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

June 14, 2022

Ms. Pam Rafferty, Regional Nurse Consultant
Elderwood At Burlington
98 Starr Farm Rd
Burlington, VT 05408-1396

Dear Ms. Rafferty

Enclosed is a copy of your acceptable plans of correction for the investigation conducted on **May 18, 2022.** 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

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

PRINTED: 05/31/2022
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 05/18/2022

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 an unannounced onsite investigation of 2 complaints and staff vaccination review on 05/18/2022. The following regulatory violations were cited as a result of these investigations.	F 000		
F 600 SS=E	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on the facility investigative report, staff interviews and record reviews, the facility failed to ensure 6 of 10 applicable residents (Residents #5, 6, 7, 8, 9 &10) were free from neglect. Findings include: On March 1, 2022 at approximately 2:30 PM, 2 (two) Licensed Nurse Aides (LNA) found when they started their shift that at least 6 residents had not received care from the LNA who had worked the previous shift. The residents were found to be	F 600	Past non-compliance - no POC required for Tag F 600	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Pamela Rafferty, RN
TITLE: Regional Nurse Consultant
(X6) DATE: 6/12/22

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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F 600	Continued From page 1 saturated in urine for the duration of the shift, and residents who wanted to get out of bed were left in their beds. On 3/9/2022 in the facility investigative summary report, which was written by the Director of Nursing (DNS), the facility was able to substantiate the allegation of neglect: On 5/18/2022 at approximately 10:30 AM, this was confirmed the Assistant Director of Nursing (ADNS). Based on corrective actions completed prior to the onsite, this citation is designated as past non-compliance. The following actions were completed by the facility: 1. After the incident during a morning meeting containing members of the Interdisciplinary Team Members (IDT) a discussion of the incident took place and plans to re-educate all staff was discussed. 2. The Licensed Nurse Aide (LNA) involved, was terminated 3/4/2022 via a telephone call. 3. Education regarding resident care and documentation was provided to all LNA's on 3/16/2022. Additionally, all staff completed their annual training regarding Resident Rights and Abuse during the month of April 2022. 4. The incident was discussed by the quality team (QAPI) on 4/28/2022 during their meeting.	F 600	See Attached Plan of Correction	
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4)	F 609		

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F 609	Continued From page 2 §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment were reported to the State Agency as required for 6 applicable residents (Resident #5, 6, 7, 8, 9 & 10). Findings include: Per record review, facility documentation and staff	F 609	**See Attached Plan of Correction**	

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F 609	Continued From page 3 interviews, a Licensed Nurse's Aide (LNA) failed to provide adequate care to at least 6 residents that were assigned to the LNA during his/her shift. The facility investigated the allegations, substantiated the neglect and terminated the LNA immediately. The facility made a report via email to Adult Protective Services (APS) and The Office of Professional Regulation. They also sent an email to what they thought was the address for the State Survey Agency, however, It was incorrect, and the State Survey Agency only found out when another agency notified them of the neglect. Per an interview on 5/18/22 at approximately 11:30 AM with the Assistant Director of Nursing (ADNS) confirmation that the wrong email address had been used and the State Survey Agency was never notified of the allegations.	F 609	See Attached Plan of Correction	
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders.	F 655		

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F 655	Continued From page 4 (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to develop a base line care plan that reflects resident specific health and safety concerns to prevent decline or injury for 1 of 10 sampled residents. Findings include: During the investigation it was noted that the resident #1 was admitted to the facility following admission for Covid-19, pneumonia and having suffered a stroke during the hospitalization. The resident previously had a below the right knee	F 655	**See Attached Plan of Correction**	

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F 655	Continued From page 5 amputation and currently had a flaccid upper left extremity as a result of the recent stroke. Upon admission to the facility the following impairments to skin integrity were noted: moisture associated skin damage (MASD) to the right groin and coccyx, abrasion on the left dorsum and calf, intact blister to coccyx. A review of the base line care plan revealed that risk for skin impairment or actual skin impairment and related interventions were not included in the care plan. Per an interview on May 18th at approximately 1:30 PM the Assistant Director of Nursing confirmed that there was nothing in the baseline care plan to address the resident's skin condition and admitted it should have been included when the care plan was initiated.	F 655	**See Attached Plan of Correction**	

Elderwood at Burlington

Plan of Correction for complaint survey from 5/18/22

The facility wishes to have this plan of correction stand as its written plan of compliance. Our date of compliance is 7/2/22. 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.

F609- Reporting of alleged violations

Resident 5,6,7,8,9, and 10 allegations of neglect were immediately addressed at the time of notification of administration, it was determined via investigation that one LNA was responsible for all incidents of neglect and the LNA was terminated immediately.

To identify other residents' potential impacted by this deficient practice an audit of all potential reportable cases since April 18, 2022, was conducted with no additional findings.

To ensure that the deficient practice does not recur. All applicable clinical staff will be educated on reportable incidents and proper reporting procedure.

Random audits of all reportable incidents 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 7/2/22.

F655 Baseline Care Plan

Resident #1 discharged on 5/9/22.

To identify other residents' potential impacted by this deficient practice a facility wide audit of care plans for all recent admission within the past 90 days 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 be educated on the baseline care plan policy. Additionally, the IDT will conduct their baseline care plan discussions immediately follow morning meeting daily to ensure completion.

To monitor the corrective action random audits of base line care plans will be done to ensure that they are appropriately initiated 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 7/2/22.

TAG F 609 and TAG F 655 POC Accepted on 06/13/22 by L. Lovell/P. Cota