nurse told her/him that the Dilaudid wasn't available because the pharmacy was closed, and the day shift would have to work on getting it. S/he reemphasized that it was the worst pain s/he had felt since surgery, s/he constantly asked for pain medication, and didn't get any relief until the following morning around 8:00 AM when s/he received her first dose of Dilaudid since being admitted to the facility. Per review of Resident #368's Medication Administration Record, Hydromorphone was not administered until 7:50 AM on 09/13/2022. Per interview on 9/20/22 at 11:05 AM, the Director of Nursing stated that Resident #368's Dilaudid was not available because the pharmacy did not have the faxed physician's orders. A faxed order is required to gain access to the CubeX [medication dispenser holding emergency medications], which is where the nurse would get the Dilaudid from at that time. Per interview on 9/20/22 at 2:16 PM, the Admission's Licensed Nurse Aide (ALNA) confirmed that Resident #368's order for Dilaudid was not faxed to the pharmacy until the following morning and it was the responsibility of the nurse that admitted Resident #368 to fax the order to the pharmacy on admission. S/he later revealed the order was faxed to the pharmacy at 7:30 AM on 9/13/22.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46135 Based on interview and record review, the facility failed to ensure residents who require dialysis receive services, consistent with professional standards of practice, and the comprehensive, person-centered care plan for one of 31 residents (Resident #54). Findings include: Review of the medical record for Resident #54 reveals the resident was readmitted to the facility on [DATE] with diagnoses that include end stage renal disease, anemia in chronic kidney disease, unspecified hydronephrosis, acquired absence of kidney, and dependence on renal dialysis. Per review of Resident #54's care plan, the resident is scheduled for dialysis treatments on Tuesdays, Thursdays, and Saturdays. Facility policy titled NSG261 Dialysis: Hemodialysis (HD) Provided by a Certified Dialysis Facility, revised on 6/1/21, states Patients who require HD services receive care consistent with professional standards of practice . Professional standards of practice include: . Ongoing communication and collaboration with the certified dialysis facility regarding HD care and services. Per interview on 09/20/22 at 3:30 PM, a Licensed Practical Nurse (LPN) stated that communication between the dialysis facility and the nursing center is kept in a binder. The binder travels to and from the dialysis facility with the resident. The dialysis facility is to return documentation which includes pre and post weights for the resident receiving dialysis and any concerns with the treatment. The LPN could not find documentation between the dialysis facility and the nursing center for Resident #54's past four appointments (9/13, 9/15/22, 9/17/22, and 9/20/22). This LPN discovered sheets filled out by nursing center staff to send to the dialysis facility for the above days, but the dialysis facility portion of the communication sheet was blank. The LPN stated that the nurse is supposed to look at the communication sheet every time the resident comes back from dialysis and if it is not there, the nurse is supposed to call the dialysis facility to get the information. S/he stated that this had not been done for the above dates. Per interview on 9/20/22 at 4:01 PM, the Assistant Director of Nursing stated that nursing center staff are to review the dialysis communication binder when a resident returns from his/her dialysis appointment and acknowledge their review by signing the bottom of the communication sheet. The ADON stated that if the sheet was not completed by the dialysis facility, the nursing staff would notify the dialysis facility of the missing information and enter a nursing note into the record that the dialysis office was notified. S/he confirmed that this process was not followed for Resident #54's past four appointments and did not meet the professional standards of communication as outlined in the facility policy.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 37055 Based on staff interview and record review, the facility failed to ensure that PRN (as needed) orders for psychotropic drugs are limited to 14 days, or if the prescribing provider believes that it is appropriate for the PRN order to be extended beyond 14 days, that there is a documented rationale in the resident's medical record and an indicated duration for the PRN order for 2 of 6 sampled residents (Resident #28 & #90). Findings include: 1. Per record review, Resident #28 has diagnoses that include but are not limited to Dementia with Behavioral Disturbances and Palliative Care. Per record review, there is a physician order dated 8/3/2022 for Lorazepam Concentrate 2mg/ml, give .25ml by mouth every 4 hours as needed for restless, agitation, with the end date listed as indefinite. In the Medication Regiment Review form dated 8/24/2022 the physician listed Hospice as rationale but did not address the lack of a stop date. Confirmation per interview with the Assistant Director of Nursing on 9/20/22 at approximately 4:00 pm, that the attending physician did not provide an end date for the PRN order of Lorazepam as required by Federal Regulation. 2. Per record review, Resident #90 has diagnoses that include but are not limited to Vascular Dementia with Behavioral Disturbances and Anxiety. Per record review, there is a physician order dated 9/7/2022 for Lorazepam Tablet 0.5mg, give 1 tablet by mouth every 24 hours as needed for Anxiety, only to be administered when trimming toenails and is anxious, with the end date listed as indefinite. Confirmation per interview with the Assistant Director of Nursing on 9/21/22 at approximately 10:30am, that the attending physician did not provide an end date for the PRN order of Lorazepam as required by Federal Regulation.