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 14, 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 16, 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

Pamela M. Cota, RN
Licensing Chief

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 _____	10/16/2019

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
E 000	Initial Comments An unannounced, onsite emergency preparedness survey was conducted during the annual recertification survey by the Division of Licensing and Protection between 10/14 -10/16/19. While the facility was found to be in substantial compliance regarding emergency preparedness, the following issue was identified that requires a plan of correction.	E 000	**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.**	
E 039 SS=C	EP Testing Requirements CFR(s): 483.73(d)(2) (2) Testing. The [facility, except for LTC facilities, RNHCIs and OPOs] must conduct exercises to test the emergency plan at least annually. The [facility, except for RNHCIs and OPOs] must do all of the following: *[For LTC Facilities at §483.73(d):] (2) Testing. The LTC facility must conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do all of the following:] (i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is	E 039		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	11-5-19

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.

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E 039	Continued From page 1 community-based or individual, facility-based. (B) A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For RNHCIs at §403.748 and OPOs at §486.360] (d)(2) Testing. The [RNHCI and OPO] must conduct exercises to test the emergency plan. The [RNHCI and OPO] must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the [RNHCI's and OPO's] response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to conduct exercises to test the emergency preparedness plan (EP) at least annually. Findings include: Per review of the facility EP plan, there is no evidence that the facility participated in or conducted a full-scale community based or	E 039	**E039 EP Testing Requirements** 1. Facility will conduct a community-based drill; facility has reached out to the Vermont Emergency Management Agency to conduct a paper-based table top exercise; a meeting has been scheduled for 11-7-2019 at 1pm to finalize the details of that exercise. 2. All residents have the potential to be affected by the deficient practice. 3. Facility will conduct a community-based drill by 11-15-2019 and annually; facility will conduct a paper-based tabletop exercise with a facilitator from the Vermont Emergency Management Agency within the next 30 days and then annually. 4. The results of the table top exercise will be brought before the QA committee to analyze the facility's response and make changes to the emergency plan as needed. Corrective action will be completed by December 15, 2019. E039 POC accepted 11/13/19 Llorell RN/PMC	

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E 039	Continued From page 2 facility-based exercise drill or a second tabletop drill to test the EP at least annually. Per interview on 10/16/19 at 11:45 AM, the Administrator confirmed that the facility is not in compliance with this regulation.	E 039	**F584** **Safe/Clean/Comfortable/Homelike Environment** 1. The ice machines on Champlain, Mansfield and Chittenden have been cleaned; resident #2 floor mats cleaned and room has been deep cleaned; resident #18 chair replaced and room deep cleaned; resident #21 chair replaced and room deep cleaned; resident #52 wheelchair and room deep cleaned, and CPAP cleaned and storage bag provided for when equipment not in use; resident #60 oxygen concentrator replaced; resident #68 room deep cleaned; resident #79 elevated toilet seat replaced and the room deep cleaned. 2. All residents have the potential to be affected by the deficient practice.	
F 000	INITIAL COMMENTS An unannounced onsite re-certification survey was conducted by the Division of Licensing and Protection between 10/14 - 10/16/19. The following regulatory findings were identified:	F 000		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;	F 584		

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F 584	Continued From page 3 §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation and confirmed by staff interview, the facility failed to provide housekeeping and maintenance services to maintain a safe, clean, and homelike environment on all three units. Specific unsanitary conditions were identified with ice machines, resident's personal belongings and medical equipment, for 7 of 27 residents sampled, (Residents #2, #18, #21, #52, #60, #68 and #79). The findings include the following: 1. Per facility tour on 10/14/19 at 1:30 PM in the presence of the facility Administrator and the Maintenance Director, the following conditions were identified: -Ice machines on the Mansfield and Champlain Units have black slimy grime in the ice storage compartment. There is also visible dust and grime accumulated in the vents located on the base of the unit;	F 584	3. Facility will be hiring a Director of Environmental Services to support housekeeping services; vendors have been contracted to support painting and floor maintenance; an automatic wheelchair cleaner has been purchased and will be installed in Mansfield shower room; the ice machines will be cleaned by vendor on a quarterly basis and as needed by maintenance staff; education will be provided to staff on process for deep cleaning rooms, equipment/furniture cleaning, and auditing facility cleanliness. 4. Random room/common area, equipment/furniture and ice machine 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. Corrective action will be completed by November 22, 2019.	

F584 POC accepted 11/13/19 LLovell RN/PMA

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F 584	Continued From page 4	F 584		

-Ice machine on the Chittenden Unit has an accumulation of mineral deposits on the front of the machine.

Confirmation was made by the Administrator and the Maintenance Director at the time of the tour that the above information was observed, and all ice makers need cleaning.

2. Per facility tour on 10/15/19 at 11:05 AM in the presence of the facility Administrator the following conditions were identified:

-Resident #2 was found with dirty floor mats next to his/her bed with noticeable brown stains and debris present. The floor is dirty with an accumulation of dust and various crumbs and walls are in need of cosmetic repairs. The resident's TV/DVD player has an accumulation of dust and the bedroom furniture needs cleaning. The resident's wheelchair and cushion have visible dried stains. The bathroom exhaust vent has an accumulation of visible dust.

-Resident #18 was found to have a chair with noticeable dried brown material and the resident's wheelchair stored in the bathroom has an accumulation of dust. The bathroom exhaust vent has an accumulation of dust and the bathroom smells of foul urine;

-Resident #21 was found to have dried food particles on the wall next to the resident's bed and a chair is stained with noticeable dried brown material. The bathroom exhaust vent has an accumulation of dust;

-Resident #52 was found to have a chair with

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F 584	Continued From page 5	F 584		

visible dried brown material and the resident's wheelchair and cushion have noticeable stains. The window curtains are stained with brown spots, and the resident's video player needs dusting. The resident has a C-Pap (Continuous Positive Airway Pressure) machine, worn nightly, that is very dusty. The mask and tubing are stored on the bedside table unprotected;

- Resident #60 was found utilizing an oxygen concentrator that is noticeably dirty/dusty and with a crack and a hole, approximately the size of a grape, on the top of the machine;

-Resident #68 was found with debris under his/her bed. The wall above the television was soiled with dried brown material that was splattered all over the wall. A soiled disposable glove and a used straw was located on the floor in the bathroom. The bathroom sink had dried brown splatter present. Confirmation was made by the Unit Manager on 10/14/19 at 12:17 PM that the above conditions were accurately identified for Resident #68.
During the tour with the administrator on 10/15/19 the soiled glove and straw were still present on the floor in the bathroom;

-Resident #79 was found with an elevated toilet seat with chipped missing paint along the front of the rusted frame. The window curtains were also very stained.

Though out the tour multiple powered and manual wheelchairs were found to have accumulated dust and grime and in need of cleaning. Confirmation was made by the administrator during the tour, that the above conditions were identified as seen and cleaning needs to be

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F 584	Continued From page 6 addressed.	F 584		
F 695 SS=E	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation and resident and staff interview, the facility failed to ensure that respiratory equipment was maintained in accordance with professional standards for 5 applicable residents (Residents # 68, 44, 144, 52, 60). Findings include: 1. Per observation on 10/14/19 at 12:05 PM, in use oxygen tubing for Residents #60, 68, 44, and 144 was unlabeled with a change date. Additionally, the tubing for Resident # 144 was on the floor and uncovered. On 10/14/19 at 12:57 PM, the Unit Manager (UM) confirmed that the tubing was not labeled for Residents #60, 68, 44, 144 and that Resident #144's tubing was uncovered on the floor. On 10/15/19 at 8:30 AM, Resident #44 and #60's tubing was observed in use and still unlabeled. Physician orders for Resident #60, identify that oxygen tubing and cannula are to be changed weekly on Sunday for infection protection. Confirmation was made by the Director on	F 695	**F695 Respiratory/Tracheostomy Care and Suctioning** 1. Oxygen tubing for resident #60, 68, 44 and 144 were changed and dated; storage bags were placed for the placement of cannulas when not in use; the CPAP machine for resident #52 was cleaned and a storage bag provided for when equipment not in use; the concentrator for resident #60 was replaced. 2. All residents with prescribed oxygen and CPAP machines have the potential to be affected by the deficient practice.	

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F 695 Continued From page 7

Nurses (DNS) on 10/14/19 at 12:52 PM that the equipment is not stored properly.

2. Per observation on during the initial tour on 10/14/19 at approximately 9 AM, Resident #52, has a C-Pap (Continuous Positive Airway Pressure) machine, worn nightly, is very dusty. The mask and tubing are stored on the bedside table unprotected. Confirmation was made by the Director on Nurses (DNS) on 10/14/19 at 12:52 PM that the equipment is not stored properly.

3. Per observation during the initial tour on 10/14/19 at approximately 9 AM, Resident #60 was found utilizing an oxygen concentrator that is noticeably dirty/dusty and has a crack and a hole, approximately the size of a grape, on the top of the machine. Confirmation was made by the Director on Nurses (DNS) on 10/14/19 at 12:52 PM that the equipment is dirty and needs repair.

Per review of the facility policy labeled Oxygen Therapy dated 03/26/18, identifies if the equipment/cannula is not in use on the resident, place in a plastic bag. C-PAP tubing needs to be disconnected from the device, cleaned before use daily and air dried. The resident confirmed on 10/14/19 at approximately 12:52 PM that s/he has been using the machine for about one month and it has not ever been cleaned.

F 838 Facility Assessment
SS=C CFR(s): 483.70(e)(1)-(3)

§483.70(e) Facility assessment.
The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations

F 695

3. Nursing staff will be educated on oxygen and CPAP machine policies; the care of oxygen delivery equipment will be performed and documented by nursing; periodic maintenance will be performed and documented by maintenance department or designee.
4. Random audits for the care of oxygen related equipment by DON, ADON or designee X4 weeks then monthly X3 months; the audit results will be reported to QA committee until compliance is achieved.

Corrective action will be completed by November 22, 2019.

F695 POC accepted 11/13/19 LLovell RN/PMC

F 838

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F 838	Continued From page 8	F 838		

and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include:

§483.70(e)(1) The facility's resident population, including, but not limited to,
(i) Both the number of residents and the facility's resident capacity;
(ii) The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population;
(iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population;
(iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and
(v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services.

§483.70(e)(2) The facility's resources, including but not limited to,
(i) All buildings and/or other physical structures and vehicles;
(ii) Equipment (medical and non- medical);
(iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies;
(iv) All personnel, including managers, staff (both employees and those who provide services under

F838 Facility Assessment

1. The facility assessment was updated on 10-16-2019.
2. All residents have the potential to be affected by the deficient practice.
3. The facility will update the facility assessment as necessary and at least annually; the facility will review and update the assessment whenever there is any change that would require a substantial modification to the assessment.
4. The facility assessment will be reviewed whenever there is a change or at least annually if no changes to determine the resources necessary to care for its residents competently during both day-to-day operations and emergencies.

Corrective action was completed on October 16, 2019.

F838 POC accepted 11/13/19 Lovell RN / PMC

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contract), and volunteers, as well as their education and/or training and any competencies related to resident care;
(v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and
(vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations.

§483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and record review, the facility failed to ensure that the complete facility-wide assessment was reviewed annually determining what resources are necessary to care for residents during both day-to-day operations and emergencies. The findings include the following:

Per review of the facility-wide assessment dated 01/10/18 and Orientation and Competencies dated 05/22/18, identifies that the facility has not conducted an annual review. Confirmation was made by the facility administrator on 10/16/19 at 8:15 AM, that the facility wide assessment has not been reviewed annually and began an update on 10/15/19, twenty-four hours after the recertification survey began.