VERMONT

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

November 5, 2019

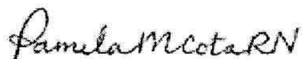
Mr. Casey Keefe, Administrator
Elderwood At Burlington
98 Starr Farm Rd
Burlington, VT 05408-1396

Dear Mr. Keefe:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **October 2, 2019.** 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
Licensing Chief

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475030	A. BUILDING ______ B. WING ______	C 10/02/2019

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 An unannounced onsite investigation of two Facility Reported Incidents was conducted by the Division of Licensing & Protection on 10/2/2019. The following regulatory deficiencies were identified as a result of the investigation.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on Resident and Staff interviews and record review the facility failed to assure the reasonable accommodation of resident needs for one resident, Resident #1. Findings include: Per record review Resident #1, who was admitted from home for respite care on 9/9/2019. On 9/10/19 the resident attempted to ambulate to get a snack, without staff assistance or a walker and fell while returning to bed. The resident had failed to use the call bell. When transferred to the Emergency Room it was found that the resident had sustained a fractured Left Radius and Ulna. On 9/30/19 the Resident complained to staff regarding a Licensed Nursing Assistant (LNA). The Resident is unable to complete a Brief Interview for Mental Status (BIMS) assessment due to short term memory issues; however, the Cognitive portion of the Minimum Data Set (MDS) states that the resident is able to recall Season,	F 558	**This Plan of Correction is the Facility's allegation of compliance.** **Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Administrator (X6) DATE: 11-1-19

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475030	A. BUILDING _____ B. WING _____	C 10/02/2019

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 558 Continued From page 1

Location of room, Staff names and faces, and that s/he is in a Nursing Home, Hospital, or Swing Bed. Her long term memory is stated to be OK.

According to the resident during their investigation and confirmed by surveyor interview on 10/2/19 at 11:30 AM, on 9/30/19 at 4 PM Resident #1 reported that LNA #5 came in to answer the call light when the resident called because the bed was wet. The LNA turned the light off and stated that s/he would "be right back." The resident waited for a time and then put the call light on again. The same LNA returned and according to the resident and took the call light, threw it up to the corner of the bed, out of reach, then turned the call light off and left the room. Resident #1 had a limitation in being able to reach the call light due to his/her recent fracture in the above noted fall on 9/10/19. According to documentation, the LNA did not attend to the resident's needs before leaving the room. The facility report states that Resident #1 clearly described the LNA and added that the Speech Therapist heard him/her calling out and came in and gave him/her the call light that had been out of reach. According to the facility investigation, an Occupational Therapist reported that the resident had been calling for help because her call light was out of reach.

The Resident states that after, s/he was able to use the call light and a different LNA came and provided care. Resident #4 reported what had happened to that LNA, who then reported to facility Administration. The incident was reported to the state agency in a timely fashion.

F 558

F558 Reasonable Accommodations Needs/Preferences

1. LNA #5 was terminated from employment; Resident #1 was provided support regarding facility call bell policy.
2. All residents have the potential to be affected by the same deficient practice; facility has a call bell policy in place that includes call bell placement.
3. Facility will provide education on call bell policy and call bell placement to staff.
4. Random call bell audits for correct call bell placement will be completed by the Administrator, DON or designee weekly X4 weeks then monthly X3 months; the audits will be reported to QA committee until compliance is achieved.

F558 POC accepted 11/4/19 MHiggins RN/PMM

F 602 SS=D Free from Misappropriation/Exploitation
CFR(s): 483.12

F 602

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475030	A. BUILDING ______ B. WING ______	C 10/02/2019

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 602 Continued From page 2

§483.12
The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.
This REQUIREMENT is not met as evidenced by:
Based on record reviews and observations the facility failed to assure that residents are free from misappropriation of resident property for 1 Resident in a sample of three (Resident #2). Findings include:

Per record review, on 9/25/2019 the facility was notified by family members that they had placed a camera in Resident #2's room and the family provided the video for the Facility Administrator to review. The camera gave the family the ability to live stream and record video footage. The family members showed the video files to the facility Administrator and the Director of Nursing Services (DNS) and pointed out their concerns on 9/25/2019.

Per record review LNA (Licensed Nursing Assistant) #1 was observed, on video (taped during August to 9/25/19), taking a personal care device, belonging to Resident #2, and placing it in a pocket of his/her uniform. When the facility DNS addressed this issue the LNA stated that it was a habit to place a resident's belonging in his/her uniform pocket as a reminder to return and complete a task. The LNA admitted, during the facility investigation, that the device was not returned and that s/he left the facility with the

F 602

F602 Free from Misappropriation/Exploitation

1. LNA #1 was terminated from employment; Resident #2 family was provided with support regarding facility abuse policy.
2. All residents have the potential to be affected by the same deficient practice; facility has an abuse policy in place that prohibits Misappropriation/Exploitation.
3. Facility will provide education on abuse policy to staff specific to Misappropriation/Exploitation.
4. Random audits by Administrator, DON or designee weekly X4 weeks then monthly X3 months; the audits will be reported to QA committee monthly until satisfied that compliance is achieved.

F602 POC accepted 11/4/19 MHiggins RN/[illegible]

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475030	A. BUILDING ______ B. WING ______	C 10/02/2019

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 602	Continued From page 3 device. Despite the facility's reported request that the device be returned, on the date of the surveyor's visit it had not been returned to the resident or facility staff.	F 602		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for	F 656	**F656 Develop/Implement Comprehensive Care Plans** 1. LNAs #2, #3 and #4 were terminated from employment; resident #2 family was provided with support. 2. All residents have the potential to be affected by the same deficient practice; facility has policy in place regarding ADL assistance and following resident care plans. 3. Facility will provide education on following care plan and use of IPOD/IPAD to access Kardex for ADL assistance to staff. 4. Random audits of staff for using IPOD/IPAD to access Kardex, following Care Plan and use of gait belts by the Administrator, DON or designee weekly X4 weeks then monthly X3 months; the audits will be reported to QA committee until compliance is achieved. Corrective action will be complete by November 15, 2019.	

F656 POC accepted 11/4/19 MHiggins RN/PMC

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475030	A. BUILDING ______ B. WING ______	C 10/02/2019

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 656	Continued From page 4	F 656		

future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
This REQUIREMENT is not met as evidenced by:
Based on record reviews and staff interviews the facility failed to assure that the comprehensive person-centered care plan for each resident is implemented for one resident in a sample of three, Resident #2.

Per record reviews on the morning of 10/2/2019 the facility was notified by family members that they had placed a camera in Residents #2's room and the family provided the video for the Facility Administrator to review. The camera gave the family the ability to live stream and record video footage. The family members showed the video files to the facility Administrator and the Director of Nursing Services (DNS) and pointed out their concerns on 9/25/2019.

During that screening, five (5) different Licensed Nursing Assistants (LNA's) were identified providing care to Resident #2. Resident #2 requires a two person transfer and facility policies require that a gait belt be used for all transfers. On the video, LNA's #2, #3, and #4 were observed transferring Resident #2, at various times, without a second staff member assisting and, during those transfers, none of the LNA's were using a gait belt. In addition LNA #3 was particularly rushed in moving the resident into a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475030	A. BUILDING ______ B. WING ______	C 10/02/2019

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 656	Continued From page 5 chair. The video was recorded some time in August through the date provided to the Facility Administrator on 9/25/2019. The family continues to tape at the time of this investigation, at their insistance, according to the Administrator. In staff interviews, conducted by the facility during the investigation, it is documented that the 3 LNA's confirmed that they had transferred the resident without help and without the use of a gait belt. The LNA's confirmed that they were aware that they should have a second staff member and that a gait belt should be used.	F 656		