AGENCY OF HUMAN SERVICES

DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

March 15, 2024

Mr. Isaac Spilman, Administrator
Elderwood At Burlington
98 Starr Farm Rd
Burlington, VT 05408-1396

Dear Mr. Spilman:

Enclosed is a copy of your acceptable plans of correction for the complaint investigation conducted on **February 23, 2024.** 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,

Pamela M Cota RN

Pamela M. Cota, RN
Licensing Chief

Enclosure

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

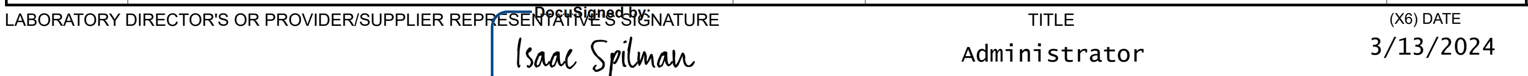
PRINTED: 03/01/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475030	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING ______	(X3) DATE SURVEY COMPLETED C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELDERWOOD AT BURLINGTON	**98 STARR FARM RD BURLINGTON, VT 05408**

(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
F 000	INITIAL COMMENTS The Division of Licensing and Protection conducted an onsite, unannounced investigation of 1 complaint (ACTS # 22663), and 2 facility reported incidents (ACTS #22516 and #22558) on 2/13/2024 and 2/14/2024, with additional offsite record review and interviews that ensued through 2/23/2024, to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. The following regulatory deficiencies were identified:	F 000		
F 609 SS=E	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in	F 609	Please see attached **Tag F 609 POC accepted on 3/15/24 by S. Stem/P. Cota**	

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



Administrator — 3/13/2024

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.

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F 609	Continued From page 1 accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and policy review, the facility failed to ensure that allegations involving abuse are reported no later than 2 hours to the Administrator of the facility and the State Survey Agency for 1 of 3 sampled residents (Resident #1); the facility failed to provide the State Agency sufficient information to describe the alleged violation and indicate how residents are being protected in its initial report for 3 of 3 sampled resident to resident altercations; the facility failed to provide sufficient information to describe the results of an investigation, and indicate any corrective actions taken, if the allegation was verified in its final investigation 5 day summary report for 2 of 2 sampled resident to resident altercations; and the facility failed to develop policies and procedures for ensuring the reporting of a reasonable suspicion of a crime in accordance with section 1150B of the Act. Findings include: 1. Per review of a facility investigation report submitted to the State Agency on 12/12/2024, a staff member was made aware on 12/12/2024 of a resident to resident altercation between Resident #1 and Resident #2 that happened a few weeks prior. Per interview on 12/13/2024 at 12:55 PM, Resident #1 explained that s/he had told Activity Staff #1 about Resident #2 inappropriately grabbing him/her a few weeks prior.	F 609		

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F 609	Continued From page 2	F 609		

Per a written statement dated 2/13/2024, Activities Staff #1 explained that Resident #1 reported to him/her that Resident #2 had touched his/her breast during an activity and that Resident #1 had physically retaliated against Resident #2. The Activities Staff confirmed that they did not report this incident to anyone.

Per interview on 2/14/2024 at 10:08 AM, the Administrator confirmed that Activity Staff #1 did not report the alleged allegation to him/herself and should have reported it as soon as s/he was aware of the allegation.

2. Review of initial reports sent to the State Agency (SA) reveals the following specific reporting requirements were not included:

An initial resident to resident altercation report received by the SA on 12/5/23 did not include: the allegation type, when the facility became aware of the incident, witness information, and if and what notifications were made to law enforcement or other agencies.

An initial resident to resident altercation report received by the SA on 12/17/23 did not include: the allegation type, details about the allegation, including any outcomes to the alleged victim, and what notifications were made to law enforcement or other agencies.

An initial resident to resident altercation report received by the SA on 2/12/23 did not include: the allegation type, when the facility became aware of the incident, information about the alleged victim and perpetrator, details about the allegation, including outcomes to the alleged victim, and if and what notifications were made to law

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F 609	Continued From page 3	F 609		

enforcement or other agencies.

Per interview on 12/13/2024 at 3:25 PM, the Administrator indicated that s/he was unaware of the specific reporting information required to be provided to the SA when the facility identifies an alleged violation and confirmed that reports made to the SA did not meet regulatory requirements.

3. Review of 5-day investigation summary reports sent to the State Agency (SA) reveals the following specific reporting requirements were not included:

A 5-day resident to resident altercation investigation summary report received by the SA following up on the initial violation reported on 12/5/23 did not include: whether the allegation was reported to another agency, steps taken to investigate the allegation or interviews, a summary of other documents obtained, such as a police report or discharge summaries, the conclusion of the investigation including whether the alleged violation was verified or inconclusive, the corrective action taken by the facility, and who investigated the incident.

A 5-day resident to resident altercation investigation summary report received by the SA following up on the initial violation reported on 12/17/23 did not include: whether the allegation was reported to another agency, steps taken to investigate the allegation or interviews, a summary of other documents obtained, such as a police report or discharge summaries, the conclusion of the investigation including whether the alleged violation was verified or inconclusive, the corrective action taken by the facility, and who investigated the incident.

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F 609	Continued From page 4 Per interview on 12/13/2024 at 3:25 PM, the Administrator indicated that s/he was unaware of the specific reporting information required to be provided to the SA when the facility submits a 5-day investigation summary report and confirmed that reports made to the SA did not meet regulatory requirements. 4. Review of facility policies titled "Reporting Suspected Crimes Under the Federal Elder Justice Act," last modified on 10/21/2019, and "Abuse Prevention, Identification, Investigation, Protection and Reporting," last modified on 2/7/2024, does not include the following: o Identifying which crimes must be reported; o Identifying which cases of abuse, neglect, and exploitation may rise to the level of a reasonable suspicion of crime and recognizing the physical and psychosocial indicators of abuse/neglect/exploitation; o Working with law enforcement annually to determine which crimes are reported; o Assuring that covered individuals can identify what is reportable as a reasonable suspicion of a crime, with competency testing or knowledge checks; o Providing in-service training when covered individuals indicate that they do not understand their reporting responsibilities; and o Providing periodic drills across all levels of staff across all shifts to assure that covered individuals understand the reporting requirements. Per interview on 12/13/2024 at 11:11 AM, the Administrator stated that s/he does not meet with law enforcement annually to determine which crimes are reported and was unable to produce a	F 609		

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F 609	Continued From page 5 list of crimes that must be reported. The facility was unable to produce evidence of the above by 2/16/2024.	F 609		
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse,	F 842	Please see attached **Tag F 842 POC accepted on 3/15/24 by S. Stem/P. Cota**	

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F 842	Continued From page 6 neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observations, interview, and record review, the facility failed to maintain medical records on each resident that are accurately documented related to skin for two of three sampled residents (Residents #3 and #4).	F 842		

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F 842	Continued From page 7	F 842		

Findings include:

1. Per record review, Resident #3 was admitted to the facility on 1/15/2024 for rehabilitation services following hospitalization for a left humerus fracture and a left femur fracture. A 1/22/24 Physician note reveals that Resident #3 was transferred to the hospital on 1/22/23 due to a displaced catheter.

Per a complaint submitted to the State Agency on 1/25/2024, Resident #3 had questionable bruising to his/her right arm on transfer from the facility to the hospital on 1/22/24. Per review of Resident #3's medical record, there was no documentation that Resident #3 had any bruising on his/her body while at the facility between 1/15/24 through 1/22/24. The following interviews and record reviews reveal that Resident #3's skin condition was not accurately documented in their medical record.

Per interview on 2/14/2024 at 2:09 PM, Resident #3's Representative stated that Resident #3 was admitted to the facility on 1/15/2024 with significant bruising on both his/her right and left sides as a result of a fall and IVs. S/He confirmed that the bruising on Resident #3's right arm was unmistakable.

Per interview on 12/14/2024 at 9:34 AM, a Licensed Practical Nurse (LPN) stated s/he remembered Resident #3 having bruising on both her right and left arms while S/he cared for him/her. Review of nursing documentation reveals that this LPN cared for Resident #3 on 1/17/2024 and 1/18/2024.

An Emergency Medical Service incident report

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F 842	Continued From page 8	F 842		

dated 1/22/24 stated, "Crew noticed some abnormal bruising on [Resident #1's] right arm." A 1/22/24 Physician note from the admitting hospital states, "Skin: Diffuse ecchymosis [bruising] to right upper extremity [arm]."

Per interview on 2/14/2024 at 8:40 AM, the Director of Nursing confirmed that bruising should be documented in the resident's record.

2. Per record review, Resident #4 was readmitted to the facility on 2/12/2024 following a 6 day hospital stay related to heart complications.

Resident #4's admission assessment dated 2/12/2024 has a skin and condition assessment section that is not completed. Per interview on 2/13/2024 at 11:33 AM, the Unit Manager reported that Resident #4 had bruising and it should be documented on the skin assessment. Per record review immediately following this interview, Resident #4 did not have a skin check completed and there was no evidence anywhere in Resident #4's medical record that s/he has bruising on his/her body.

Per observation and interview on 2/14/24 at 11:34 AM, Resident #4 was seen lying in bed. His/Her legs and arms were exposed revealing the following bruises:
Left leg measuring approximately 10 inches x 8 inches
Right leg measuring approximately 2 inches x 1.5 inches
Right leg measuring approximately 3 inches x 2 inches
Inner left arm measuring approximately 6 inches x 3 inches
Upper left arm measuring approximately 3 inches

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F 842	Continued From page 9 x 2 inch Right palm measuring approximately 3 inches by 1.5 inch When asked about the bruising, s/he stated that most of them were from a fall s/he had at the hospital but some of them were from IVs.	F 842		

DocuSigned by:
Isaac Spilman
4CF6A02596A04E9...
Administrator 3/13/2024

The filing of this plan of correction does not constitute an admission of the allegations set forth in the statements of deficiencies. Elderwood at Burlington has prepared and executed a plan of correction as evidence of the facilities continued compliance with the applicable federal and state laws.

F609 Reporting Alleged Violations

Corrective Action
The immediate corrective action for this alleged deficient practice was the reporting of the allegation on 2/12/24 to DLP, APS and on 2/13/24 to the Burlington Police Department. Both care plans updated and care plan for the aggressor immediately updated to include increased monitoring and seating away from others during group activities.

All residents have the potential to be affected by this alleged deficient practice.
All alleged violations of abuse related to resident-to-resident altercations from 2/15/24 will be identified, investigated and reported to the State Survey Agency, as required.

Systematic Changes
The facility will review and revise accordingly the policies titled "Reporting Suspected Crimes Under the Elder Justice Act' and the "Abuse Prevention, Identification, Investigation, Protection and Reporting" to ensure they include all required information for the reporting of a reasonable suspicion of a crime.

All staff will be re-educated on the updated facility's policy titled, "Abuse Prevention, Identification, Investigation, Protection and Reporting" and the policy titled, "Reporting Suspected Crimes Under the Federal Elder Justice Act" to ensure that all allegations of abuse related to resident-to-resident altercations are reported per regulation. The Administrator will be educated by the Director of Nursing/Designee on the specific reporting information required to be provided to the State Agency when the facility identifies an allegation of abuse resulting from a resident-to-resident altercation. Education will include timeframes for reporting and content/information required in an initial and 5-day investigative summary report sent to the State Agency.

The Administrator will meet with law enforcement to determine which crimes require reporting to law enforcement.

Monitoring
Facility will monitor for allegations of resident-to-resident altercations / abuse. The facility will audit documentation for timely reporting and completion of the initial and 5-day report to ensure it includes all required information. Allegations of resident-to-resident altercations/abuse will be audited weekly x 4, then monthly x 2 months by the Director of Nursing or Designee(s). The audits will be reviewed through the QAPI Committee until such time that the Committee feels

systemic changes are effective and no further monitoring is necessary. The Administrator will be responsible for the oversight of this corrective measure.
Completion date: 3/28/24

F 842 Resident Records-Identifiable Information

Corrective Action: Resident # 3 discharged from the facility on 1/26/24. Resident # 4 had an immediate skin assessment on 2/13/24.

All residents have the potential to be affected by this alleged deficient practice.

All admissions/readmissions from 2/15/24 currently residing in the facility will have a head to toe skin assessment completed to accurately identify the residents skin condition. Findings will be documented on the SNF Skin Assessment Form.

Systemic Changes
Licensed nurses will be reeducated on the Admission/Readmission Skin process to ensure that skin issues present upon admission/readmission are accurately documented in the medical record on the SNF Skin Assessment Form. Skin assessments will be completed by a Registered Nurse.

Facility will identify a Skin / Wound Champion who will reassess all admissions/readmissions within 24-72 hours of admission to ensure residents skin condition is accurately documented in the medical record.

Monitoring
The Skin / Wound Champion will audit the admission/readmission SNF Skin Assessment weekly x 4 and then monthly x 2 for accuracy. The audits will be reviewed through the QAPI Committee to ensure substantial compliance is maintained. The Director of Nursing will be responsible for the oversight of this corrective measure.
Completion date: 3/28/24