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

December 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 recertification survey and complaint investigation conducted on **November 17, 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

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 11/17/2021

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 The Division of Licensing and protection conducted an unannounced onsite emergency preparedness survey on 11/17/21. The facility was found to be in substantial compliance with emergency preparedness regulations.	E 000		
F 000	INITIAL COMMENTS The Division of Licensing and Protection conducted an unannounced onsite recertification survey 11/15/21 - 11/17/21. The following regulatory violations were cited as a result of the recertification survey:	F 000	See attached Plan of Correction	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will	F 656		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Lisa Peacock | TITLE: Administrator | (X6) DATE: 12/17/21

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.

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 11/17/2021

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 provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for 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 observation, interview, and record review, the facility failed to implement interventions per the resident's Plan of Care for 2 residents [Res. #95 & #69] of 27 sampled residents. Findings include: 1). Review of Res. #95's Care Plan reveals the resident identified as "having alteration in my mood/behavior and psychosocial wellbeing and have been ordered psychotropic medication related to a diagnosis of bipolar disorder, an alteration in respiratory status related to Obstructive Sleep Apnea and acute respiratory failure, and at risk for Hyper/Hypoglycemia related to Diabetes", all with Care Plan interventions that include "Provide medication as ordered" and "Administer medications per MD/Nurse Practioner order".	F 656	See attached Plan of Correction	

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 11/17/2021

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 Per observation on 11/16/21 at 2:26 PM, the Staff LPN assigned to Res. #95 approached the resident seated at a table in the common area in front of the Champlain Unit's Nurses Station. The Staff LPN was holding a plastic medicine cup with medications visible inside the cup. The LPN stated "Here's your afternoon pills and your pills from this morning". A review Physician Orders and of Res. #95's Medication Administration Record [MAR] for 11/16/21 reveal the following medications scheduled to be administered between 7:00 & 10:00 AM: Lisinopril- give 2 tablet by mouth in the morning for Hypertension; Divalproex Sodium tablet delayed release- give 2 tablet by mouth in the morning for bipolar mood; Furosemide tablet- give 1 tablet by mouth in the morning for fluid balance related to Acute Respiratory Failure with Hypoxia; Glucophage- give 2 tablet by mouth two times a day for type II Diabetes; Aspirin- give 1 tablet by mount in the morning for coronary artery disease; Polyethylene Glycol Powder- give orally every morning for constipation; Vitamin B 12- give 2 tablet by mouth in the morning; Calcipotriene Cream- apply to all areas on the body topically every morning. An interview was conducted with a second Staff Nurse on the Champlain Unit on 11/17/21 at 1:32 PM. The Nurse was asked to review the medications administered to Res.# 95 on 11/16/21 and the time the medications were administered. Per interview and record review, the Staff Nurse confirmed that the 8 medications	F 656	**See attached Plan of Correction**	

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 11/17/2021

NAME OF PROVIDER OR SUPPLIER	STREETADDRESS, 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 3 listed above were time-stamped as given at 2:22 PM and 2:23 PM. The Staff Nurse confirmed that the medications were ordered to be given 'in the morning', within the scheduled times of 7:00 AM and 10:00 AM, and were not administered as ordered. 2). Per record review, Res. #69 was admitted to the facility on 10/2/20 with diagnoses that include repeated falls, disorders of bone density and structure, cervical disc disorder, and encounter for closed fracture with delayed healing. A review of Res. #69's Care Plan reveals the resident is identified as having "a deficit in Activities of Daily Living function/mobility related to left ankle fracture", with Care Plan interventions that include "Transfer - Total Dependence, Mechanical Lift (Hoyer) / Two+ person physical assist." [Hoyer Lifts are assistive medical devices which apply specially-designed slings and pads to safely lift a patient from a bed to a wheelchair, toilet, or stretcher]. Per interview with Res. #69 on 11/16/21 at 10:59 AM, the resident stated s/he put the call light on because s/he wanted to get out of bed and was waiting for assistance. Per observation on 11/16/21 at 11:42 AM, a single Licensed Nursing Assistant [LNA] entered Res. #69's room by h/herself, pushing a Hoyer lift. The LNA closed the door behind her after entering the room. The LNA was observed leaving Res. #69's room with the Hoyer lift by herself approximately 10 minutes later. Per observation and interview on 11/16/21 at 1:52 PM, Res. #69 was observed sitting in a wheelchair in the common area on the unit. The resident stated one person transferred h/her from the bed to the wheelchair via the Hoyer lift 'at 12 noon today'. The resident stated it is "always" one	F 656	See attached Plan of Correction	

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 11/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELDERWOOD AT BURLINGTON	98 STARR FARM RD BURLINGTON, VT 05408

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 4 person transferring h/her. An interview was conducted with a Staff LPN on Res. #69's unit on 11/17/21 at 1:32 PM. The Staff LPN stated that the facility's policy and procedure when using a Hoyer lift is there should "always" be two staff members transferring the resident to ensure resident safety. The Staff LPN confirmed that Res. #69's Care Plan interventions included "Transfer - Total Dependence, Mechanical Lift (Hoyer) / Two+ person physical assist."	F 656	**See attached Plan of Correction** **TAG F 656 POC Accepted on 12/20/21 by R. Tremblay/P. Cota**	
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary	F 657		

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 11/17/2021

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 657	Continued From page 5 team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to review and revise the Care Plans for 4 residents [Res. #40, #19, #16, & #205] of 27 sampled residents. Findings include: 1). Review of Res. #40's Medical Record reveals the resident was admitted to the facility on 6/23/21 with diagnoses that include abnormalities of gait and mobility, macular degeneration, cognitive communication deficit, and need for assistance with personal care. Review of Res. #40's Care Plan reveal the resident was assessed as 'at risk for falls related to Impaired gait, Incontinence, need for an ambulatory device, History of 5 CVAs [strokes]'. Care Plan interventions to prevent falls are dated 6/24/21, the day after admission, with one intervention dated 6/28/21. Review of Nurse's Notes for Res. #40 on 11/11/21 record "Staff member walking past room noted resident sitting on floor with her back to her bed, surrounded in all her bedding. Resident indicated she slid out of bed ..." Review of Nurse's Notes on 11/14/21 record Res. #40 "had a second unwitnessed fall this evening." "Resident found sitting on floor outside of bathroom ... resident states she hit her head, visible lump on high occipital region to top of her head. no open areas noted. Will assess for mental status changes. neuro checks initiated ...does state she can feel the lump on her head." Additional notes reveal the resident also reported "right elbow and knee	F 657	See attached Plan of Correction	

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 11/17/2021

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 657	Continued From page 6 pain". An interview was conducted with the Care Plan Coordinator/Social Service Director [SSD] on 11/16/21 at 11:48 AM. The SSD stated that a resident's Care Plan should "absolutely" be reviewed and revised "after each fall". Per record review of Res. #40's Care Plan, there were no new interventions added to prevent future falls and/or injury after either documented falls on 11/11/21 and 11/14/21, the latter which resulted in "visible lump on high occipital region to top of her head" and "right elbow and knee pain". 2. Per record review, Resident #19 was found on the floor on their room on 11/4/21. Resident #19 told staff that they had gotten up to try and use the bathroom despite staff reminders that they cannot transfer or ambulate independently. Per a nursing note on 11/4/21 at 9:57 PM, "Pt was in bed for the evening and had a fall out of bed. Pt reports he was getting up to go to the bathroom, however, his is non-ambulatory." Resident #19 sustained a right knee fracture as a result of the fall. Per review of Resident #19's Quarterly Minimum Data Set Assessment from 8/19/21, Resident #19 is frequently incontinent of bowel and bladder and requires extensive assistance or is totally dependent on staff for all mobility and care. Per review of Resident #19's care plan, Resident #19 had a care plan focus for "risk for falls" added on 2/7/2020. The most recent intervention under this care plan focus was added in October of 2020. There have been no updates to Resident #19's care plan since their fall with major injury on 11/4/21. Resident #19's care plan also has a care plan focus for "elimination" with an intervention of	F 657	See attached Plan of Correction	

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 11/17/2021

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 657	Continued From page 7 "toileting schedule every 3 hours" added on 6/2/2020 and an intervention of "scheduled toileting every 2 hours to decrease incontinence" added on 9/10/2020. Resident #19's care plan focus for "functional/mobility/restorative care" has an intervention that states "Toileting: transfer - total dependence, mechanical lift (hoyer)/two+ person assist." This intervention was added on 11/16/2020 and revised on 6/11/2021. Per interview on 11/17/21 at approximately 1:30 PM, a full-time LNA (licensed nursing assistant) who works with Resident #19 regularly stated that Resident #19 receives incontinence care every 2 hours and confirmed that their task list (the Kardex system) states to provide this care every 2 hours, not 3. The LNA also stated that Resident #19 no longer gets mechanically lifted to the bathroom every 2 hours because they are incontinent and non-ambulatory. Per interview on 11/17/21 at approximately 2:00 PM, the long-term care Social Worker confirmed that Resident #19's care plan had not been updated. 3. Per record review, Resident #16 was found outside the facility in the courtyard on the premises on 7/11/21. Per a nursing note on 7/11/21 at 11:40 AM, "Chittenden courtyard alert panel went off; this writer went to investigate the alarm; the res alongside RN manager was walking back on this unit and this writer was informed res was found outside by therapy. No apparent injuries noted." A separate nursing note from 7/11/21 at 12:00 PM states, "Daughter informed; RN supervisor will follow up with risk management."	F 657	**See attached Plan of Correction**	

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 11/17/2021

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 657	Continued From page 8 Per record review, Resident #16 has an extensive history of exit seeking and wandering as evidenced by many progress notes documenting behaviors. Per review of Resident #16's care plan, there is a care plan focus for "Elopement" that was initiated on 4/8/19. All interventions for this care plan focus were initiated in 2019 and last revised in 2019 with the exception of an intervention initiated on 2/24/21 that states, "15-minute safety checks." There were no new interventions initiated in the elopement care plan following Resident #16's elopement on 7/11/21. Per interview on 11/17/21 at approximately 1:30 PM, a full-time LNA who works with Resident #16 regularly stated that LNAs do not document 15-minute safety checks on Resident #16 and confirmed that this was not an LNA documentation task in the Kardex. Per interview on 11/17/21 at approximately 2:00 PM, the long-term care Social Worker confirmed that Resident #16's care plan had not been updated. 4. Per record review, Resident #205's care plan has a care plan focus for "Elimination" with an intervention that states, "Scheduled Toileting: offer patient to toilet at bedside commode when [they need] to have a bowel movement or shortly after [they have] been given suppository for bowel movement. Wedge commode between foot of bed and wall, slide board transfers to commode minimum-moderate assist with 2 wheeled walker." This intervention was initiated on 5/31/21 and was revised on 7/26/21. Per observation of Resident 205's room on 11/16/21 at approximately 3:00 PM, there was no	F 657	See attached Plan of Correction	

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 11/17/2021

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 657	Continued From page 9 commode present in Resident 205's room. Per interview with Resident 205 at the same time, Resident #205 stated that they are often not able to tell if they have had a bowel movement or not and they prefer to not have to call for help to the commode and just receive incontinence care. They stated that the commode was removed from the room a while ago. Per interview on 11/17/21 at approximately 1:30 PM, a full-time LNA who works with Resident #205 regularly stated that Resident #205 exclusively receives incontinence care approximately every 2 hours and does not use a commode for toileting. Per interview on 11/17/21 at approximately 2:00 PM, the long-term care Social Worker confirmed that Resident #205's care plan had not been updated.	F 657	**See attached Plan of Correction** **TAG F 657 POC Accepted on 12/20/21 by R. Trembay/P.Cota**	
F 658 SS=D	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 observation, interview, and record review, the facility failed to ensure services provided met professional standards of quality regarding resident medications administered as ordered for 1 resident [Res.#95] of 27 sampled residents. Findings include:	F 658		

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 11/17/2021

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 10 Review of the American Nurses Association's Standards of Professional Nursing Practice (Nursing: Scope and Standards of Practice (wordpress.com)) reveals "The Standards of Professional Nursing Practice are authoritative statements of the duties that all registered nurses, regardless of role, population, or specialty, are expected to perform competently". Under 'Standard 5. Implementation: -The registered nurse implements the identified plan. - Implements the plan in a timely manner in accordance with patient safety goals. -Documents implementation and any modifications, including changes or omissions, of the identified plan'. Review of Res. #95's Care Plan reveals the resident identified as "having alteration in my mood/behavior and psychosocial wellbeing and have been ordered psychotropic medication related to a diagnosis of bipolar disorder, an alteration in respiratory status related to Obstructive Sleep Apnea and acute respiratory failure, and at risk for Hyper/Hypoglycemia related to Diabetes", all with Care Plan interventions that include "Provide medication as ordered" and "Administer medications per MD/Nurse Practioner order". Per observation on 11/16/21 at 2:26 PM, the Staff LPN assigned to Res. #95 approached the resident seated at a table in the common area in front of the Champlain Unit's Nurses Station. The Staff LPN was holding a plastic medicine cup with medications visible inside the cup. The LPN stated "Here's your afternoon pills and your pills from this morning". A review of Physician Orders	F 658	See attached Plan of Correction	

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 11/17/2021

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 11 and of Res. #95's Medication Administration Record [MAR] for 11/16/21 reveal the following medications scheduled to be administered between 7:00 & 10:00 AM: Lisinopril- give 2 tablet by mouth in the morning for Hypertension; Divalproex Sodium tablet delayed release- give 2 tablet by mouth in the morning for bipolar mood; Furosemide tablet- give 1 tablet by mouth in the morning for fluid balance related to Acute Respiratory Failure with Hypoxia; Glucophage- give 2 tablet by mouth two times a day for type II Diabetes; Aspirin- give 1 tablet by mount in the morning for coronary artery disease; Polyethylene Glycol Powder- give orally every morning for constipation; Vitamin B 12- give 2 tablet by mouth in the morning; Calcipotriene Cream- apply to all areas on the body topically every morning. An interview was conducted with a second Staff Nurse on the Champlain Unit on 11/17/21 at 1:32 PM. The Nurse was asked to review the medications administered to Res.# 95 on 11/16/21 and the time the medications were administered. Per interview and record review, the Staff Nurse confirmed that the 8 medications listed above were time-stamped as given at 2:22 PM and 2:23 PM. The Staff Nurse confirmed that the medications were ordered to be given 'in the morning', within the scheduled times of 7:00 AM and 10:00 AM, and were not administered as ordered.	F 658	**See attached Plan of Correction** **TAG F 658 POC Accepted on 12/20/21 by R. Tremblay/P. Cota**	
F 675 SS=E	Quality of Life CFR(s): 483.24	F 675		

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 11/17/2021

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 675	Continued From page 12 § 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, the facility failed to assure residents were provided the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, regarding the dining experience for multiple residents observed. Findings include: 1. Per observation on 11/15/21 at 12:20 PM, Resident # 18 was eating his/her noon meal in his/her bed. The Resident was positioned at approximately a 20 degree angle in bed (meaning the resident was not in an upright position). The Resident was unsuccessfully attempting to eat his/her meal and stated that he/she needs staff assistance to be pulled up in bed to eat. Per the care plan, resident requires assist of 2 staff with bed mobility. 2. On 11/15/21 at 12:32 PM, 3 residents were observed by 2 surveyors sitting at a table in the Mansfield common area for the noon meal, including Resident # 7 and Resident # 38. Resident # 38 is seated in large soft chair and is unable to reach items on his/her tray. Resident # 38 was observed dropping food on the floor when	F 675	See attached Plan of Correction	

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 11/17/2021

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 675	Continued From page 13 trying to bring utensils to his/her mouth. Resident # 38 was served a meal at 12:22 PM. A tablemate, Resident # 7 was not served a meal until 12:44 PM, meaning the resident had to wait 22 minutes after the tablemate was served, for their meal to arrive. 3. During the noon meal on 11/15/21, staff were observed putting clothing protectors on all residents in the common area without asking if they wanted one. Staff were observed touching residents hands, bodies and utensils and without sanitizing, doing the same with other residents at different tables in the room. On 11/15/21 at 1:02 PM, the Unit Manager (UM) stated that it is his/her expectation that staff ask residents prior to putting on clothing protectors. The UM also stated that it is his/her expectation that staff sanitize hands when between assisting different residents.	F 675	**See attached Plan of Correction** **TAG F 675 POC Accepted on 12/20/21 by R. Tremblay/P. Cota**	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, and record review, the facility failed to ensure that a resident who is unable to carry out activities of daily living receives the necessary services to maintain personal hygiene for one of 27 residents (Resident #15) as evidenced by the facility failing to accommodate Resident #15's shower needs. Findings include:	F 677		

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 11/17/2021

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 677	Continued From page 14 1. Per interview on 11/16/21 at approximately 10:00 am, Resident #15 stated that they have not taken a shower in "forever" because the facility has not acquired a shower chair that allows Resident #15 to keep their legs elevated in the shower. Resident #15 stated that, due to lymphedema in their legs (swelling in the legs caused by lymphatic system blockage), it is very painful for them to have their legs lower than their torso and that the facility only has shower chairs that require residents to be sitting upright with legs dangling. They stated that they had been told by the facility a long time ago that they would order a new chair to accommodate Resident #15's needs, but they have not received a shower since. They have also not received any updates from the facility about the status of the new chair. Resident #15 stated that showers make them feel a lot better physically and that they prefer them to bed baths. Per record review, Resident #15 has a diagnosis of "Lymphedema, not elsewhere classified" that was entered into the record on 4/23/21. Per review of Resident #15's care plan, there is an intervention in the care plan that states that Resident #15 "will receive bed baths until a shower bed can be obtained." This intervention was added to the care plan in April of 2021. Review of bathing records for Resident #15 also showed that Resident #15 has only been receiving bed baths for their hygiene needs. Per interview on 11/17/21 at approximately 9:30 AM, the Administrator stated that they had unsuccessfully tried many times to order a shower bed from their usual vendors but that they had either been unavailable or backordered. The Administrator could not provide evidence of any	F 677	See attached Plan of Correction	

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 11/17/2021

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 677	Continued From page 15 previous attempts being made to order a shower bed from their vendors or any communications with the vendors regarding shower beds. However, the Administrator provided me with evidence that they were able to place an order for a shower bed from an outside vendor on 11/16/21 at 4:23 PM, shortly after this surveyor first brought up the concern. The Administrator confirmed that they had not previously attempted to order the shower bed from an outside vendor.	F 677	**See attached Plan of Correction** **TAG F 677 POC Accepted on 12/20/21 by R. Tremblay/P. Cota**	
F 686 SS=D	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 observations, staff interview and record review the facility failed to ensure that treatment and services are provided consistent with professional standards of practice for residents with pressure ulcers for 1 of 4 residents in the applicable sample (Resident # 13). Findings include: Per record review Resident #13 has a stage 4	F 686		

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 11/17/2021

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 16 pressure ulcer on her/his sacrum and an unstageable pressure area to her/his left ankle. A care plan focus initiated on 12/31/2019 states "I have alterations in skin integrity r/t (related to) presence of stage 4 pressure ulcer history located on sacrum. My pressure ulcer will show signs of improvement during weekly skin assessments as evidenced by a decrease in size, drainage, odor, erythema of surrounding skin and show no signs and symptoms of infection." Interventions include assess and document status of wound/skin sites weekly and as needed." Resident # 13 also has a care plan focus that states "I have an alteration in skin integrity related to a coccyx stage 4, moisture associated skin issues, and scab areas to my fingers where I have self-mutilated." with interventions listed that include "assess and document status of wound/skin sites weekly and as needed." A facility policy titled Skin Conditions, Wounds and Pressure Ulcers (Assessment and Monitoring Program) provided by the Regional Nurse Consultant (RNC) states: 6. Skin conditions and/or wounds will be reassessed weekly by a registered nurse (RN) until the presence of the condition is resolved. 7. Assessments will be documented utilizing Point Click Care's Skin and Wound Management Solution... A Skin and Wound Eval completed on 11/9/2021 reflects a newly identified unstageable wound to her/his left malleolus (ankle). However, there is no evidence of RN weekly assessments of Resident #13's sacral wound in the record. During interview on 11/17/2021 at 3:10 PM the	F 686	See attached Plan of Correction	

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 11/17/2021

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 17 RNC and the Regional Director of Clinical Services were asked where weekly wound assessment are documented. The RNC reported that due to a loss of key staff such as the Nurse Educator and others, wound rounds have not been completed or documented consistently. A plan for a regional team to come in and evaluate wounds has been implemented over the past two weeks. The RNC will be doing wound rounds and making recommendations moving forward. However, no evidence of documented Wound Evals for Resident #13's sacral wound was provided by the RNC.	F 686	**See attached Plan of Correction** **TAG F 686 POC Accepted on 12/20/21 by R. Tremblay/P. Cota**	
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services 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)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding	F 726		

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 11/17/2021

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 726	Continued From page 18 to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to ensure that staff possessed the specific competencies and skill sets necessary to care for 1 of 27 residents in the sample (Resident # 55). Findings include: Per record review Resident #55 has a diagnosis of End Stage Renal Disease and is dependent on renal dialysis. A Physicians order dated 9/28/2021 states "Dialysis AV (arteriovenous) Graft/Fistula (used for hemodialysis) Monitoring: Verify for bruit and thrill at LUE (left upper extremity) every shift for monitoring." Review of Resident #55's November 2021 Treatment Record reflects that on the day shift of November 1, 2, 4, 6, 9, 10, 13,14, and 15 the Registered Nurse (RN) assessed the AV fistula and documented an absence of bruit and thrill. An absence of a bruit or thrill would require physician notification. There was no documentation that this absence of bruit or thrill was addressed or reported to the physician. On 11/17/2021 at approximately 1:00 PM during interview with the RN who had been assigned to Resident #55 on the above dates s/he stated that the facility did not verify her/his competencies prior to assigning her/him to care for the	F 726	See attached Plan of Correction	

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 11/17/2021

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 726	Continued From page 19 residents. Per interview with the Regional Nurse Consultant (RNC) and the Regional Director of Clinical Services (RDCS) on 11/17/2021 at 3:10 PM, the contracted agency is responsible to ensure that the nurses hired are competent in the skills required to care for the residents. The RNC did provide evidence that the RN had been provided training and assessed for competency on 11/17/2021 after becoming aware that the RN was documenting an absence of AV fistula bruit and thrill. Per review of an undated skills checklist provided to the facility by the agency that employs the RN, competency in assessment of an AV fistula used for Hemodialysis is not a listed skill.	F 726	**See attached Plan of Correction** **TAG F 726 POC Accepted on 12/20/21 by R. Tremblay/P. Cota**	
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical	F 756		

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 11/17/2021

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 756	Continued From page 20 director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to act on reported irregularities identified by the consulting pharmacist for 2 of 5 sampled residents (Residents # 27, #57). Findings include: 1. Per record review, a consultant pharmacist made a written recommendation on 6/10/21 to avoid dosing of Midodrine after 5:00 PM for Resident #27. Review of the Medication Administration Records (MAR) for June and July 2021 indicates the the medication continued to be administered between 8:00 - 10:00 PM. There is no physician order to make the change change as recommended. This is confirmed by the Unit Manager on 11/16/21 at 2:10 PM. 2. Per record review, progress notes written by the consultant pharmacist on 8/16/2021 and 9/8/2021 for Resident #57 state that	F 756	See attached Plan of Correction	

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 11/17/2021

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 756	Continued From page 21 "Recommendations made and forwarded to appropriate IDT (Interdisciplinary Team) members." Per review of 2 Pharmacist Recommendations provided by the Regional Nurse Consultant (RNC), the Pharmacist states that Resident # 57 is currently ordered Hydroxyzine 25 mg every 6 hours as needed (PRN) for anxiety. "Please review this PRN order and consider [discontinuing] if appropriate or document continued need for therapy and specify stop date". A third Pharmacist Recommendation states that "This resident (Resident #57) has been taking Aripiprazole 5 mg daily since 2/2012 without a GDR. Could we attempt a dose reduction at this time to verify this resident is on the lowest possible dose?" There is no evidence in the Medical Record that the Pharmacist's recommendations were reviewed or addressed by the Physician. The hand written notes documented on the Pharmacy Recommendations that were provided by the RNC state "no MD response in PCC (electronic medical record)" and "no MD note" confirming that there is no documented response or actions taken to address these recommendations by the Physician.	F 756	**See attached Plan of Correction** **TAG F 756 POC Accepted on 12/20/21 by R. Tremblay/P. Cota**	
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including	F 757		

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 11/17/2021

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 757	Continued From page 22 duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure that each resident's drug regimen is free from unnecessary drugs for one of 27 residents (Resident #102) as evidenced by the facility ordering a drug for Resident #102 without adequate indications for its use. Findings include: 1. Per record review, Resident #102 had an order placed for "Lyrica (a controlled nerve pain medication) 150 milligram capsule" on 10/22/21 at 1:48 PM. The administration instructions state, "give 1 capsule by mouth every morning and at bedtime for ?". The indication for this medication's use was not entered and instead the ordering provider used a question mark to communicate a lack of understanding as to why Resident #102 is receiving this medication. Per interview on 11/17/21 at approximately 2:00 PM, the Regional Nurse Consultant confirmed	F 757	**See attached Plan of Correction** **TAG F 757 POC Accepted on 12/20/21 by R. Tremblay/P. Cota**	

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 11/17/2021

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 757	Continued From page 23 that this is not an acceptable order and that it would be amended right away.	F 757	**See attached Plan of Correction**	
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that—- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs	F 758		

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 11/17/2021

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 758	Continued From page 24 are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure PRN (as needed) orders for psychotropic drugs are limited to 14 days for 2 of 5 sampled residents (Residents # 23, #57) and that a GDR (gradual dose reduction) was attempted for 1 of 5 sampled residents (Resident #57). Findings include: 1. Per review of Resident #23's clinical record, there is an Nurse Practitioner's (NP) order dated 10/01/21 for Seroquel (an antipsychotic) 12.5 milligrams (mg) po (by mouth) every 12 hours PRN without a stop date. Review of the October and November Medication Administration Records (MAR) shows that the resident received PRN seroquel 13 times in October and 4 times in November 2021. Per interview with the Unit Manager (UM) on 11/16/21 03:21 PM , h/she confirms the above order and that it has been in place for 47 days. The UM Agreed that antipsychotic medications are limited to 14 days. 2. Per record review Resident #57 has a Physicians order dated 11/13/2020 for Hydroxyzine HCl (an antianxiety medication) 25	F 758	**See attached Plan of Correction**	

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 11/17/2021

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 758	Continued From page 25 mg by mouth every 6 hours as needed for anxiety. There is no stop date indicated for this psychotropic medication. On 9/28/2021 Resident # 57 was transferred to the hospital and returned to the facility on 9/29/2021 with a new order for Hydroxyzine HCl 25 mg by mouth every 6 hours as needed for anxiety. There was no stop date indicated nor is their evidence that the Physician documented a rationale for extending the order beyond 14 days. Medication Administration Records for July 2021 through October 2021 were reviewed and reflect that Resident # 57 received the as needed Hydroxyzine 1 time in July, 1 time in August, and 3 times in October of 2021. During interview with the Regional Nurse Consultant (RNC) on 9/17/2021 at 3:10 PM s/he confirmed that the Physicians order for Hydroxyzine did not have stop date. A Pharmacist Recommendation states that "This resident (Resident #57) has been taking Aripiprazole (Antipsychotic) 5mg daily since 2/2012 without a GDR. Could we attempt a dose reduction at this time to verify this resident is on the lowest possible dose?" A Minimum Data Set (MDS) Assessment dated 10/2/2021 reflects that Resident #57 received an Antipsychotic and a that a GDR has not been documented as inappropriate since 7/27/2020. A hand written notation on the Pharmacy Recommendation for a GDR that was provided by the RNC states "No MD response in PCC (electronic medical record) " and "No MD note" confirming that there is no Physician follow up to attempted GDR.	F 758	**See attached Plan of Correction** **TAG F 758 POC Accepted on 12/20/21 by R. Tremblay/P. Cota**	

Elderwood at Burlington

Plan of Correction for annual survey from 11/17/21

The facility wishes to have this plan of correction stand as its written plan of compliance. Our date of compliance is 12/31/21. Preparation and/or execution of this does not constitute an admission or agreement with the existence of or scope and severity of the cited deficiencies. This plan is prepared and/or executed to ensure compliance with regulatory requirements.

F656- Develop/Implement Comprehensive Care Plan

Resident #95 medication review will be conducted by the provider and adjustments made to accommodate residents preferred time of medication administration. Resident #69 care plan was reviewed and the LNA assigned to the resident was educated regarding Hoyer transfer using staff competency tool with return demonstration.

To identify other residents' potential impacted by this deficient practice a medication administration audit and Hoyer transfer audit will be conducted to ensure that no other residents were affected by the same deficient practice

To ensure that the deficient practice does not recur. All applicable clinical staff will be educated on medication administration policy and Hoyer transfers and complete staff competency.

Random audits of medication administration times and resident transfers will be conducted. These audits will be completed weekly for four weeks and monthly for three months with remedial action taken as needed.

Results of these audits will be brought to the QAPI committee for review monthly for three months.

The Director of Nursing is responsible for this plan of correction.

Substantial compliance will be achieved by 12/31/2021.

F657 Care Plan Timing and Revision

The four residents in the sample, residents #40, #19, #16, and #205 will have a review and update of their care plans.

To identify other residents' potential impacted by this deficient practice a facility wide audit of care plans will be conducted to ensure that no other residents were affected by the deficient practice.

The following measures will be put into place to ensure that the deficient practice does not recur. The IDT will discuss any resident changes daily at morning stand up meetings and contribute to care plan intervention changes/updates. The IDT will be educated on daily report items for review and discussion.

To monitor the corrective action random audits of care plans will be done to ensure that they are appropriately reviewed and revised. This will be done weekly for four weeks and monthly for three months.

Results of these audits will be brought to the QAPI committee monthly for review for three months with remedial action taken as necessary.

The Director of Nursing and the Director of Social Services are responsible for this plan of correction.

Substantial compliance will be achieved by 12/31/2021.

F658- Services Provided Meet Professional Standards

Residents #95 a medication review will be conducted by the provider and adjustments made to accommodate residents preferred time of medication administration.

To identify other residents' potential impacted by this deficient practice a medication administration audit will be conducted to ensure that no other residents were affected by the same deficient practice.

To ensure that the deficient practice does not recur all applicable clinical staff (LPN, RN, Med techs) will be re-education on the medication administration policy.

To monitor the corrective action random audits of medication administration times. These audits will be conducted weekly times four weeks then monthly for three months.

Results of these audits will be submitted to the QAPI committee for review monthly for three months with remedial action taken as needed.

The Director of Nursing is responsible for this plan of correction.

Substantial compliance will be achieved by 12/31/21.

F675- Quality of Life

Resident #18 will be screened by therapy for proper meal positioning.

Resident #7 and # 38 Residents seated together at a table will all be served at the same time as their table mates to ensure quality of life. Staff will ensure that residents seated at a table have proper positioning to reach the table and their meal.

To ensure quality of life and resident choice and dignity for all residents, staff will ask residents prior to meal service if they desire a clothing protector. Staff will also sanitize their hands prior to assisting residents with meals/ utensils, after touching resident hands and bodies, and in between any assistance provided to other residents.

To identify other residents' potential impacted by this deficient practice meal rounds will be conducted daily and immediate remediation of staff will be conducted if deficient practice is observed.

To ensure that the deficient practice does not recur all clinical staff will be educated on resident's rights, positioning for meals, meal service procedure, and hand hygiene during meal service.

To monitor corrective actions random dinning audits will be conducted weekly times four weeks across all dining areas and then monthly for three months.

Audit will be presented at the monthly QAPI meeting for three months

The Director of Nursing and the Unit Managers are responsible for this plan of correction.

Substantial compliance will be achieved by 12/31/21.

F677- ADL Care Provided for Dependent Residents

Resident #15 upon identification the facility ordered a large shower stretcher to accommodate the bathing preference of this resident. A rental was obtained on 11/19/21 to ensure resident preference was met.

To identify any other residents that may be affected by this deficient practice a facility wide audit of resident ADLS and care preference care plans will be conducted.

To ensure that the deficient practice does not recure all applicable clinical and supply procurement staff will be educated on the process of procuring supplies timely that are required to ensure ADL care is provided at the appropriate level of dependance, safety, and resident preference.

To monitor the corrective action random audits of resident care plan ADLS and preference will be conducted weekly for four weeks then monthly for three months. Audits will be presented to the QAPI committee monthly for three months with remedial action taken as needed.

The Administrator, The Director of Nursing and the Rehab Director are responsible for this plan of correction.

Substantial compliance will be achieved by 12/31/21.

F686- Treatment/Svcs to Prevent/Heal Pressure Ulcer

Resident #13 weekly wound evaluations are being conducted with noted improvement.

To identify other residents that may be affected by this potential deficient practice the wound team conducted skin rounds on all residents with existing wounds and conferred with direct care staff providing ADL care to inquire regarding all resident skin status to ensure no new skin areas needed additional assessment.

To ensure that the deficient practice does not recur a wound care team to include the DON and unit managers was established to conduct weekly wound rounds. All clinical staff will be educated to report any new skin issues upon discovery to the nursing staff for prompt evaluation. All clinical staff will be educated on the skin care, wound and pressure ulcers policy.

To monitor the corrective action random skin and wound audit will be conducted weekly for four weeks then monthly for three months.

Results of those audits will be brought to the QAPI committee monthly for three months with remedial action taken as needed.

The Director of Nursing and the Unit Managers are responsible for this plan of correction.

Substantial compliance will be achieved by 12/31/21.

F726- Competent Nursing Staff

Resident #55's was immediately assessed upon notification of finding and a bruit and thrill were present. It was noted that nurse that had marked the absence of a bruit and thrill did not understand how to assess a dialysis fistula.

To identify other residents that were potentially affected by this deficient practice a review of all dialysis resident treatment records was conducted to ensure no further deficient practice.

To ensure that the deficient practice does not recur the nurse was immediately educated on assessment of dialysis fistula for bruit and thrill. All clinical staff will be re-educated on the policy of care of residents receiving off-site dialysis.

To monitor this corrective action random audits of residents receiving dialysis will be conducted weekly times four weeks then monthly for three months.

Results of these audits will be brought to the QAPI committee monthly for three months with remedial action taken as needed.

The Director of Nursing is responsible for this plan of correction.

Substantial compliance will be achieved by 12/31/21.

F756- Drug Regimen Review

Residents number #27 and #57 were reviewed with the consulting pharmacist upon notification of finding and orders for recommendations were completed.

To identify other residents that may be affected by the deficient practice an audit of all pharmacy recommendations was conducted.

To ensure that this deficient practice does not recur the pharmacy consultant amended her email group to include recent staff changes. The GDR monthly IDT meetings to review pharmacy recommendations were started on 12/1/21 and will be conducted monthly on an ongoing basis. All clinical staff will be re-educated on the Medication Regimen Review by Pharmacy Consultant Policy.

To monitor this corrective action, monthly audits will be conducted for four months. Weekly audits of this process are not applicable since the process occurs on a monthly basis.

Results of these audits will be presented to the QAPI committee monthly for three months.

The Director of Nursing and the Unit Managers are responsible for this plan of correction.

Substantial compliance will be achieved by 12/31/21.

F757- Drug Regimen is Free from Unnecessary Drugs

Resident #102 was a short-term rehab resident that was admitted on 10/22/21 with Lyrica following acute CVA discharged to home on 11/23/21 to follow up with his primary care provider for further medication management.

To identify other residents potentially affected by this deficient practice an audit of all residents receiving pain medication will be conducted to ensure adequate pain management with the lowest therapeutic dose.

To ensure that this deficient practice does not recur the random audits of pain medication orders will be conducted to ensure indication of use and appropriate diagnosis. All clinical staff will be re-educated on Medication Reconciliation policy.

To monitor this corrective action random audit of medication, reconciliation process will be conducted weekly times four weeks then monthly for 3 months.

Results of these audits will be brought to the QAPI committee monthly for three months with remedial action taken as needed.

The Director of Nursing and the Medical Director are responsible for this plan of correction.

Substantial compliance will be achieved by 12/31/21.

F758- Free form Unnecessary Psychotropic Med/PRN Use

Residents #23 and #57 will be evaluated by the provider regarding medication regimen for PRN anti-psychotic medication.

To identify other residents potentially affected by this deficient practice an audit of all PRN medication orders will be conducted to ensure no other residents are affected by this practice. An assessment of other PRN medications will be done to ensure that all have the appropriate gradual dose reductions in place as required.

To ensure that this deficient practice does not recur, the clinical staff and medical director will be educated on the psychotropic drug policy and need for re-evaluation every 14 days for PRN psychotropic drug regimens.

To monitor this corrective action, random audits will be completed weekly for four weeks then monthly for three months.

Results of these audits will be brought to the QAPI committee monthly for three months.

The Director of Nursing is responsible for this plan of correction.

Substantial compliance will be achieved by 12/31/21.

POC Accepted on 12/20/21 by R. Tremblay/P. Cota