VERMONT

AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

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

February 7, 2023

Mr. Isaac Spilman, Administrator
Elderwood At Burlington
98 Starr Farm Rd
Burlington, VT 05408-1396

Dear Mr. Spilman:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **January 11, 2023.** 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

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 01/11/2023

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 complaint investigation on 1/11/23. The following regulatory violation was cited as a result.	F 000	The facility wishes to have this plan of correction stand as its written plan of compliance. Our date of compliance will be Feb 28, 2023. Preparation and/or execution of this Plan of correction 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.	
F 712 SS=E	Physician Visits-Frequency/Timeliness/Alt NPP CFR(s): 483.30(c)(1)-(4) §483.30(c) Frequency of physician visits §483.30(c)(1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter. §483.30(c)(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. §483.30(c)(3) Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally. §483.30(c)(4) At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (e) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure residents are seen by physicians personally, face-to-face, at the same physical location for 4 sampled residents (Residents # 1, 2, 3 ,4). Findings include: Resident # 1 was admitted to the facility on	F 712	What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident's # 1,2,3,4 have been seen in person by a physician and are in compliance with CFR 483.30(c)(1)-(4). How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents who reside at the center are at risk for this alleged deficient practice.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Chelsea Spellman | TITLE: Administrator | (X6) DATE: 1/31/23

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 712	Continued From page 1 9/30/22. There is no evidence in the clinical record that the resident was seen in person by a physician. The first telehealth visit by a physician was on 1/3/23. Resident # 2 was admitted to the facility on 11/3/22. There is no evidence in the clinical record that the resident was seen in person by a physician. The first telehealth visit by a physician was on 1/3/23. Resident # 3 was admitted to the facility on 10/31/22. There is no evidence in the clinical record that the resident was seen in person by a physician. Resident # 4 was admitted to the facility on 5/27/22. . There is no evidence in the clinical record that the resident was seen in person by a physician. The first telehealth visit by a physician was on 1/10/23. Per interview with facility management on 1/11/23, the facility believed that the CMS requirement for physician in-person visits had been waived until 1/11/23. They were unaware that the waiver had expired on 5/7/22.	F 712	What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recure? The provider services group was educated on CFR 483.30(c)(1)-(4) as it relates to in person visit requirements. All current residents will be seen in person by an MD as required per CFR 483.30(c)(1)-(4). Compliance date for this to be completed will be Feb 28, 2023. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The administrator will be responsible for this plan of correction. Medical Records Coordinator or designee will conduct weekly audits X 4 and monthly X 2 to ensure continued compliance. The results of these audits will be brought to QAPI for review and y further interventions as necessary. Tag F 712 POC Accepted on 02/01/2023 by R. Tremblay/P. Cota The date of compliance for this corrective action will be Feb 28, 2023.	