

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 27, 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 **January 6, 2021**. 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

PRINTED: 01/15/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>475030</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/06/2021</b>
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NAME OF PROVIDER OR SUPPLIER  <b>ELDERWOOD AT BURLINGTON</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>98 STARR FARM RD BURLINGTON, VT 05408</b>
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(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
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F 000	INITIAL COMMENTS	F 000		
F 690 SS=D	<p>The Division of Licensing and Protection conducted an unannounced onsite complaint investigation on 1/6/21. The following regulatory deficiency was identified as a result:</p> <p>Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3)</p> <p>§483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.</p> <p>§483.25(e)(2) For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-</p> <p>(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;</p> <p>(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and</p> <p>(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.</p> <p>§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must</p>	F 690	The facility wishes to have this submitted plan of correction stand as its written allegation plan of compliance. Our date of compliace is 01/27/21. Preparation and/or execution of does not constitute admission to nor agreement with existence of or scope and severity of the cited deficiencies. This plan is prepared and/or executed to ensure compliace with regulatory requirements.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Lisa Peacock* TITLE *Administrator* (X6) DATE *1/26/21*

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.

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NAME OF PROVIDER OR SUPPLIER  <b>ELDERWOOD AT BURLINGTON</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>98 STARR FARM RD</b> <b>BURLINGTON, VT 05408</b>		
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F 690	<p>Continued From page 1</p> <p>ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on staff interview and record review, the facility failed to ensure that 2 of 4 applicable residents (Residents # 1 and #2) with an indwelling catheter, receives the appropriate care and services to prevent urinary tract infections to the extent possible. Findings include:</p> <p>1. Per review of the December 2020 and January 2021 treatment record (TAR), staff failed to document that urinary output was checked as ordered by the physician for Resident # 1. A physician order dated 3/16/20 stated to notify the provider if output is &lt; 100 milliliters (mls) per shift. Urinary output was not documented in the TAR on 19 occasions in December 2020 and on 2 occasions in January 2021.</p> <p>2. Per review of the December 2020 TAR, staff failed to document catheter care as ordered by the physician for Resident # 2. A physician order dated 11/27/17 stated to flush catheter with 30 mls of sterile normal saline twice a day. This was not documented as being done on the TAR on 4 occasions in December 2020. Additionally, a physician order dated 8/19/16 stated to cleanse the catheter every shift. This was not documented as done on 4 occasions in December 2020.</p> <p>At 12:47 PM on 1/6/21, the Director of Nurses and the Regional Nurse Consultant both confirmed that there was no evidence in the clinical record that catheter care for residents # 1 and #2 had been provided as ordered by the</p>	F 690	<p>F 690 Resident #1 has had his urinary output documented on his TAR Resident #2 His catheter flush has been completed and signed on his TAR.</p> <p>All resident's with urinary catheters have had their TAR's reviewed.</p> <p>All licensed nurse's will be re-educated on documentation of urinary catheters</p> <p>TAR's will be audited twice weekly for two weeks, then weekly for three weeks, then monthly times two with as assigned by DON with results to QAPI committee for review.</p> <p>The Director of Nursing will be responsible to ensure any further recommendations are carried out.</p> <p>F690 POC accepted 1/26/21 R.Tremblay, RN/PMC</p>	01/27/21	

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