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

January 21, 2021

Ms. Lisa Peacock, Administrator
Elderwood At Burlington
98 Starr Farm Rd
Burlington, VT 05408-1396

Dear Ms. Peacock:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **December 10, 2020.** 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

PRINTED: 12/29/2020
FORM APPROVED
OMB NO. 0938-0391

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
	476030	A. BUILDING _____ B. WING _____	C 12/10/2020

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 unannounced onsite investigations of 5 complaints 12/9/20 - 12/10/20. The following regulatory deficiencies were identified as a result.	F 000		
F 656 SS=E	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.	F 656	F 656 Corrective Action: Resident #1 wound updated Identfication of other Residents: All Residents with wounds updated Systemic Changes: Re-educate licensed staff on need to document wound status weekly to include measurments. Monitoring: Audit of wound measurement report run weekly x4, then monthly x3, with results to QAPI committee for review. The Director of Nursing is responsible for this plan of Correction. F656 POC accepted 1/16/21 R.Tremblay, RN/PMC	12/16/2020 01/08/2021 01/08/2021 ongoing

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Lisa Peacock
TITLE: Administrator
(X6) DATE: 1/8/21

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.

PRINTED: 12/29/2020
FORM APPROVED
OMB NO. 0938-0391

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 12/10/2020

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 1 (B) The resident's preference and potential for 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 staff and resident interview and record review, the facility failed to implement the care plan for 1 of 9 applicable residents (Resident # 1). Findings include: During an interview on 12/10/20 at 9:15 AM, Resident # 1 stated that staff had not changed his/her dressing for "at least 2 days". Resident # 1 has a stage 4 pressure ulcer on his/her buttock. There is a physician order dated 10/10/20 to change dressing every day and evening shift. Per review of the treatment record (TAR), the dressing change has not been documented as done on 5 occasions in December 2020, on the day shift 12/2, 12/3,12/7 and evening shift on 12/7, 12/8. The care plan for an actual pressure ulcer stated "pressure ulcer will show signs of improvement during weekly skin assessments as evidenced by a decrease in size, drainage, odor and erythema of surrounding skin and will show no signs & symptoms of infection". The care plan also stated to "assess and document on status of pressure ulcer weekly and as needed". Per review of nursing assessments, the last wound measurement was documented on 11/4/20. On 12/10/20 at 9:45 AM, the interim Director of	F 656		

PRINTED: 12/29/2020
FORM APPROVED
OMB NO. 0938-0391

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 12/10/2020

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 2 Nurses (DON) confirmed that there was no documentation that the dressing changes had been done on the above dates. The DON stated that if the resident had refused, staff should document that refusal. The Regional Nurse Consultant (RNC) stated that the wound should be assessed by skilled nursing at each dressing change and that a full assessment, including wound measurements should be done weekly. The RNC confirmed that there is no evidence that the wound had been assessed since 11/4/20.	F 656		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that medications were administered per Physicians orders for twelve of thirteen Residents in the applicable sample (Residents #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, and #13). Findings include: 1. Per record review, Resident #1 has physicians orders for Fluoxetine HCl capsules 40 mg in the morning for depression scheduled for administration between 7:00 AM - 10:00 AM, Aspirin 81 mg scheduled between 7:00 AM - 10:00 AM related to Arteriosclerotic Heart Disease, Midodrine HCl tablet 5 mg for Hypertension (HTN), hold for Systolic Blood Pressure greater than or equal to 130, scheduled for 8:00 AM and 12:00 PM, Oxycodone HCl 10	F 658	F658 Corrective Action: Licensed nurse who failed to administer medications no longer employed . Idenfication of other Residents: Review all Medication Administration Records (MARs) Systemic Changes: Re-educate licensed staff on proper medication administration and documentation. Monitoring: Audit dashboard for completion of MARs 3x week, weekly x2, monthly x2, with results to QAPI committee for review. The Director of Nursing is responsible for this plan of Correction. F658 POC accepted 1/16/21 R. Tremblay, RN/PMC	12/7/2020 01/08/2021 01/08/2021 ongoing

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

PRINTED: 12/29/2020
FORM APPROVED
OMB NO. 0938-0391

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 12/10/2020

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 658	Continued From page 3	F 658		

mg scheduled at 11:00 AM for pain management, Pregabalin 150 mg scheduled for 8:00 AM for pain, Senna Tablet 8.6 scheduled between 7:00 AM - 10:00 AM. Tegretol-XR 1200 Hour 100 mg give 2 capsule by mouth two times a day for finger biting 7:00 AM- 10:00 and 4:00 PM- 6:00 PM, Tizanidine HCl 8 mg three times a day for Cerebral Palsy 7:00 AM, 12:00 - 2:00 PM, 8:00 AM- 10:00 PM, Tylenol 650 mg three times a day for pain management 7:00 - 9:00, 12:00- 2:00 PM, 8:00 PM - 10:00 PM. Per review of her/his Medication Administration Record (MAR), on 12/2/2020 there were no initials indicating any medications had been administered between 7:00 AM and 2:00 PM.

2. Per record review,Resident #2 has physicians orders for Acetaminophen 1000 mg three times a day for pain, 7:00-10:AM, 12:00 - 2:00 PM, and 8:00 PM - 10:00 PM. Diltiazem HCl Extended Release 24 hour 120 mg in the morning for HTN, Check Blood Pressure and Heart Rate (HR) according to vital sign orders. Hold for SBP less than 90 or HR less than 50 bpm (beats per minute) and notify provider, 7:00 AM- 10:00 AM. Loratadine Tablet 10 mg for allergies in the morning 7:00 AM- 10:AM, Acetazolamide 125 mg in the morning for diuretic 7:00 AM-10: AM. Aspirin EC tablet delayed release 81 mg in the morning 7:00 AM - 10:00 AM. Clopidogrell Bisulfate Tablet 75 mg in the morning 7:00 AM-10:00 AM Folic Acid 1 mg in the morning 7:00 AM- 10:00 AM, Furosemide Tablet 10 mg in the morning for Congestive Heart Failure 7:00 AM-10:00 AM Lidocain Patch 5%, apply to cervical spine topically one time a day for pain 8:00 AM. MS Contin Tablet Extended Release 15 mg, give 3 tablets every 12 hours for pain 8:00 AM and 8:00 PM. Per review of Residents #2's

PRINTED: 12/29/2020
FORM APPROVED
OMB NO. 0938-0391

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 12/10/2020

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 658	Continued From page 4	F 658		

MAR, on 12/2/2020 there were no intitials indicating that any medications ordered were administered to Resident #2 between 7:00 AM and 2PM.

A progress note written by the Nurse Practitioner on 12/3/2020 at 11:13 AM states "[Resident # 2's family member] expressing concern that [Resident # 2] reported not getting her/his heart meds. Upon review of MAR (Medication Administration Record) resident did not receive morning medications on 12/2/20. Management made aware".

3. Per record review, Resident #3 has physicians orders for the following medications. Novolog 11 units subcutaneous two times per day for diabetes give with lunch and dinner 12:00 PM and 17:00. Novolog inject per sliding scale 8:00 Am, 11:30 Am, 4:30 PM, and 8 PM. Check Blood Sugars before meals related to Type 2 Diabetes Mellitus with Diabetic Polyneuropathy 7:30 AM, 11:30 AM and 4:30 PM. Notify MD of any finger sticks under 60 and above 350 before meals and at bedtime 7:30 Am 11:30 Am, 4:30 PM and 8:00 PM. Per review of Resident #3's MAR, on 12/2/2020, there were no Nurses initials indicating that a blood sugar was obtained or that the 11:30 sliding scale dose, the scheduled 12:00 PM dose of Novolog was administered.

4. Per record review, Resident #4 has physicians orders for Allopurinol tablet 100 mg in the morning for Gout, 07:00 AM- 10:00 AM. Escitalopram Oxalate 10 mg in the morning for depression 7:00 AM- 10 AM. Fluticasone Propionate HFA 2 puffs inhale orally every 12 hours for asthma 8:00 AM - 10:00 Am. Lamotrigine tablet 100 mg give 100 mg every

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

PRINTED: 12/29/2020
FORM APPROVED
OMB NO. 0938-0391

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 12/10/2020

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 658	Continued From page 5	F 658		

morning and at bedtime for seizures 7:00 AM-10:00 AM and 8:00 PM -10:00 PM. Lorazepam Tablet 0.5 mg twice a day for anxiety 8:00 AM and 2:00 PM. Risperdal tablet 0.5 mg give 0.5 mg by mouth in the afternoon for bi-polar 12:00 AM - 2:00 PM. Risperdal tablet 0.5 mg by mouth in the morning for delusional thoughts 7:00 AM-10:AM. Per review of Resident #4's MAR, on 12/2/2020 there are no Nurses initials indicating that the prescribed medications above were administered.

5. Per record review Resident #5 has physicians orders for Buspirone HCL tablet 10 mg by mouth three times a day for depression at 7:00 Am- 9:00 AM, 12:00 PM - 2:00 PM, 8:00 PM- 10:00 PM. Per Resident #5's MAR on 12/2/2020, there is no evidence that the RN administered the 7:00 Am-9:00 AM dose of Buspirone.

6. Per record review Resident #6 has physicians orders for Hydrochlorothiazide tablet 25 mg by mouth in the morning for HTN 7:00 Am-10:00 Am. Amlodipine Besylate tablet 2.5mg give by mouth in the morning for HNT 7:00 AM- 10:00 AM. Baclofen tablet 10 mg by mouth 3 times a day for muscle spasms 7:00 AM- 9:00 AM, 12:00 PM- 2:00 PM, 8:00 PM- 10:PM. Fenofibrate tablet 48 mg by mouth every morning and at bedtime for Hyperlipidemia 7:00 AM- 10:00 and 8:00 PM-10:00 PM. Potassium chloride ER tablet by mouth 20 meq by mouth 2 times a day for supplement 7:00_10:00 and 4:00 PM - 6:00 PM. Pyridostigmine Bromide tablet 60 mg give 2 tablets by mouth 4 times a day related to Myasthenia Gravis 7:00 AM- 8:00 AM, 11:00 AM-12:00 PM, 4:00 PM-5:00 PM and 9:00 PM-10:00 PM. Per review of Resident #6's MAR, on 20/2/2020, there are no Nurse initials

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 12/10/2020

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 658	Continued From page 6	F 658		

indicating that any of the above scheduled medications were administered between 7:00 AM - 2:00 PM.

7. Per record review Resident #7 has physicians orders for Bumetanide tablet 1 mg by mouth in the morning for bilateral lower extremity edema 7:00 AM- 10:00 AM. Diltiazem HCL Extended Release capsule 24 hour 120 mg by mouth in the morning related to chronic Atrial Fibrillation 7:00 AM-10:00 AM. Apixaban tablet 5 mg by mouth 2 times a day for blood thinner 7:00 AM- 10:00 Am and 4:00 PM- 6:00 PM. Metoprolol Tartrate tablet 100 mg by mouth 2 times a day for HTN, 7:00 Am-10:00 AM and 4:00 PM- 6:00 PM. Per review of Resident #7's MAR, on 12/2/2020 there are no initials indicating that any of the above 7:00 AM-2:00 PM prescribed medications were administered.

8. Per record review, resident #8 has physicians orders for Cyanocobalamin tablet 1000 mcg by mouth in the morning for supplement 7:00 Am-10:00 AM. Dorzolamide HCL SOlution 2% instill one drop in both eyes every morning and at bedtime for Glaucoma 7:00 AM- 10:00 AM, 8:00 PM - 10:00 PM. Sertraline HCL tablet 100 mg by mouth in the morning for depression 7:00 AM-10:00 AM. Timolol Maleate Sol. 0.5% instill one drop in both eyes every morning and at bedtime. 7:00 AM- 10:00 AM and 8:00 PM-10:PM. Per review of Resident #8's MAR, on 12/2/2020, there are no initials indicating that the above scheduled 7:00 AM - 2::00 PM where administered.

9. Per record review, Resident #9 has physicians orders for Blood Pressure daily in the morning related to Cerebral Infarction 7:00 AM- 10:00 AM.

PRINTED: 12/29/2020
FORM APPROVED
OMB NO. 0938-0391

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 12/10/2020

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 658	Continued From page 7	F 658		

Amlodipine Besylate tablet 10 mg by mouth 1 time a day for high Blood Pressure 8:00 AM. Hydrochlorthiazide tablet 50 mg by mouth in the morning for High Blood Pressure 7:00 AM- 10:00 AM. Aspirin 81 mg by mouth in the morning for anticoagulation 7:00 Am- 10:00 AM. Metformin HCL 500 mg by mouth 2 times a day for Diabetes Mellitus 7:00 AM- 10:00, 4:00 PM - 6:00 PM. Quinapril HL 10 mg give 2 tablets by mouth 2 times a day for Congestive Heart Failure 7:00 AM- 10:00 AM and 4:00 PM- 6:00 PM. Per review of the MAR, on 12/2/2020 there are no initials indicating that the above medications scheduled between 7:00 AM and 2:00 PM were administered.

10. Per record review, Resident #10 has physicians orders for Gabapentin 300 mg by mouth 3 times a day related to epilepsy 7:00 AM- 9:00 AM, 12:00 - 2:00 PM and 8:00 PM - 10:00 PM. Erenumab-Aooe Solution Autoinjector 70 mg/ml inject 1 syringe subcutaneous 1 time a day every 28 days for migraines 8:00 AM. Per review of the Residents MAR, on 12/2/2020, the are no initials indicating that the 12:00 PM - 2:00 PM dose of Gabapentin or the 8:00 AM injection of Erenumab was administered per Physicians order.

11. Per record review, Resident #11 has physicians orders for Ambien 5 mg by mouth 3 times a day for insomnia 7:00 AM- 9:00 AM 12:00 PM- 2:00 PM and 8:00 PM- 10:PM. Tylenol 1000 mg by mouth 3 times a day for pain, 7:00 Am-9:00 AM, 12:00 PM - 2:00 PM, 8:00 PM - 10:00 PM. Per review of the MAR, on 12/2/2020, there were no initials indicating that the 12:00 PM Ambien or Tylenol were administered.

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

PRINTED: 12/29/2020
FORM APPROVED
OMB NO. 0938-0391

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 12/10/2020

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 658	Continued From page 8 12. Per record review Resident #13 has physicians orders for Amlodipine Besylate 5 mg by mouth in the morning related to HNT 7:00-10:00 AM. Apixaban 5 mg by mouth 2 times a day for blood thinner 7: 00 AM- 10:00 Am 4:00 PM -6:00 PM. Synthroid 75 mcg by mouth related to Hypothyroidism take 30 minutes before breakfast 7:30 AM. During an interview with the Regional Nurse Consultant on 12/10/2020 at 11:50 AM, confirmation was made that the Director of Nursing (DON) had been aware that the Licensed Practical Nurse on duty on 12/2/2020 between 7:00 AM and 2:00 PM had failed to administer medications to several Residents. The DON had met with the Nurse and s/he was fired.	F 658		
F 686 SS=E	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure 1 of 9 applicable residents (	F 686	F686 Corrective Action: Resident #1, dressing changed per MD order. Identification of other Residents: Review all Treatment Administration Records (TARs) Systemic Changes: Re-educate licensed staff on dressing change and propper documentation. Monitoring: Audit dashboard for completion of TARs 3x week, weekly x2, monthly x2, with results to QAPI committee for review. The Director of Nursing is responsible for this plan of Correction. F686 POC accepted 1/16/21 R. Tremblay, RN/PMC	12/11/2020 01/08/2021 01/08/2021 01/08/2021

PRINTED: 12/29/2020
FORM APPROVED
OMB NO. 0938-0391

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 12/10/2020

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 686	Continued From page 9	F 686		

Resident #1) with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Findings include:

During an interview on 12/10/20 at 9:15 AM, Resident # 1 stated that staff had not changed his/her dressing for "at least 2 days". Resident # 1 has a stage 4 pressure ulcer on his/her buttock. There is a physician order dated 10/10/20 to change dressing every day and evening shift. Per review of the treatment record (TAR), the dressing change has not been documented as done on 5 occasions in December 2020, on the day shift 12/2, 12/3,12/7 and evening shift on 12/7, 12/8. The care plan for an actual pressure ulcer stated "pressure ulcer will show signs of improvement during weekly skin assessments as evidenced by a decrease in size, drainage, odor and erythema of surrounding skin and will show no signs & symptoms of infection". The care plan also stated to "assess and document on status of pressure ulcer weekly and as needed". Per review of nursing assessments, the last wound measurement was documented on 11/4/20.

On 12/10/20 at 9:45 AM, the interim Director of Nurses (DON) confirmed that there was no documentation that the dressing changes had been done on the above dates. The DON stated that if the resident had refused, staff should document that refusal. The Regional Nurse Consultant (RNC) stated that the wound should be assessed by skilled nursing at each dressing change and that a full assessment, including wound measurements should be done weekly. The RNC confirmed that there is no evidence that the wound had been assessed since 11/4/20.

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

PRINTED: 12/29/2020
FORM APPROVED
OMB NO. 0938-0391

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 12/10/2020

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 725 SS=F	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interviews and record review, the facility failed to have sufficient nursing staff with the appropriate competencies and skill sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments	F 725	F725 The residents affected have now had their care issues addressed. The facility continues to hire, train and schedule enough competent staff to meet the needs of the residents and surpass the minimum staffing requirements set forth by the state regulations of 3.00 hours per patient per day. Staff will be re-educated and competencied on the medication pass and treatment protocols. Medication pass and treatment records will be audited for aompliance. Results of these	

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

PRINTED: 12/29/2020
FORM APPROVED
OMB NO. 0938-0391

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 12/10/2020

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 725	Continued From page 11 and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population. This has the potential to effect all residents of the facility. Findings include: 1. Resident # 1 has a stage 4 pressure ulcer. There is a physicians order to change the dressing twice a day. Per review of the treatment record (TAR), the dressing change has not been documented as done on 5 occasions in December 2020, on the day shift 12/2, 12/3, 12/7 and evening shift on 12/7, 12/8. Additionally, the care plan for an actual pressure ulcer stated to "assess and document on status of pressure ulcer weekly and as needed". Per review of nursing assessments, the last wound measurement was documented on 11/4/20. On 12/10/20 at 9:45 AM, the interim Director of Nurses (DON) confirmed that there was no documentation that the dressing changes had been done on the above dates. The DON stated that if the resident had refused, staff should document that refusal. The Regional Nurse Consultant (RNC) stated that the wound should be assessed by skilled nursing at each dressing change and that a full assessment, including wound measurements should be done weekly. The RNC confirmed that there is no evidence that the wound had been assessed since 11/4/20. Throughout the survey, unit nurses during interview stated that they try to get all the resident care done but there just isn't enough time or staff do get it all done. 2. Per record review, on December 2, 2020 a Licensed Practical Nurse (LPN#1) who was working the day shift failed to administer medications to twelve Residents in her/his care, causing the potential for adverse reactions and	F 725	audits will be presented to the QAPI committee monthly X3 with remedial action taken as needed. The person responsible for this plan of correction is the Administrator Substantial compliance will be achieved by 1/10/21. F725 POC accepted 1/16/21 R. Tremblay, RN/PMC	

PRINTED: 12/29/2020
FORM APPROVED
OMB NO. 0938-0391

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 12/10/2020

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 725	Continued From page 12 significant medication errors. Per interview on 12/10/2020 at 2:10 PM, LPN #2 who was also on duty on 12/2/2020, stated that LPN #1 reported to work on a different unit than s/he was assigned to. LPN #1 did not want to work on the assigned unit and did not report to the unit for over an hour. When LPN #1 did report to the unit s/he was working extremely slow. LPN #2 reported that she/he did administer some of the Resident medications to try to help LPN #1, and get the medication pass done, but the other LPN just wasn't getting them done. S/he reported that it was a really busy day with the outbreak and room changes, stating "I don't know how much training [LPN #1] had, maybe she was a new Nurse". During an interview with the RNC and DON on 12/10/2020 at 11:50 AM, the RNC confirmed that on 12/2/2020, the LPN had not administered physician ordered medications to several Residents in her care. 3. Per interview on 12/10/20 at 9:17 AM, 2 different residents (who wish to remain anonymous), each reported that there have been times in which they had to wait longer than 45 minutes for someone to respond to their call light and it has been much worse the last 2 weeks. One of the residents reported that while waiting for someone to come, s/he has leaked urine before assistance arrived. Both residents require assistance with Activities of Daily Living (ADL's) and both are able to make their needs known. 4. Per interview on 12/10/20 at 9:17 AM a resident (who wishes to remain anonymous) who is able to make his/her needs known reported	F 725		

PRINTED: 12/29/2020
FORM APPROVED
OMB NO. 0938-0391

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 12/10/2020

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 725	Continued From page 13	F 725		

that there have been times in which s/he had to use the call light to have someone empty his/her urinary catheter bag as it was full and not being emptied regularly.

5. Per observation on 12/10/20 at 12:35 on The Champlain Unit, a resident call light in a room with 2 residents that both require assistance with Activities of Daily Living (ADL's) began to flash. At 1:07 PM, 32 minutes later, a staff member entered the room to assist the residents. When interviewed, the staff member who doesn't normally work as a Licensed Nurse's Aide (LNA), and requested anonymity, was asked why it took so long to respond, s/he stated there just isn't enough staff to meet resident needs, especially during mealtime.

6. Per interview on 12/9/2020 at 4:50 PM, a Licensed Nursing Assistant reported that the facility has been short staffed especially since the COVID outbreak. "It is hard but we do get the work done by the end of the shift."

7. Per interview with a resident's family member (who wishes to remain anonymous) their loved one "was left in bed for 14 days" due to lack of staff, and that staff had reported that they were afraid if s/he was to get out of bed s/he would think they could come out of their room. Per interview with an LPN on 12/10/2020 at 1:40 PM, confirmation was made that the above Resident had been in bed for several days, and that if there had been more staff s/he would have been able to get up.

8. Per interview with an LNA on 12/10/2020 at 1:55 PM, s/he stated "the work gets done by the end of the day, but you just can't give that

PRINTED: 12/29/2020
FORM APPROVED
OMB NO. 0938-0391

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 12/10/2020

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 725	Continued From page 14 personalized care for them. We do the best we can, but it's just not personal, it has been hard not having time to do the extras they deserve".	F 725		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record reviews, the facility failed to ensure that 2 of 16 Residents in the applicable sample (Residents #3 and #11) received Physician ordered medications on 12/2/2020, creating significant medication errors. Findings include: 1. Per record review, Resident #3 has physicians orders for the following medications. Novolog 11 units subcutaneous two times per day for diabetes give with lunch and dinner 12:00 PM and 17:00. Novolog inject per sliding scale 8:00 Am, 11:30 Am, 4:30 PM, and 8 PM. Check Blood Sugars before meals related to Type 2 Diabetes Mellitus with Diabetic Polyneuropathy 7:30 AM, 11:30 AM and 4:30 PM. Notify MD of any finger sticks under 60 and above 350 before meals and at bedtime 7:30 Am 11:30 Am, 4:30 PM and 8:00 PM. Per review of Resident #3's MAR, on 12/2/2020, there were no Nurses initials indicating that a blood sugar was obtained or that the 11:30 AM sliding scale dose or, the scheduled 12:00 PM dose of Novolog was administered. At 4:30 PM, the Resident's blood sugar was 198 and required a dose of 4 additional units of Novolog per the ordered sliding scale.	F 760	F760 Corrective Action: Nurse involved in mention medication errors no longer employed at facility Identification of other Residents: Review all Medication Administration Records (MARs) Systemic Changes: Re-educate licensed staff on proper medication administration and documentation. Monitoring: Audit dashboard for completion of MARs 3x week, weekly x2, monthly x2, with results to QAPI committee for review. The Director of Nursing is responsible for this plan of Correction. F760 POC accepted 1/16/21 R. Tremblay, RN/PMC	01/08/2021 01/08/2021 01/08/2021

PRINTED: 12/29/2020
FORM APPROVED
OMB NO. 0938-0391

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 12/10/2020

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 760	Continued From page 15 2. Per record review, Resident #11 has physicians an order for Tylenol 1000 mg by mouth 3 times a day for pain, 7:00 Am-9:00 AM, 12:00 PM - 2:00 PM, 6:00 PM - 10:00 PM. Per review of the MAR, on 12/2/2020, there were no initials indicating that the 12:00 PM - 2:00 PM Tylenol were administered. On 12/2/2020 the 10:00 PM - 8:00 AM documented that the Resident reported a pain level of 7 out of 10. During an interview with the Regional Nurse Consultant on 12/10/2020 at 11:50 AM, confirmation was made that the Director of Nursing (DON) had been aware that the Licensed Practical Nurse on duty on 12/2/2020 between 7:00 AM and 2:00 PM had failed to administer medications to several Residents. The DON had met with the Nurse and s/he was fired.	F 760		
F 885 SS=F	Reporting-Residents,Representatives&Families CFR(s): 483.80(g)(3)(i)-(iii) §483.80(g) COVID-19 reporting. The facility must — §483.80(g)(3) Inform residents, their representatives, and families of those residing in facilities by 5 p.m. the next calendar day following the occurrence of either a single confirmed infection of COVID-19, or three or more residents or staff with new-onset of respiratory symptoms occurring within 72 hours of each other. This information must— (i) Not include personally identifiable information; (ii) Include information on mitigating actions implemented to prevent or reduce the risk of transmission, including if normal operations of the facility will be altered; and	F 885	F885 Corrective Action: Residents and residents families have been notified of any new Covid19 cases by 5PM of the following day.	12/7/2020

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

PRINTED: 12/29/2020
FORM APPROVED
OMB NO. 0938-0391

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 12/10/2020

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 885	Continued From page 16 (iii) Include any cumulative updates for residents, their representatives, and families at least weekly or by 5 p.m. the next calendar day following the subsequent occurrence of either: each time a confirmed infection of COVID-19 is identified, or whenever three or more residents or staff with new onset of respiratory symptoms occur within 72 hours of each other. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to notify the family of one Resident in the applicable sample (Resident # 14) of confirmed COVID-19 cases, along with mitigating actions in a timely manner. Findings include: On 12/10/2020 at 12:15 PM, during an interview, Resident # 14's family member reported that the facility had not been updating her/him enough on what was going on within the facility. S/he stated "It's pretty bad when you have to hear it on the news or newspaper". S/he reported that there had been 2 automated phone calls with updates that s/he had received during the outbreak. Per review of the facility "Covid Positive Sequence of Events", on 12/3/2020 eight new Residents were confirmed positive for COVID-19, and on 12/4/2020, four new employees were confirmed positive for COVID-19. Per review of Resident # 14's medical record the facility provided notification of the first confirmed resident COVID case on 11/25, a COVID update on 11/26 and family updates on 11/29, 12/1 and 12/7/2020. There was no evidence that families had been notified of the the new confirmed cases on between 12/3/2020- 12/7/2020.	F 885	Identification of other residents: Cliniconex system is used to Notify residents and families By 5PM of the following if there Are any new Covid19 cases. 1/8/2021 Systemic Changes: The Administrator or designee utilizes a calendar to track new cases of Covid19 and to ensure proper notifications have been made. 1/8/2021 Monitoring: A copy of this calendar will be brought to the QAPI committee monthly x3 to ensure proper completion. 1/8/2021 The person responsible for this plan of correction is the Administrator.	

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

PRINTED: 12/29/2020
FORM APPROVED
OMB NO. 0938-0391

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 12/10/2020

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 885	Continued From page 17 On 12/14/2020. 4:25 PM the facility Administrator confirmed that resident's families were not being notified of each confirmed positive COVID test. S/he stated that Resident families have been updated regarding new positive cases at least every seven days.	F 885	F885 POC accepted 1/16/21 R. Tremblay, RN/PMC	