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	06/12/2024

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50431 Per interview and record review, the facility failed to include the resident and their representative in developing a baseline care plan and failed to provide the resident and the representative a baseline care plan summary for 3 of 3 residents sampled (Residents #1, #2, and #3). Findings include: 1. Record review reveals that Resident #1 was admitted to the facility on [DATE] for rehabilitation following a hospital stay related to a craniotomy (opening of the skull) for a subdural hematoma (brain bleed) post fall. Per a 3/30/24 nursing note, Resident #1 was transferred to the hospital on 3/30/24 after suffering an unwitnessed fall in which s/he suffered facial injuries. S/He was readmitted to the facility on [DATE]. Per Post Admission Patient/Family Conference forms dated 3/27/24 and 4/5/24, there is no evidence that Resident #1 or their Representatives were in attendance to help develop Resident #1's base line care plan or that a baseline care plan summary was given to Resident #1 and their Representative after their admission or readmission to the facility. Per interview on 6/12/24 at 10:08 AM, Resident #1's Representative explained that s/he was concerned with the plan of care for Resident #1. S/He explained that Resident #1 had suffered a couple days after s/he was admitted which resulted in a 6-day hospital stay. S/He believes that the fall could have been avoided if proper care interventions were put into place, and s/he. The Representative explained that s/he was never invited to either of Resident #1's baseline care plan conferences, nor did s/he ever receive a copy of Resident #1's care plan at any point during Resident #1's stay. 2. Record review shows that Resident #2 was admitted from the hospital to facility on 4/11/24 for post-acute care following a lumbar (lower back) fracture. Per a Post Admission Patient/Family Conference form dated 4/11/24, there is no evidence that Resident #2 or their Representatives were in attendance to help develop Resident #2 's baseline care plan or that a baseline care plan summary was given to Resident #2 and their Representative. Per telephone interview on 6/12/24 at 12:45 PM with Resident #2's Representative and confirmed that s/he was not given a copy of Resident #2's baseline care plan. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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Burlington Health & Rehab	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)
F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Record review reveals that Resident #3 was admitted to the facility on [DATE] for rehabilitation following a hospital stay related to a subdural hematoma post fall. Per nursing note dated 5/31/24, Resident #3 was transferred to the hospital on 5/31/24 for seizure-like activity. S/He was readmitted to the facility on [DATE]. Per Post Admission Patient/Family Conference forms dated 4/17/24 and 6/7/24, there is no evidence that Resident #3 or their Representatives were in attendance to help develop Resident #3's baseline care plan or that a baseline care plan summary was given to Resident #3 and their Representative after their admission or readmission to the facility. Per interview on 6/12/24 at 1:08 PM, Resident 3's Representative stated that s/he was never invited to a post admission conference after Resident #3's admission or readmission. S/He stated that s/he was not given Resident #3's baseline care plan. Facility policy Person-Centered Care Plan last reviewed 10/24/22 states, The center must provide the patient and his/her representative with a summary of the baseline care plan .The medical record must contain evidence that the summary was given to the patient and resident representative .The Post Admission Patient/Family Conference will be held with the patient, resident representative, care team, and community providers as available. The center will provide the patient and patient representative, if applicable, with advanced notice of care planning conferences to enable patient/representative participation. Per interview on 6/12/24 at 12:10 PM, a Social Service Specialist explained that if a family member was invited to a post admission care conference, it would be documented in the record or there would be an email to the family member with a link to a meeting. S/He explained that it is not part of the process to give the resident or their family member a copy of the resident's baseline care plan. Per interview on 6/12/24 at approximately 1:30 PM, the Social Service Director revealed that it is not a part of the process to give a resident or their family member and/or representative a copy of the resident's baseline care plan unless they ask for it. S/He confirmed that there was no evidence that the resident's family member and/or representative were invited to the post admission conference or that the resident and family member and/or representative were provided a copy of the resident's baseline care plan for Residents #1, #2, and #3.