

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475003	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/20/2025
NAME OF PROVIDER OR SUPPLIER Birchwood Terrace Rehab & Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 43 Starr Farm Rd Burlington, VT 05408	

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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>Based on observation and interview, the facility failed to provide dignity and respect to residents who require feeding assistance for 8 of 8 sampled residents. Findings include: Observation on 8/18/25 at 12:20 PM revealed four staff members feeding eight residents. Each staff was feeding 2 residents at a time. Per interview on 8/18/25 at approximately 12:40 PM, an LNA (Licensed Nursing Assistant) regarding residents requiring assistance stated, we usually do have two staff members feeding the 'feeders' because we don't have enough staff for each 'feeder' to have their own staff member to feed them. This LNA asked if the facility has a lot of residents who require assistance with eating, s/he stated, yes, we have lots of feeders. Per interview on 8/18/25 at approximately 2:45 PM, the Administrator confirmed that staff should not be referring to residents as feeders and they are residents that require assistance with meals.</p>

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observations, interviews, and policy reviews, the facility failed to store food in accordance with professional standards for food service safety. This deficiency has the potential to impact all residents in the facility. Findings include: Per the initial tour of the kitchen on 8/18/25 at 10:05 AM, revealed in the freezer room, three uncovered boxes that contained frozen vegetables. All three boxes were open to air. There were no expiration dates on the items. Per interview, the Assistant Dietary Manager confirmed items should be covered in the storage area. Per review of a facility policy Food Safety Requirements (Revised 2/2024), Practices to maintain safe refrigeration storage include . Keeping food covered or in tight container. Per interview on 8/19/25 at 11:10 AM, the Dietary Manager confirmed items in storage should be covered or in a container, labeled and dated.</p>