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

April 12, 2024

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 revisit survey conducted on **March 7, 2024.** 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,

PamelaMCotaRN
Pamela M. Cota, RN
Licensing Chief

Enclosure

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 _____	R 03/07/2024

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	{E 000}		
{F 000}	INITIAL COMMENTS The Division of Licensing and Protection conducted an unannounced, onsite follow up survey on 3/6/2024 through 3/7/2024 to determine compliance with previously cited deficiencies under 42 CFR Part 483 requirements for Long Term Care Facilities. The following deficiencies were identified:	{F 000}		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to provide care and treatment consistent with the resident's physician orders and professional standards of practice, placing the resident at risk for infection for 1 of 4 residents in the sample (Resident #4). Findings include: During an interview with Resident #4 on 3/6/24 at 11:40 AM it was noted that they had a dressing on their lower right leg with a date of 3/3/24 written on it indicating that the dressing was last changed on 3/3/24.	F 684	See Attached Tag F 684 POC accepted on 4/12/24 by S. Stem/P. Cota	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: administrator | (X6) DATE: 4/14/24

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 _____	R 03/07/2024

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 684	Continued From page 1 Per record review, both the physicians orders and Treatment Administration Record (TAR) indicate that Resident #4 has a wound on their left leg [instead of the right] and that the dressing should be changed daily. A physician's order dated 2/28/24 states "LLE (left lower extremity) Wound Care: Cleanse with NS (normal saline), and skin prep around open area, apply non-adherent, cover with coversite, every day shift for Wound Care." The TAR also reflected that nursing staff had been signing that the dressing on the left lower leg had been changed daily through 2/28/24 - 3/6/24. During observation of the right lower leg wound dressing change on 3/6/24 at approximately 1:30 PM, the Licensed Practical Nurse (LPN) confirmed that the dressing was dated 3/3/24 and that it had not been changed daily as ordered. The LPN also confirmed that the wound had been documented as a lower left leg wound rather than a right lower leg wound.	F 684		
{F 686} SS=G	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	{F 686}	See Attached Tag F 686 POC accepted on 4/12/24 by S. Stem/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 _____	R 03/07/2024

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 2 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 observation, interview, and record review, the facility failed to provide effective skin and wound care consistent with professional standards of practice and facility policy for preventing and treating existing pressure ulcers for 2 of 4 sampled residents (Residents #1 and #2), resulting in two new pressure ulcers for Resident #1. Findings include: Facility policy titled "Pressure Ulcer, Pressure Injury & Other Skin Conditions: Initial Assessment, Care Planning, Ongoing Evaluation and Management" last revised on 2/27/2023 reveals the following under procedures: "Ongoing assessment of existing pressure ulcers, pressure injuries & other skin conditions will be conducted weekly by facility staff and/or a consultant who specialized in wound management. Progress, treatment, and care plan interventions are reviewed at that time and will be documented in the medical record. . .The assessment will include characteristics of the wound and surrounding tissue such as but not limited to presence of epithelial or granulation tissue, measurements, stage, presence of exudates, necrotic tissue such as eschar or slough and evidence of erythema or swelling around the wound." 1. Per record review, Resident #1 was readmitted to the facility on 2/21/24 following a 2 week hospital stay related to a bowel obstruction with diagnoses that include paraplegia (inability to	{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 _____	R 03/07/2024

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 3	{F 686}		

voluntarily move the lower parts of the body), morbid obesity, heart disease, and respiratory failure. Per Resident #1's Minimum Data Set (MDS; a comprehensive assessment used as a care-planning tool) dated 1/3/24, s/he is a risk for developing pressure ulcers. A 2/8/24 discharge with return anticipated MDS indicates that Resident #1 has no unhealed pressure ulcers stage 1 or higher.

Per observation and interview on 3/6/24 at approximately 1:00 PM, a Licensed Practical Nurse (LPN) was observed doing wound care for Resident #1. Resident has open wounds on both buttocks. The LPN stated that these wounds had been open for weeks. Resident #1 explained that the wounds were uncomfortable and it hurts to have treatment done.

Per review of a 2/21/24 readmission skin assessment, Resident #1 has a 1.5 cm x 1 cm left buttock excoriation and a 2.5 cm x 1.3 cm scabbed abrasion on his/her sacrum. There is no information about the characteristics of the wounds and surrounding tissue. This assessment was completed and signed by an LPN. There was no evidence that an RN reviewed this assessment. Per record review, while Resident #1 has a care plan for skin, it was not revised to reflect his/her actual wounds on readmission and there are no physician orders to treat his/her skin conditions on readmission.

Per review of a 2/28/24 skin assessment, Resident #1 has MASD (moisture-associated skin damage) on his/her groin, a left buttock excoriation, and a scabbed abrasion on his/her sacrum. There is no information about the characteristics of the wounds and surrounding

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 _____	R 03/07/2024

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 4 tissue, including measurements. These 3 wounds are also marked as "first observance," even though two of the wounds were documented a week earlier. Per review of a 3/2/24 skin assessment, Resident #1 has an "in-house acquired" stage 2 right buttock pressure ulcer measuring 7.5 cm x 4.5 cm x 0.1, and a stage 2 right buttock pressure ulcer measuring 2 cm x 2.5 cm x 0.1 cm. Record review reveals that this was the first time these wounds were documented. Per interview on 3/7/23 at 12:20 PM, the Unit Manager, a Licensed Practical Nurse (LPN), confirmed that Resident #1 did not have treatment orders for wound care until 3/3/24 and his/her care plan did not reflect his/her actual skin status until 3/2/24. S/He explained that treatment orders and the care plan should have been updated on readmission by a registered nurse. Per interview on 3/7/24 at approximately 4:45 PM, the Registered Nurse that did the 2/28/24 skin assessment reviewed the skin assessment and stated that it was not accurately filled out. S/He said that the form did not reflect Resident #1's actual skin and it was an error on his/her part for not filling it out correctly. Per interview on 3/7/24 at 5:13 PM, the Director of Nursing stated that unless a resident is being seen in wound rounds by the wound provider, weekly wound assessments are being completed on the skin assessment form. S/He explained that registered nurses are either completing the skin and wound assessments themselves or signing off on LPNs skin assessments after observing the skin themselves. S/He confirmed that Resident	{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 _____	R 03/07/2024

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 5 #1's skin and wound assessment had not been signed off by a registered nurse, that Resident #1 did not have a care plan that reflected his actual skin on readmission, and s/he did not have physician orders for wound treatment until 3/3/24, even though wounds were first documented on 2/21/24, twelve days earlier. 2. Per a record review, Resident #2 has lived in this facility since 2/11/2021. His/Her diagnoses include dementia, need for assistance with personal care, congestive heart failure, and other signs and symptoms involving cognitive functions and awareness. A review of his/her Medication Administration Record (MAR) reveals Resident #2 has a wound care order for Calzink/Dimethicone (skin protectant) to his/her sacral wound three times a day and as needed that was initiated and administered since 1/18/24. Resident #2's care plan does not reflect that s/he has an actual wound. A 2/2/24 skin assessment reveals that Resident #2 has a pressure ulcer on their sacrum measuring 0.4 x 0.3 x 0.1cm. There are no weekly skin assessments between 2/3/24 and 2/22/24. On 2/23/24, three weeks after Resident #2's last skin assessment, a skin assessment reveals that Resident #2 has no skin condition requiring documentation. There are no additional skin assessments in Resident #2's medical record after 2/23/24. Per interview on 3/7/2024 at approximately 12:30 PM, the Unit Manager stated that Resident #2 did have a wound on their sacrum that was being treated and confirmed that the 2/23/24 skin assessment was not accurate. The Unit Manager confirmed that the facility failed to document	{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 _____	R 03/07/2024

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 6 weekly skin and wound assessments and failed to update the care plan to reflect the presence and treatment of an actual wound for Resident #2. S/He confirmed the facility did not follow its policy relating to assessing and documenting pressure ulcers.	{F 686}		
{F 697} SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide pain management that met professional standards of practice for 1 of 4 residents in the sample (Resident #4). Findings include: Per record review, Resident #4 suffers from chronic leg pain, spondylosis (osteoarthritis of the spine), chronic back pain, and is prescribed morphine sulfate for chronic pain for spinal stenosis. Review of physicians orders reveal that Resident #4 has an order dated 2/28/24 for Morphine Sulfate (Concentrate) Solution 20 MG/ML (milligram/milliliter). Give 0.5 ml sublingually (under the tongue) every 6 hours as needed for pain or Shortness of breath 0.25 ml = 5 MG. Resident #4's care plan goals include "I will experience an acceptable level of pain relief as evidenced by verbal/nonverbal communication	{F 697}	See Attached Tag F 697 POC accepted on 4/12/24 by S. Stem/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 _____	R 03/07/2024

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 697}	Continued From page 7 and/ or increased functional ability through next review. My acceptable level of pain is a "6" on the 1-10 scale." Care plan interventions include "Provide medication as ordered," and "Assess characteristics of pain: location, severity on a scale of 0-10, type, frequency, precipitating factors, alleviating factors and vital signs or Non-verbal indications of pain as needed." Review of Resident #4's March 2024 Medication Administration Record (MAR) reveals that Resident #4 was medicated with the prescribed PRN Morphine once on 3/1, twice on 3/2 and 3/3, once on 3/4, and twice on 3/5, 3/5, and 3/7. The only pain level documented on administration was a progress note written on 3/3/24 and on the MAR on 3/7 which reflected Resident #4's pain at a 9 out of 10. There was also no indication on the MAR whether 0.5 ml was given for pain or if 0.25 ml was given for shortness of breath. The only place that the dose was documented was in the Control Substance Book which is not part of the resident's record. Per interview on 3/7/24 at 12:30 PM with the Licensed Practical Nurse (LPN) Unit Manager, nurses had not been documenting pain scales when administering Resident #4's PRN Morphine. The Unit Manager also confirmed that the MAR should not have two separate doses for two separate indications without the ability to document which dose and indication were administered or why the medication was needed.	{F 697}		
F 758 SS=E	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	F 758	See Attached Tag F 758 POC accepted on 4/12/24 by S. Stem/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 _____	R 03/07/2024

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 8 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 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.	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 _____	R 03/07/2024

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 9 §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 interview and record review the facility failed to ensure residents who are receiving as-needed psychotropic medications have a 14-day stop date for 5 of 5 residents sampled. (Residents #2, #5, #6 #7 and # 8) Per record review on 3/7/24 Resident #7 has a Physician's order that started on 2/28/24 for Lorazepam (an anti-anxiety psychotropic medication) give 0.25 milligrams (mg) sublinguaily (SL) a route of administration in which the medication is placed under the tongue and is absorbed through the mucous membrane) every 4 hours as needed (PRN) for anxiety/SOB (shortness of breath). There is no 14-day stop date included in the order. Resident #7 also has a Physician order started on 2/28/24 for Haldol (an antipsychotic psychotropic medication given for agitation) give 0.5 milliliters (ml) by mouth every 6 hours as needed for agitation. There is no 14-day stop date for this psychotropic medication order. Per record review Resident #6 has a physician's order that started on 12/9/23 for Haldol to give one 1 tablet (0.5mg) by mouth every 4 hours as needed for agitation. There is no 14-day stop date for this psychotropic medication. Resident #6 also has a Physician's order for Lorazepam 0.5 mg give 1 tablet by mouth every 2 hours as needed for anxiety. There is no 14-day stop date	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 _____	R 03/07/2024

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 10 for this psychotropic medication order. Per record review Resident #8 has a physician order that started on 2/28/24 for Lorazepam give 0.5mg sublingually every 3 hours as needed for anxiety. There is no 14-day stop date for this psychotropic medication order. Resident #8 also had a physician's order that started on 2/16/24 for Haldol give 0.5mg by mouth every 4 hours as needed for agitation/hallucinations/paranoia. There is no 14-day stop date for this Psychotropic medication order. Per record review Resident #2 has a physician order that started on 2/15/24 for Lorazepam 0.5 mg give one tablet by mouth every 2 hours as needed for anxiety. There is no 14-day stop date for this psychotropic medication. Per record review Resident #5 has a physician order that started on 2/26/24 for Haldol give 0.5 ml by mouth every 6 hours as needed for agitation. There is no 14-day stop date for this psychotropic medication. Resident # 5also has an order started on 2/26/24 for Lorazepam give 0.5mg sublingually every 2 hours as needed for anxiety/Shortness of breath. There is no stop date for this psychotropic medication. Per an interview on 3/8/24 at 5:45 PM with a Licensed Practical Nurse, unit manager, reviewed with this surveyor all of the above resident's medication orders. S/he confirms that all the residents with psychotropic medication orders named above (Resident #7, #6, #8, #2, and Resident #5) have no 14-day stop dates in place for their as-needed psychotropic medication orders.	F 758		

The filing of this plan of correction does not constitute an admission of the allegations set forth in the statements of deficiencies. Elderwood at Burlington has prepared and executed a plan of correction as evidence of the facilities continued compliance with the applicable federal and state laws.

F684

The corrective action for residents found to be affected by the alleged deficient practice: Resident # 4 was assessed by a Registered Nurse on 3/12/24. The wound was healed. The Treatment Record and physician orders were amended to reflect treatment for the proper leg on 3/6/24.

To identify other residents potentially affected by this alleged deficient practice: Whole house skin assessments were completed to ensure physician orders, treatments and wound assessments are complete and accurate.

To ensure this alleged deficient practice does not recur: all nursing staff will be educated on the facility policy titled: Pressure Ulcer, Pressure Injury & Other Skin Conditions: Initial Assessment, Care Planning, Ongoing Evaluation and Management (BUR, HAM, LIV, SS, WAV, WMS,) Education will be focused on the following: Wound risk, Wound Assessments, Care planning, Interventions, Wound documentation and Wound treatments. Weekly wound rounds continue to ensure appropriate treatment and services to prevent pressure ulcers. Education by Ameriwound staff regarding wound assessment is scheduled for April 4th, 2024. Weekly skin checks have been implemented for all residents.

The corrective action will be monitored by continuing weekly skin audits X4 weeks then monthly for at least 3 months to ensure substantial compliance is maintained. Results of the audits will be reviewed by management and reported to the Quality Assurance Committee at the scheduled meetings.

The corrective action will be completed by April 12, 2024. The Director of Nursing or designee will be responsible for this corrective action.

F686

The corrective action for residents found to be affected by the alleged deficient practice: Resident # 1 was assessed on 3/7/24 by the IDT, including a Registered Nurse. The care plan and treatment orders were reviewed and updated as needed. Resident # 2 was assessed by a Registered Nurse on 3/2/24. The wound was found to be closed.

All residents with wounds can be affected by this alleged deficient practice: The facility has conducted house-wide skin assessments by Registered Nurses to ensure all

skin conditions have been accurately assessed and documented. Treatment orders and care plans have been updated as appropriate.

To ensure the alleged deficient practice does not recur; all nursing staff will be educated on the facility policy titled: Pressure Ulcer, Pressure Injury & Other Skin Conditions: Initial Assessment, Care Planning, Ongoing Evaluation and Management (BUR, HAM, LIV, SS, WAV, WMS,) Education will be focused on the following: Wound risk, Wound Assessments, Care planning, Interventions, Wound documentation and Wound treatments. Weekly wound rounds continue to ensure appropriate treatment and services to prevent pressure ulcers. Education by Ameriwound staff regarding wound assessment was completed on April 4th, 2024.

The corrective action will be monitored by continuing wound audits weekly X4 weeks, then monthly for at least 3 months to ensure substantial compliance is maintained. Results of the audits will be reviewed by management and reported to the Quality Assurance Committee at the scheduled meetings.

The corrective action will be completed by April 12, 2024. The Director of Nursing or designee will be responsible for this corrective action.

F697

The corrective action for resident #4 found to be affected by this alleged deficient practice: Resident #4's medication order was clarified, and a new order obtained on 3/12/24.

To identify other residents potentially affected by this alleged deficient practice the facility conducted an audit of all pain medications to ensure clarity of dose and indication for use for each order. All orders were updated to have only one dose per order. For orders with an indication for pain or shortness of breath, Supplemental documentation was added to the order requiring the nurse to document the indication for which the medication is being administered. Any discrepancies were corrected by 4/4/24.

To ensure that the alleged deficient practice does not recur all nursing staff will be educated on obtaining and entering provider orders, obtaining clarification of orders as needed to ensure clear dosing and indication. For orders with an indication for Pain or Shortness of breath, Nurses will be educated on the newly added supplemental documentation and the requirement to document the indication for which the medication is being administered on the MAR.

The corrective action will be monitored through audits of new orders for accuracy and indication of use. Audits will be weekly X 4 weeks then monthly x3 months and any discrepancies will be corrected immediately. The audits will be reported to the Quality Assurance Committee at the monthly meetings.

The corrective action for this alleged deficient practice will be completed by 4/12/24. The Director of Nursing/Designee is responsible for this corrective action.

F758

The corrective action for residents found to be affected by this alleged deficient practice: Residents 2, 6, 7 and 8's psychotropic medication orders have been corrected to reflect a 14 day stop date. Resident # 5 has expired.

All residents on psychotropic medications have the potential to be affected by this alleged deficient practice. Whole house audits of PRN psychotropic medications have been performed. Orders have been corrected as needed.

To ensure the alleged deficient practice does not recur: All nursing staff will be educated regarding facility policy titled: Psychotropic Drugs. The dashboard will be reviewed every morning by the Director of Nursing or designee for psychotropic medication orders from the past 24 hours.

The corrective action will be monitored by completing audits of PRN Psychotropic medications for the 14 day stop date/reevaluation. Audits will be completed weekly x 4weeks and monthly x 3 months to ensure substantial compliance. Results of the audits will be reviewed by management and reported to the Quality Assurance Committee at the scheduled meetings.

The corrective action will be completed by April 12, 2024: The Director of Nursing or designee will be responsible for this corrective action.