

#### DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection

HC 2 South, 280 State Drive
Waterbury, VT 05671-2060

<a href="http://www.dail.vermont.gov">http://www.dail.vermont.gov</a>
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

December 3, 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 **November 5, 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

Lamila MCotaRN

Licensing Chief

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

PRINTED: 11/14/2019 FORM APPROVED OMB NO. 0938-0391

CEMIE	NO FUN MEDICANE	a MEDICAID SERVICES			1VD 1VD. 0330-033		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
475030		T00/1979/2012 - 2020			С		
		B. WING		11/05/2019			
NAME OF PROVIDER OR SUPPLIER  ELDERWOOD AT BURLINGTON			98	REET ADDRESS, CITY, STATE, ZIP CODE S STARR FARM RD URLINGTON, VT 05408			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DE COMPLETION		
F 000 F 689 SS=G	conducted an unant of 2 facility self-reports and the series of Accident Harch (S): 483.25(d) (1) \$483.25(d) (2) Each of The facility must ensign system of accident harch (S): 483.25(d)(1) The mass free of accident harch (S): 483.25(d)(2) Each of supervision and associdents. This REQUIREMENT by: Based on medical resident interview, reinvestigation of the inpolicies, the facility for resident interview, reinvestigation and assistent finding include:  Per record review, R transported to a medical reasonable the arrangement company to get the mappointment. Per the on 11/4/19 at 10:30 A up inside the building	ensing and Protection nounced onsite investigation orts and 2 complaints on 11/4 owing regulatory deficiencies result. zards/Supervision/Devices 1)(2).  Its. sure that - esident environment remains nazards as is possible; and resident receives adequate istance devices to prevent  T is not met as evidenced ecord review, staff and eview of the facility internal ncident, and review of facility ailed to ensure that 2 of 2 eceived adequate stance to prevent accidents.  esident #1 was being lical appointment by a private any on 10/18/19. The facility ents with the transportation esident to the medical e resident, during interview M, the driver picked him/her t, took them out to the van,	F 689	This plan of correction is the facility's allegation of compliance.  Preparation and/or execution of this p correction does not constitute admissi and/or agreement by the provider of t truth of the facts alleged or conclusions forth in the statement of deficiencies. plan of correction is prepared and/or executed solely because it is required be provisions of federal and state law.  1. Resident #1 and #2 remains the facility; use of the private transportation company noted during survey has been discontinued; the Elderwood wheelchair van will be primary mode of transportation to medical appointments for resident #1 and #2; facility has an agreement with a preferred provider, Garnet Transport Medicine LLC, to support transportation of resident #1 and #2 to medical appointments when facility van is unavailable/in use.	on the s set The by the by the latter and the latte		
	and placed a seat be	elchair to the floor of the van It across his/her body. S/he know if it was secured					
ann france	MOLOTORIC OR PROMITE	DICTION IED DENDECENTATISTES CICAL	ATLIPIT	TITI E	IVELDATE		

Any deficiency statement ending with an asterisk (\*) devotes 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.

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

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUP		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	(X3) DATE SURVEY COMPLETED		
			7. Bolebino		С	
475030			B. WING	11/05/2019		
NAME OF PROVIDER OR SUPPLIER  ELDERWOOD AT BURLINGTON			98	REET ADDRESS, CITY, STATE, ZIP CODE STARR FARM RD URLINGTON, VT 05408	2	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION	
	resident reported I felt the wheelchair her/his hand on the prevent themselve wheelchair. The dupushed the resident driving. A few min heard the "clicking who then stopped out of the wheelch under the driver's at their other leg was report extreme pair Services (EMS) was transferred to the I diagnosed with a letibia fracture require up with orthopedical report, staff and remains the minimum at the diagnosed with a letibia fracture require up with orthopedical report, staff and remains the minimum at the diagnosed with a letibia fracture require up with orthopedical report, staff and remains the diagnosed with a letibia fracture require was taken from the van. The Director on 11/4/19 at 4:15F responsible for taking and securing them. Additionally, during investigation, it was resident, Resident while being transpot by the same transported to wheelchair fell backpain. The resident the facility at the time. Although the facility use for appointment.	minutes into the transport the hearing a "clicking noise" and lurch forward and s/he placed a back of the driver's seat to a from falling out of the river stopped the vehicle and not back and then continued utes later the resident again noise" and yelled to the driver, abruptly, and the resident slid air with one leg being wedged seat and was not sure where wedged. The resident did not resident was no spital and subsequently and the resident was no spital and subsequently and fibula and a right ing additional medical follows. Per the facility incident sident interviews, the resident of Nursing Services confirmed that the driver is not the tresident from the facility inside the van.  The facility's internal and fibula appointment of the facility that their was injured on 10/16/19 and the facility that their ward, causing back and neck did not report the incident to ne it happened.	F 689	2. All residents have the potential to be affected by the same deficient practice; facility wheelchair van will be primary mode of transportation for residents; facility has discontinued use of the private transportation company noted during survey and signed a preferred provider agreement with Garnet Transport Medicine, LLC., to support external transports when facility van is unavailable/in use.  3. Facility will utilize the Elderwood wheelchair van as the primary mode of transportation for residents facility will recruit for a full time drive and maintenance team will be backup when driver is absent; training and education will be provided to the backup maintenance team and the full time driver [once hired] prior to being allowed to transport a resident; equipment to secure a wheelchair in the van will be checked to ensure in good operating condition to maintain resident safety on a weekly basis; facility has signed a preferred provider agreement with Garnet Transport Medicine LLC as a backup for transportation needs when facility van is unavailable/in use; facility will develop and implement a process to ensure resident		
	being unable to hire	enough qualified staff to		safety while on transport		

Medicine, LLC.

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

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	475030	B. WING	*	С
NAME OF PROVIDER OR SUPPLIER	4/3030	B. WING _	STREET ADDRESS, CITY, STATE, ZIP CODE	11/05/2019
ELDERWOOD AT BURLINGTON			98 STARR FARM RD BURLINGTON, VT 05408	*
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	IĎ PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDERICIENCY)	D BE COMPLETION
documents, there is Vendor Information the transportation or information and sign company. The form in writing, for assuring residents. The facilities in New York unable to provide an transportation compathat would indicate the additiver would or she being allowed to transportation compathat would indicate the additional transportation compatible to the provide and whether the equation is very would or she would be a driver would or she would be a driver would and whether the equation in the transportation compatible to provide a driver would or she would be a driver would or she would be a driver w	lar basis. Per review of facility a 1-page form titled "New Form" that was completed by ompany, with basic contact ned by the owner of the does not address protocols, ag safety requirements for ty transportation policy and very generic and geared to a State. The facility was a actual contract with the any, and they have nothing the training and education that build have received prior to asport a resident. The facility bout vehicle maintenance, ipment to secure a was in good operating	F 68	4. Random audits of reside being transported to/fro medical appointments by Elderwood wheelchair va and Garnet Transport Medicine, LLC., by the Administrator, DON or designee weekly X4 week then monthly X3 months. The results of the audits value be reported to the QA committee until satisfied compliance is achieved.  Corrective action will be complete to December 11, 2019.  FLS9 POC accepted 12-12-19 PM	m y the in is vill that
Administrator confirm have a written contra company. There is a delineates how resid facility or who is respective resident is secured. The secure of Outside Resonance of CFR(s): 483.70(g)(1) Secure of Outside Resonance of of Outside R	(2)	F 840		

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER				PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLÉTED		
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		475030	B. WING		11/05/2019		
NAME OF	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE			
CL DEDIA	OOD AT BURLINGTO	N.	1	98 STARR FARM RD			
ELDERM	TOOD AT BURLINGTO	4.5		BURLINGTON, VT 05408			
(X4) ID PREFIX TAG				PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	LD BE COMPLETION		
F 840	section 1861(w) of pertaining to service resources must speassumes responsibility) (i) Obtaining services	agements as described in the Act or agreements as furnished by outside acify in writing that the facility lifty for-	F 840	1. Resident #1 remains at the facility; use of the private transportation company noted during the survey been discontinued; facility will utilize the Elderwood wheelchair van as primar	e has ty		
A STATE OF THE STA	standards and princ professionals provide and (ii) The timeliness of This REQUIREMENT by: Based on staff interreviews and review the facility failed to be transportation compute responsibilities of company versus the maintaining resident	diples that apply to ding services in such a facility; of the services. It is not met as evidenced eviews, medical record of policies and procedures, have a contract with the early that specified, in writing, of the transportation services a facility responsibility in the safety.		mode of transportation for resident #1 to medical appointments; facility has agreement with a preferr provider, Garnett Transportation of resident to medical appointments when facility van is unavailable/in use.  2. All residents have the potential to be affected by the same deficient practic facility wheelchair van will primary mode of	or s an red ort t t #1		
	transported to a metransportation compincident report, staff resident was taken to fithe van. Per the 11/4/19 at 10:30 AM wheelchair to the floseat belt across his/did not know if it was About 15 minutes in reported hearing a "wheelchair lurch for hand on the back of themselves from fall	Resident #1 was being dical appointment by a private any on 10/18/19. Per the and resident interviews, the from the facility by the driver resident, during interview on the driver secured his/her or of the van and placed a her body, s/he reported s/he is secured properly.  To the transport the resident clicking noise" and felt the ward and s/he placed her/his the driver's seat to prevent ing out of the wheelchair. he vehicle and pushed the		transportation for resident facility has discontinued the use of the private transportation company noted during survey and signed a preferred provide agreement with Garnett Transport Medicine, LLC., support external transport when facility van is unavailable/in use.	to		

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475030			(X2) MULTIPLE CONSTRUCTION A BUILDING		(X3) DATE SURVEY COMPLETED
		B WING		11/05/2019	
NAME OF	NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
ill and or	1 (10 119211 011 00) / 1141			98 STARR FARM RD	
ELDERY	VOOD AT BURLINGTO	N		BURLINGTON, VT 05408	
					ATION
(X4) ID PREFIX TAG	(EACH DEFICIENC	RTEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	PREFIX TAG		OULD BE COMPLETION
	minutes later the re "clicking noise" and stopped abruptly, a wheelchair with one driver's seat and wa leg was wedged. E (EMS) were called a transferred to the hadiagnosed with a le tibia fracture requiri up with orthopedics  Although the facility use for appointment being unable to hire operate it on a regu documents, there is Vendor Information the transportation or information and sign company. The form in writing, for assuring residents. The facility unable to provide an transportation comp that would indicate to a driver would or she being allowed to tran has no knowledge a and whether the equ wheelchair in the val condition to maintain	hen continued driving. A few sident again heard the yelled to the driver, who then not the resident slid out of the eleg being wedged under the as not sure where their other mergency Medical Services and the resident was ospital and subsequently fit tibia and fibula and a righting additional medical follow.  does have their own van to te, the Administrator reports enough qualified staff to lar basis. Per review of facility a 1-page form titled "New Form" that was completed by ompany, with basic contact hed by the owner of the does not address protocols, and safety requirements for ity transportation policy and very generic and geared to a State. The facility was a factual contract with the any, and they have nothing the training and education that ould have received prior to insport a resident. The facility bout vehicle maintenance, sipment to secure a mass in good operating in resident safety.	F8	3. Facility will utilize the Elderwood wheelchair the primary mode of transportation for reside facility has signed a pre provider agreement with Garnet Transport Medic LLC., as a backup for transportation needs we facility van is unavailable facility will develop and implement a process to ensure resident safety von transport with Garnet Medicine, LLC.  4. Random audits of reside being transported to/from medical appointments by Garnet Transport Medici LLC by the Administrator DON or designee weekly weeks then monthly X3 months. The results of taudits will be reported to QA committee until satist that compliance is achieved.  Corrective action will be complete December 11, 2019.	lents; ferred cine, hen e; vhile et nts m y ne c; X4 he be the offied yed. by
		11/4/19 at 1:33 PM, the			

have a written contract with the transportation

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			B. WING						C 11/05/2019		
NAME OF PROVIDER OR SUPPLIER  ELDERWOOD AT BURLINGTON			B. WING	STR 98 S	EET ADDRE STARR FAR RLINGTOI	M RD	TATE, ZIP COD	<u> </u>	11/	05/2019	
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