

**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 <u>http://www.dail.vermont.gov</u> 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

September 23, 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 complaint investigation conducted on **August 15, 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,

Jamela M Cota RN

Pamela M. Cota, RN, BS Assistant Division Director State Survey Agency Director

Enclosure

CENTERS FOR MEDICARE & MEDICAID SERVICES				PLE CONSTRUCTION		TE SURVEY
	CORRECTION	(X1) PROVIDENCIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN			NE SURVEY
						С
		475030	B. WING			B/15/2024
AME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE	
	OD AT BURLINGTON			SE STARR FARM RD		
				BURLINGTON, VT 0540	<b>16</b>	
(X4) ID		ATEMENT OF DEFICIENCIES	i iD PREFIX		S PLAN OF CORRECTION CTIVE ACTION SHOULD BE	(XS) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG	•= •••	NCED TO THE APPROPRIATE	DATE
1				1	DEFICIENCY)	1
F 000	INMAL COMMENTS	3	FO	00		() ()
				a.		
10	The Division of Licer			÷		
		unannounced investigation				1
		S #23182, #23200, and				1
		and 8/13/24, with additional	22 10			1
		and interviews that ensued	1			1
		determine compliance with				
		uirements for Long Term	1			
	Care Facilities. The f		.*S			
	deficiencies were ide		1			1
F 677		or Dependent Residents	Fe	FR77 Sandifia	Corrective Action	
SS≖E	CFR(s): 483.24(a)(2)				COLLACTIVA MOROL	1
3	6483 24/aV(2) A macid	lent who is unable to carry	E.	ł		1
		living receives the necessary	•	1		1
		good nutrition, grooming, and		1.The correctiv	e action for this	54 U
	personal and oral hyp				nt practice: Education	1
		r is not met as evidenced			ded to all appropriate	i
	, by:		i.		the ADL needs of all	1
		on, resident and resident			nts, including how to	•
		iew, staff interview, and	•)		dex and Care plan to	
		cility failed to ensure that a	10		re is provided per	ð.
		le to carry out activities of			ence. Education has	÷.
		thout assistance receives the		<ul> <li>been provided</li> </ul>		
		ance for 8 of 11 sampled			staff to answer and	
		•	1	*		3.
		#1, #4, #5, #6, #7, #8, #9, esident). Findings include:			priately to resident ess of assignment.	
3	anu an anony 1003 1	oor which i manings invidue.			as of assigning in	
3	1. Per record review	Resident #7's care plan		i		24
	states that s/he has "	-		×		
		ation [related to] impaired	i	2 To identify of	ther potential deficient	
		3/18/19 and that s/he has "a			sidents requiring	
	•	mobility related to cerebral	1		n ADL's have the	
		ctive disorder," revised on	5. <b>*</b> 5			
		terventions include total		potential to be	מווסטובט.	
		ling hygiene, revised on	1	I.		
		ssistance for transferring,	86			
		and for staff to "provide				
	1		1	<u> </u>		
ORATON	DIRECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNATU	RE			(XS) DATE
11		0			1 00	17.0120

Any deficiency state ment ending with an esterisk (\*) denotes a deficiency which the institution may be accessed from correcting providing it is determined that other sanguages provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are discloseble 30 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 discloseble 14 days following the date fless documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEDADTMENT OF HEALTH AND HUMAN SEDVICES

PRINTED: 09/05/2024

PRINTED: 09/05/2024 FORM APPROVED OMB NO. 0938-0391

	of deficiencies Corfection	(X1) PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:	(72) MULTI A. BUILDIN	PLE CONSTRUCTION G		E SURVEY PLETED C
		475030	B. WING		08	/15/2024
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZP COC 98 STARR FARM RD BURLINGTON, VT 05408	E	P
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION (EACH CORRECTIVE ACTION CROSS REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(XIS) CONPLETIO DATE
<ul> <li>F 677 Continued From page 1</li> <li>prompt incontinent care," initiated on 8/7/19. On 6/10/24, Resident #7 was assessed to have a BIMS of 15 (brief interview for mental status; a cognitive assessment score Indicating cognitive intactness).</li> <li>Per observation and interview on 8/13/24 at 10:42 AM, Resident #7 was lying in bed. S/He stated that s/he had solled him/herself in bed that moming and had asked staff over a half an hour ago for help getting cleaned up. S/He explained that s/he is still in bed today by choice since s/he does not feel well but would still like help getting cleaned up. S/He explained that it takes staff a long time to get him/her into their wheelchair daily. S/He said s/he would like to get up at 8 or so and staff are lete getting him/her into the wheelchair, between 10:00 and 11:00 AM about 3 or 4 times a week. Resident #7's call light was</li> </ul>		F 6	F677 continued 3. What measures will be place or what systemic cl will make to ensure that to practice does not recur: A staff will be educated on access the Kardex and c the expectation to review Kardex/care plan daily at beginning of and through for updates or changes to care needs. All nursing s educated on the expecta answer, respond appropri resident ADL needs and care provided regardless assignment.	hanges you he deficient All nursing how to are plan and the the out their shift o resident taff will be tion to stately to document		
	<ul> <li>#7 said that staff had clean up from the ad s/he needs to urinate put their call light on Resident #7's call light on Resident #7's call light on 11:47 AM.</li> <li>2. Per record review states s/he is "alway bladder. [Intervention incontinent care," rerequires one assist for 03/10/2023.</li> <li>Per observation and 10:30 AM, Resident receive timely incontinent care.</li> </ul>	8 AM. When asked, Resident d still not helped him/her xident this moming and now e again, for which s/he had a bit ago to get help. th was not answered until r, Resident #10's care plan rs incontinent of bowel and ns Include] provide prompt vised on 12/29/2021 and for incontinent care, revised interview on 08/13/2024 at #10 stated s/he does not tinent care. S/He stated that ntinent care at 8:00 AM on		<ul> <li>4. To ensure this alleged practice does not recur, a completed to verify that A being completed per the These audits will be cond x 4 weeks, bi-weekly x 4 monthly x 2 months. The these audits will be broug monthly QAPI Committee review and recommenda DON or designee will be for this corrective action.</li> <li>Date of compliance 09/2 Tag F 677 POC accepter S, Stem/P, Cota</li> </ul>	audits will be ADL care is care plan. ducted weekly weeks, then results of ght to the o for further tions. The responsible	с с т т т т т

FORM CMS-2567(02-99) Previous Versions Obsolute

Facility ID: 475030

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES TOR EOD MEDICADE & MEDICAID SEDVICES OFNIT

	S FOR MEDICARE & ME				OMB NO. 0938-03
	CORRECTION	) PROVIDER/SUPPL/ER/CLIA IDENTIFICATION NUMBER:	(22) MULT A. BUILDIN	IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED
		477000	B. WING		C
<u>.</u>		475030	B. TVING		08/15/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,	ZIP CODE
ELDERWOOD AT BURLINGTON				96 STARR FARM RD BURLINGTON, VT 05406	
(X4) ID PREFIX TAG	(EACH DEFICIENCY M	MENT OF DEFICIENCIES UST BE PRECEDED BY FULL IDENTIFYING INFORMATION}	ID PREFU TAG	(EACH CORRECTIVE CRUSS-ACFECTIVE	N OF CORRECTION (XS) ACTION SHOULD BE COMPLETE TO THE APPROPRIATE DATE NENCY)
F 677	Continued From page 2		Fé	<b>577</b>	
	Resident #10 stated that	s/ha comptimes waite			
3	for hours for his/her care		1		1
		s/her call light a total of 6	to)	3	
	times starting at 10:43 A	-	1		
	AM. During the time of o			8	
	answered the light and i				
	care, they told the reside			8	
	return to provide his/her		i		1
2		censed Nursing Assistant		ř	8
i	#4 (LNA) who answered	-	i.		
		s/he stated that Resident	-1 ·		e
	#10 requested to "be cha				1
	explains that Resident #	•			
1	for incontinent care and			1	
	-	e stated that s/he had not			-
	-	sident #10 since the start	1	1	
		M. Per interview with LNA	1		ĩ
	#5 on 08/13/2024 at 10:				5
	that s/he is assigned to I			:	
	since start of his/her shill	nent care to Resident #10			1
	interview on 08/13/2024		i		
	who was scheduled to w				×
	day, rather than do patie	••••			
	provided incontinent can	-			×
	on 08/13/2024 at 11:40				•
	that Resident #10 was in			845 24 -	
I	feces.		1		
	3. Per record review, Re	sident #1's care plan			
	states that s/he has a "d				
	function/mobility related		1	1	<b>X</b>
	blindness," revised on 2			61	
	•	e for eating and "I should	1	1	T.
	be out of bed for meals,		10	34.1	ř
	"preferred dining location	n: common area,"	<u>(</u>		
	initialed on 11/15/21.				
	Per observation and inte	rview on 8/10/24 at 6:05	÷.		

CENTER	S FOR MEDICARE &	MEDICAID SERVICES	_			OMB NO. 0938-0391	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:	(X2) MUL A. BUILD	nple construc Ng	NON	(X3) DATE SURVEY COMPLETED	
		475030	B. WING			C 08/15/2024	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDR	ESS, CITY, STATE, ZIP CODE		
				SS STARR FA	RM RD		
ELDERWO	OD AT BURLINGTON			BURLINGTO	N, VT 05408		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INPORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION EACH CORRECTIVE ACTION SHOULD B OSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
F 677	Continued From page	e 3	' F	677			
		s lying in bed. At 6:43 PM, a		••••			
	-	sistant (LNA) left Resident		ŧ		( <b>1</b> .)	
		ned that Resident #1 ate	ļ.	5		(*)	
		. The LNA stated that		Ĩ			
	Resident #1 always e			2			
		at 1:35 PM, Resident #1's	1	!			
		nined that it is his/her wish to	1				
	have Resident #1 out	t of bed for all meals every	1	a.		34	
		. Par interview on 8/13/24 at	1				
		r of Nursing confirmed that		1		1	
	Resident #1 should b night.	e out of bed for dinner every		1			
	4. Per record review, states that s/he has a function/mobility rela						
	nontraumatic Intracer	•		¥			
Ş		[weakness] and other	£	1		1	
	-	and mobility," revised on	1				
	•	ention for a one person					
ļ		ait belt for transfer, revised ire plan, s/he is "independent					
		related to my BIMS,"					
	-	n 7/24/24 Resident #8 was					
	assessed to have a E			21			
		mpairment). A 8/12/24 fall	:	,			
	•	als that Resident #8 had an					
1	unwitnessed fall and	sustained an abrasion to				9	
	[his/her] back."		1				
		2/24 at 11:09 AM, Resident					
		ad a fall the previous night.					
		s/he had waited for about 15					
		to help answer his/her call r to the bathroom but					
		go so bad, s/he went to the	1	1		1	
		own even though s/he knew	689	8			
		sistence. Once s/he returned					
		sat on the bed and then slid	1	1		1	
			-				

FORM CMS-2587(02-99) Previous Versione Obsolete

Event ID: OLDJ11

Facility ID: 475030

If continuation sheet Page 4 of 23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDENSLIPPLIER CLA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY
		475030	B. WING		C 08/15/2024
	ROVIDER OR SUPPLIER DOD AT BURLINGTON			STREET ADDRESS, CITY, STATE, ZIP CODE 18 STARR FARM RD BURLINGTON, VT 05408	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL USC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	AD BE COMPLETION
F 677	Continued From page	<b>a</b> 4	F 677		
	_	r. S/he explained that it was as before the staff helped I.		:	
	(point of care; electro for LNAs) that Reside	entation in the LNAs' POC nic documentation system int #8 had assistance being at during the evening or			
	night shift on 8/12/24		1	- -	1911 -
	states that s/he has a	Resident #4's care plan "deficit in ADL ed to surgical amputation		i	101
	secondary to gangrer interventions that incl	re," revised on 11/6/23, with ude assistance for bed to weding silde board and	l ¥		1
8	-	t to get out of bed, revised A Resident #4 was	а. Т	!	38 1
	stated that response of staff. S/He explaine of bed after lunch and	/24 at 6:14 PM, Resident #4 time is very long due to lack ad that s/he likes to get out I needs shaft to help as s/he	ĸ		
	s/he has to wait until don't get him/her up a	own. S/He explained that 4:00 PM to get up or they at all because they are so that It is about 2-3 times a	ï	* 2	
	week that s/he can't g	let up when s/he wants to t enough staff to help.			1 283
1	states that s/he has a function/mobility relat	ed to recent amputation			ţ.
	for a 2 person physics for transferring, initiat	5/27/24, with an intervention al assist with mechanical lift ed on 12/22/24. On 5/29/24 assed to have a BIMS of 15.		1	 135 242
FORTAM CAMS-258	7(02-89) Previous Versione Obe		! J11 F	i adiity ID: 475030   f	continuation sheet Page 5 of 23

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CENTER	S FOR MEDILARE &	MEDICAID SERVICES			UMB NU. 0938-0391
	OF OEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE ( A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		475030	B. WING		C 08/15/2024
NAME OF P	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE	
			98	STARR FARM RD	
ELDERWO	SOD AT BURLINGTON	1721	BL	IRLINGTON, VT 05408	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	id Prefeta Tag	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E GROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 677	Continued From page		F 677		1
		nterview on 8/13/24 at			
0		as lying in bed and stated	i i		
		be out of bed "right now."	- I i		
		whe was out of bed earlier,	. 1		1
	•	to bed but would like to be			
	-	that there are not enough	* *		1
		since s/he needs a Hoyer	· 1		i i
	•	ited by staff) to get out of	1		1
	bed.		L.		
	7		- F		300
		nterview on 8/12/24 at 10:26	Ť		
		d that s/he does not get	1 1		
		s s/he should because there	Ť		1
		to help. S/He explained	1		Ť
	-	tort and s/he misses his/her	4		
		dy," and doesn't like that	4		( <b>\$</b> )
	-	t was able to understand all	- I - ,		1
	•	im/her by giving reasonable Instrated that s/he was alert	i .		1
	and orientated to per		i i i		
	and unentated to per		ĩ		
	8. Per interview with	Resident's #11 Power of	5		
		3/13/2024 at 3:15 PM, s/he	{		
		to the facility every day and	Ĩ.		1
		vide care for Resident #11.			
		dent #11 has missed two	i I		
		wo weeks, S/ne stated that	1 4		21
	there is not enough a	taff do address Resident #11	20		
		on the weekends. S/He	E.		1
		t the facility the Nurse	1		
		tly working the medication			
		icensed Nursing Assident.			34
		feels if s/he did not go to	1		
		Resident #11 would not	1 3		
	receive the ADL care				
			1		
6		w with 3 LNAs on 8/10/24 at	. 1		
is is	6:43 PM, UNA #1 sta	ted that the facility is really			
	short staffed and has	been since they reopened			1
PORTA CHIS-258	57(112-89) Previous Versions Obs	soleta Event ID: DL	DJ11 Fac	any ID: 475030 If cont	inuation sheet Page 6 of 23

#### FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (NE) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION DENTIFICATION NUMBER: COMPLETED A. BUILDING С 475030 B. WING 08/15/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **98 STARR FARM RD** ELDERWOOD AT BURLINGTON BURLINGTON, VT 05408 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (25) COMPLETEON (X4) ID Ð (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY F 677 | Continued From page 6 F 677 the rehab unit. S/He explained that there were only 3 LNAs on Unit B at that moment, and to do a good job, there should be 5. S/He explained that there are so many residents that require 2 staff to assist with care. S/He explained that it is really hard to get their work done and it takes a long time to get residents the help they need. LNA #2 and #3 agreed with the above. A review of resident lists with an LNA from Unit B on the evening of 8/10/24 showed the following: 3 of the F711 Specific Corrective Action 39 residents needed assistance with eating and 15 of the 39 residents required 2 staff members 1. The corrective action for this alleged to assist with some or all of their ADLs. deficient practice was review of the F 711 resident's total program of care, F 711 Physician Visits - Review Care/Notes/Order SS=D CFR(s): 483.30(b)(1)-(3) including medications and treatments 1 §483.30(b) Physician Visits 2. To identify other potential deficient The physician mustpractice, all residents in the facility are at risk to be affected by this alleged §483.30(b)(1) Review the resident's total program deficient practice. of care, including medications and treatments, at each visit required by paragraph (c) of this 3. To ensure this alleged deficient section: practice does not recur house wide audit will be §483.30(b)(2) Write, sign, and date progress conducted to ensure physicians and notes at each visit; and other providers have reviewed the resident's total program of care, §483.30(b)(3) Sign and date all orders with the including medications and treatment exception of influenza and pneumococcal plan at each regulatory visit in the past vaccines, which may be administered per 60 days. Any resident affected will physician-approved facility policy after an have an updated regulatory visit to essessment for contraindications. review their total program of care. This REQUIREMENT is not met as evidenced 1 Education will be provided to the bv: Medical Director and other providers Based on staff interview and record review, the regarding their regulatory requirement facility failed to ensure that physicians and other 1 to review each resident's total program providers (as delegated to per regulation) review of care. the residents' total program of care, including

FORM CMS-2567(02-99) Previous Versions Obsolule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Event ID: DL 0.111

Facility ID: 475030

If continuation sheel Page 7 of 23

PRINTED: 09/06/2024

PRINTED: 09/05/2024 FORM APPROVED OMB NO. 0938-0391

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION	(XG) DATE SURVEY COMPLETED	
		475030	B. WING			C 08/15/2024	
	RÖVIDER OR SUPPLIER	<u>(180)</u>		ST	REET ADDRESS, CITY, STATE, ZIP CODE	00/13/2024	
	DOD AT BURLINGTON			98	STARR FARM RD		
			141	BL	JRLINGTON, VT 05408		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	D   PREFI   TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
F 711	Continued From page	97	F	7 <b>1</b> 1	F711 continued		
	medications and treat	lment plan at each visit as		İ	4. The corrective action will be		
	required for 1 of 3 sar	mpled residents (Resident's	ļ.	I	monitored by the DON/designee	hv i	
	#9). Findings include:	:	<u>b</u>		conducting weekly audits X 4 and		
	Dha alalan a da data d			ļ	then monthly X 3 to ensure regul		
	•	6/4/2024 under section titled Ins" reads "ALZHEIMER'S	ĸ		visit documentation, including rev		
	DISEASE, UNSPECI		1	ġ	of all parts of care, is completed		
	•	episodes of screaming out,	i	i	substantial compliance maintaine		
	·	ation. [S/he] currently is on	ĩ	I	Audits will be reviewed at QAPI f		
		Ativan without behavior		ĩ	further review and recommendat	ons	
		ds for now Per record	i	d.	Date of compliance 09/27/24	6	
	review Seroquel was	discontinued 05/23/2024.	3.º	i			
	Per review of Reside	nt #9's physician orders	•:			:	
		hows that Resident #9 was		Ŧ	Tag F 711 POC accepted on 9/2	3/24 by:	
	taking the following m	edication at the time of		i.	S. Stem/P. Cota	163	
		eridol oral iablet 2 milligrams		Ĩ			
		by mouth two times a day for	5	1		1	
	agitation, Lorazepam tablet by mouth at be	oral tablet 0.5 mg give 1	• 95	æ			
	Labier by mount at be		<u>ij</u>			549	
	A Physician note date	d 7/20/2024" "Assessment	R.	1			
	and Plans" "ALZHEIN			Ű.			
		.9-With behaviors, [s/he]	<u>,</u> 2	19			
		aming out, restlessness and	•	a.		1	
		ntly is on Seroquel Haldol havior changes continue	Ĩ.	- î			
	meds for now			4		125	
			i	1		(9)	
	A review of Resident	#9's physician orders	5)	1			
		s/he is was taking the					
		Haloperidol oral tablet 2		1			
		one tablet by mouth two	r	1		182	
	• •	on, Lorazepam oral tablet y mouth at bedtime for		2			
		tablet 5 mg give one tablet	I	a.		1	
		ing for agitation and one		I		1	
		evening for behaviors.	ŧ.	1			
			1	i		1	
PORM CMS-256	7(02-99) Previous Versions Obs	olete Event ID: DLD	111	Faci	ity ID: 475030 If contin	walion shaet Page 8 of 2	

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475030			(X3) DATE SURVEY COMPLETED C	
	CVIDER OR SUPPLIER	675050		REET ADDRESS, CITY, STATE, ZIP CODE	08/15/2024	
		ı	98	STARR FARM RD IRLINGTON, VT 05408		
(X4) ID PREFLX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES         ID         PROVIDER'S PLAN OF (           NCY MUST BE PRECEDED BY FULL         PREFIX         (EACH CORRECTIVE ACT)           R LSC IDENTIFYING INFORMATION)         TAG         CROSS-REFERENCED TO TO		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	ON SHOULD BE COMPLETIO	
F 711	Continued From pa	age 8	F 711		1	
		acticed registered Nurse 18/5/2024 section titled	i l		1	
1	"Assessment and I	Plans" "ALZHEIMER'S	1			
	DISEASE, UNSPE	CIFIED - G30.9 Without	E E			
		and Seroquel still has			1	
8	behaviors. [S/he] a	lso can get Haldol.*				
1						
		nt #9's physician orders on	1			
		ws that s/he was taking the on: Haloperidol oral tablet 2				
		ve one tablet by mouth two	1		1	
times a da		tation, Lorazeparn oral tablet	1 .			
		at by mouth at bedtime for				
3		ral tablet 5 mg give one tablet	- en - <sup>8</sup>		1	
8		oming for agitation and one	Ĩ.		6	
		the evening for behaviors.	ñ			
	There is no order for	or Seroquel	1			
	Per interview with t	the Director of Nursing on	1 1		Ĩ.	
		AM s/he confirmed the provider	1			
3		regulatory visits, did not reflect				
		ions that Resident #9 had			Ĵ.	
	orders for at the tin	ne of visit, and did not				
	accurately review t	the resident total program of	1 *			
	care and it should		a. 1			
	Sufficient Nursing		F 725		12	
SS=F	CFR(s): 483.35(a)	(1)(2)				
	§483.35(a) Sufficie	ent Staff.				
		ave sufficient nursing staff with				
		mpetencies and skills sets to	29 E			
	provide nursing an	d related services to assure	3		3	
	•	f attain or maintain the highest	i i		ĩ	
		al, mental, and psychosocial				
	-	resident, as determined by	1		ĩ	
		ents and individual plans of care	1			
		e number, acuity and				
1	unagnoses or me ta	acility's resident population in	1 .			
				ity ID: 475030  f	21	

	OF DEFICIENCIES	& MEDICAID SERVICES	0001100				. 0938-039
	CORRECTION	DENTIFICATION NUMBER:	A. BURLOW		ONSTRUCTION	(X3) DATE : COMPI	
			1.0.20				2
		475030	B. WING		1 -	5/2024	
NAME OF P	ROVIDER OR SUPPLIER			STR	LEET ADDRESS, CITY, STATE, ZIP CODE		
ELDERWOOD AT BURLINGTON			98 5	STARR FARM RD			
			22.00	BUR	RLINGTON, VT 05408		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	id Prefix Tag		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) Completion Date
<b>C</b> -05		_	1	1	F725 Specific Corrective Action	5	
F 720	Continued From pa		F 72	25 <sub>i</sub>		]	
	accordance with the at §483.70(e).	1	Ì		1		
	1		1	1	1. What corrective action will be	1	
		acility must provide services			accomplished for those residents		
		re of each of the following	1	1	found to have been affected by t		
		on a 24-hour basis to provide esidents in accordance with	1	Ē	deficient practice; The dally PPD		
   	resident care plans:				the last 30 days was reviewed to		
	•	Ived under paragraph (e) of	.1		ensure that the PPD was not les than 3.0.	S	
	, this section, license		1		ulan 3.0.		
		arsonnel, including but not		i		1	
	i limited to nurse aid		!		2.To identify other potentially all	bene	
	i		1		deficient practice, a dally audit w		
		pt when waived under	1		completed for the last 30 days to		
		s section, the facility must	1	Т	review the daily PPD. All reside		
		d nurse to serve as a charge	1		have the potential to be affected		
	nurse on each tour	÷	24		·····	1	
	by:	NT is not met as evidenced	1			3	
		lon, resident and staff		i	3.To ensure this alleged deficier		
		ord review, the facility failed to			practice does not continue, a da		
	•	sufficient number of skilled		Ι	PPD call has been started effect		
		rse aides, and other nursing	•		August 19, 2024 to review staffin		
	personnel to provid	e care and respond to each	14		needs and implement strategies		
		eds and individual needs as	1	<i>a</i>	needed to maintain a minimum I		
		dent's diagnoses, medical	1		of 3.0. An audit of the daily PPD		
		f care, potentially impacting all	:	0	be completed daily. Supplement staffing and shifting of responsit		
	residents of the faci	ility. Findings Include:	1		to areas of need will be impleme		
	1 Obeen offens and	d interviews reveal that ADL			when indicated. (i.e. Nurses wor		
		aily living) was not provided in			as LNAs, therapist providing AD		
	a timely manner.	- y		120	care). Recruitment of staff will		
	,		1		continue with weekly recruitmen	t and ;	
	a. Per record review	v, Resident #7's care plan			retention IDT meetings. The fact		
	states that s/he has			!	will recruit staff as needed to	-	
		nation [related to] impaired	I	312	maintain staffing levels of no les	S I	
	•	n 3/18/19 and that s/he has "a		023	than 3.0 daily.	6	
		on/mobility related to cerebral	*				
	paisy and schizoaff	ective disorder," revised on				i	

FORM CMS\_ZEE7(02-89) Previous Versions Obsolete

Facility ID: 475030

If continuation sheet Page 10 of 23

PRINTED: 08/05/2024 FORM APPROVED OMB NO: 0938-0391

GENIER	S FUR MEDICARE &	MEDICAID SERVICES			OWP NO. 0330-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _		(X3) DATE SURVEY COMPLETED C
		475030	B. WING		08/15/2024
NAME OF P	ROVIDER OR SUPPLIER		8	TREET ADDRESS, CITY, STATE, ZIP CODE	
			9	8 STARR FARM RD	
ELUCRA	DOD AT BURLINGTON		E	SURLINGTON, VT 05488	
(X4) ID PREFIX	(EACH DEFICIENC	ATEMENT OF OFFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	FROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION	SHOULD BE CONFLETION
TAG	REGULAIORY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE A DEFICIENCY	
F 725	Continued From page	a 10	F 725	S320 continued	1
		terventions include total	1	5. 2	
8		ing hygiene, revised on	1	4. The corrective action v	will be
	-	ssistance for transferring,	Ŧ	monitored through contin	4
	<sup>1</sup> revised on 5/23/24, a	nd for staff to "provide	i	PPD calls to include the	
		are," initiated on 8/7/19. On	1	administration and gover	-
		was assessed to have a		and auditing of PPD daily	
	BIMS of 15 (brief inte	rview for mental status; a	÷	and then weekly x2 mon	
		t score indicating cognitive	T	substantial compliance is	
	intactness).		i	maintained. The DON/D	
			i	responsible for this corre	
		interview on 8/13/24 at 10:42		Audits will be reviewed a	1
		lying in bed. S/He stated	1	QAPI for further review a	
		im/herself in bed that		recommendations	
	1	ed staff over a half an hour	•		
0		leaned up. S/He explained			
0		I today by choice since s/he			9
		would still like help getting	1	Date of Compliance 09/2	7/2024
		plained that it takes staff a	i .		i
		er into their wheelchair	1		a de la companya de la company
		would like to get up at 8 or		Tag F 725 POC accepte	d on 9/23/24 by
		getting him/her into the		S. Stem/P. Cota	
	-	10:00 and 11:00 AM about 3			1
		esident #7's call light was		2	
3		AM. When asked, Resident			
	1	still not helped him/her		1	1
	•	dent this morning and new	1	1	1
	put their call light on a	again, iei inner anno inae			
		ht was not answered until	1	L	1
	11:47 AM.		1		1
				10:	
	h. Per record raview	Resident #10's care plan			
		s incontinent of bowel and			
	•	is include] provide prompt	3		
		ised on 12/29/2021 and			
		or incontinent care, revised		10	
	on 03/10/2023.				
				÷.	
	Per observation and	interview on 08/13/2024 at	1		
FORM CMS-25	37(02-99) Previous Versions Ob	solete Event ID: DLC	DJ11 Fe	acility ID: 475030	if continuation sheet Page 11 of 23

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA DENTFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		475030	475030 B. WING		C 08/15/2024	
NAME OF PR	OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
ELDERWO	OD AT BURLINGTON			96 STARR FARM RD BURLINGTON, VT 05408		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	id Prefix Tag	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE COMPLETION THE APPROPRATE DATE	
F 725	Continued From page	ə 11	F 72	5	1	
	10:30 AM. Resident	#10 stated s/he does not				
	•	nent care. S/He stated that	i	1		
	•	tinent care at 8:00 AM on			!	
		ew and was still waiting.				
	-	hat s/he sometimes waits		1		
	for hours for his/her o	are. During observation,	!		1	
	Resident #10 pressed	d his/her call light a totel of 6	R	1	1	
i	times starting at 10:4	3 AM and ending at 11:50		1	2	
	-	of observation, 6 people				
		d instead of providing her	ř			
		sident his/her LNA would			1	
	return to provide his/	<b>16r care.</b>				
		Licensed Nursing Assistent	!			
I	#4 (LNA) who answe	-	*3	1	1	
1		AM s/he stated that Resident		1	1	
		changed." The LNA, #4		7		
		he Resident #10 requires nent care and is not on			3	
		. Per LNA #4 s/he stated	42			
		isted in caring for Resident			3	
		his/her shift at 6:00 AM. Per		Ϋ́.		
		5 on 08/13/2024 at 10:58				
		hat s/he had not provided			ű.	
	•	esident #10 since start of	<b>R</b> 2			
84	his/her shift at 6:00 A	M. Per interview on				
	08/13/2024 at 11:50	AM, LNA # 6, who was	1			
		ntral supply that day, rather				
	than do patient care,	stated that s/he provided				
		esident #10 alone S/he	:			
10		ent #10 was incontinent of	( <u>@</u> )			
i	urine and feces.		I	1		
i		Resident #1's care plan	2000	8	1	
(3	states that s/he has a			2		
	function/mobility relat		1	I.	1	
1	•	n 2/24/24. Interventions		*	1	
		ance for eating and "I should				
	be out of bed for mea			:		

#### **FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION DENTIFICATION NUMBER: COMPLETED A. BULDING С 475030 B. WING 08/15/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 98 STARR FARM RD ELDERWOOD AT BURLINGTON BURLINGTON, VT 05408 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) F 725 Continued From page 12 F 725 "preferred dining location: common area," initiated on 11/15/21. Per observation and interview on 8/10/24 at 6:05 PM, Resident #1 was lying in bed. At 6:43 PM, a Licensed Nursing Assistant (LNA) left Resident #1's room and explained that Resident #1 ate dinner in his/her bed. The LNA stated that Resident #1 always eat dinner in bed. Per interview on 8/13/24 at 1:35 PM, Resident #1's Representative explained that it is his/her wish to have Resident #1 out of bed for all meals every day, including dinner. Per interview on 8/13/24 at 5:08 PM, the Director of Nursing confirmed that Resident #1 should be out of bed for dinner every night. d. Per record review. Resident #8's care plan states that s/he has a "deficit in ADL function/mobility related to secondary to nontraumatic intracerebral hemorrhage, | Parkinsons disease, [weakness] and other · abnormalities of gait and mobility," revised on 8/7/24, with an intervention for a one person physical assist and gait belt for transfer, revised on 8/5/24. Per the care plan, s/he is "independent with decision making related to my BIMS, revised on 8/7/24. On 7/24/24 Resident #8 was assessed to have a BIMS of 11(Indicating moderate cognitive impairment). A 8/12/24 fall evaluation note reveals that Resident #8 had an unwitnessed fall and sustained an abrasion to 2 [his/her] back." Per interview on 8/12/24 at 11:09 AM, Resident #8 stated that s/he had a fall the previous night. S/He explained that s/he had waited for about 15 minutes for someone to help answer his/her call : light and help him/her to the bathroom but FORM CMS-2007(02-89) Previous Versions Obsoliets Event ID: DLD.111 Facility ID: 475030 If continuation sheet Page 13 of 23

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 09/05/2024

STAYEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIEVCLIA IDENTIFICATION NUMBER:	(X2) MULTE A. BUILDIN	4LE CONSTRUCTION 3	(3) DATE SURVEY COMPLETED C
		475030	B. WING_	<u></u>	08/15/2024
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z 98 STARR FARM RD BURLINGTON, VT 05408	
(X4) 1D PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	I ID PREFIX TAG	PROVIDERTS PLAN (EACH CORRIECTIVE/ CROSS-REFERENCED T DEFICI	ACTION SHOULD BE COMPLETION TO THE APPROPRIATE DATE
F 725	Continued From page	e 13	F7	25	8
		go so bad, sine went to the			
		own even though s/he knew	1		i
		sistance. Once s/he returned	1	1	:
		at on the bed and then slid	1		
		or. S/he explained that it was	4		ļ
j	-	es before the staff heiped	i i	E.	!
	him/her back into bec	•		*	
					i i
	There was no docum	entation in the LNAs' POC	1		i
		nic documentation system	2		1
	•	ent #8 had assistance being	1	-10°	1
		et during the evening or	9 <b>2</b>	i.	
	night shift on 8/12/24	•		É	
		Desident #4% case also			1
	states that s/he has a	Resident #4's care plan		1	
	•	ted to surgical ampulation		te.	
		ne," revised on 11/6/23, with	1		
		lude assistance for bed to	1	1	
		needing slide board and	3	7.02	
		it to get out of bed, revised			т
	on 12/12/23. On 6/5/		3	E.	
	assessed to have a E	BIMS of 15.			
					2
		V24 at 6:14 PM, Resident #4			2
		time is very long due to lack			Î
		ed that s/he likes to get out			×.
		d needs staff to help as s/he	a.	•	Ť
		own. S/He explained that	8 <b>.</b>		ĩ
		4:00 PM to get up or they			
	• •	l because they are so busy. is about 2-3 times a week	8		ĩ
	that s/he can't get up		3	÷	1
		ot enough staff to help.	1	1	i
	f. Per record review,	Resident #5's care plan	1	I	1
	states that s/he has a	a "deficit In ADL	1		1
	function/mobility relat	ted to recent amputation		39 -	1
	surgery," revised on	5/27/24, with an intervention	1		<u>r</u>
FORM CAS-20	37(12-03) Previous Versions Ob	solete Event ID: DLD	J11	Facility ID: 475030	If continuation sheet Page 14 of 23

UERIER	S FOR MEDICARE &	MEDICAID SERVICES				N-1 0936-0391
	of Deficiencies Correction	(X1) PROVIDER SUPPLIER CLIA DENTFICATION NUMBER:	(X2) MULTIPI A. BUILDING	E CONSTRUCTION		ATE SURVEY OMPLETED
		476030	B. WING		2 2	C
NAME OF R	ROMDER OR SUPPLIER		_	STREET ADDROSS, CITY, STATE, Z		08/15/2024
				98 STARR FARM RD		
ELDERWO	DOD AT BURLINGTON			BURLINGTON, YT 05408		
(X4) ID PREFIX TAG	(EACH DEFICIENC	XTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE (ROAS-REFERENCED DEFICI	ACTION SHOULD BE TO THE APPROPRIATE	(25) COMPLETION DATE
F 725	Continued From page	e 14	/   F72	5		
		al assist with mechanical lift				2
		led on 12/22/24. On 5/29/24		i		1
		essed to have a BIMS of 15.	1	Ì		
			1			
	Per observation and	interview on 8/13/24 at	1			1
	10:23, Resident #5 w	as lying in bed and stated	4	1		1
		be out of bed "right now."				
		the was out of bed earlier,		1		1
	had asked to go back	to bed but would like to be	1	1		1
	up now and was told	that there are not enough				i
	staff to help him/her a get out of bed.	since s/he needs a Hoyer to		U		1
	a. Per a confidential i	interview on 8/12/24 at 10:26	1			1
	•	I that s/he does not get	i	- • ·		1
		s s/he should because there		. •0		-
	•	to help. S/He explained		т.		
		nort and s/he misses his/her	1			
		dy," and doesn't like that	1			
		was able to understand all	1	T.		
		invher by giving reasonable				1
	•	nstrated that s/he was alert	1	1.00		
	and orientated to per		29 29			
				(1)		!
	h. Per Interview with	Resident's #11 Power of				
	• • •	3/13/2024 at 3:15 PM, s/he	1	1		4
		to the facility every day and	1	s <b>k</b> a		ļ
		vide care for Resident #11.	1	1		1
	e	dent #11 has missed two				
	•	wo weeks. S/he stated that	1			
	-	taff do address Resident #11				
	-	on the weekends. S/He				1
		t the facility the Nurse	ĩ			
	• •	tly working the medication				8
		Nursing Assistant. S/He		241		I
		if s/he did not go to the		31) 		ī
		sident #11, would not receive	1	(9)		
	the ADL care s/he ne	<b>B</b> 0 <b>B</b> 0.	i			
					Letter a	ř.
FORM CMS-25	67(02-09) Previous Versions Obs	solela Event ID: DLD	J11	Facility ID: 479030	If continuation	sheet Page 15 of 23

If continuation sheet Page 15 of 23

#### FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDERSUPPUER/CLA (22) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING С 475030 B. WING 08/15/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 98 STARR FARM RD ELDERWOOD AT BURLINGTON BURLINGTON, VT 05408 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID n (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREEIX REGULATORY OR LSC IDENTIFYING INPORMATION) DATE CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 725 i Continued From page 15 F 725 2. Additional resident and resident representative interviews reveal that LNA tasks are not completed on a regular or timely basis a. Per interview on 8/10/24 at 4:27 PM, Resident #2 explained that the facility is short staffed and s/he has to wait a very long time for call bells to be answered and get help. S/He said it is really bad at night when aldes are passing dinner trays. b. Per record review, Resident #3's care plan states that s/he has "limitations or [is] at risk for limitations in my ROM (range of motion) related to progressive weakness neurological," revised on ; 4/3/21, and has the interventions for "ROM of 1 bilateral lower extremity, please incorporate during care," initiated 3/2/24, "patient performs BUE [bilateral upper extremity] strengthening FMP (functional maintenance program) with 5# [pound] dumbbells independently," revised on 3/5/24. I <sup>1</sup> Per interview on 8/10/24 at 6:14 PM, Resident #3 stated that there are not enough aides to help him/her with his/her exercises and s/he does not want to loose anymore function. Per documentation in the LNAs' POC for August 1-12, 2024, lower extremity ROM was completed 4 out of 12 days and dumbbell upper extremity strengthening was performed 1 out of 12 days. 3. Additional staff interviews and record review reveal that the facility does not always have enough direct care shaff to provide the care needed. Per review of resident lists with LNAs from each unit on the evening of 8/10/24 showed the PORM CMS-2587(02-99) Previous Versions Obsolets Event ID: DLDJ11 Facility ID: 475030 If continuation sheet Page 16 of 23

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 09/05/2024

CENTER	S FUR MEDILARE &	MEDICAID SERVICES				UMB NO. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:	(X2) MUL A. BUILD		MSTRUCTION	(X3) DATE SURVEY CONFLETED
		475030	B. WING			C 08/15/2024
NAME OF PA	ROMDER OR SUPPLIER			STRE	EET ADDRESS, CITY, STATE, ZIP CODE	
ELDERWO	OOD AT BURLINGTON				TARR FARM RD RLINGTON, VT 05409	
			ĩ			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	iD PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEPICIENCY)	E COMPLETION
F 725	Continued From page	a 16	i F F	725		
			•	723		1
	following: On Unit A, 4 of the 42	meldeste seeded		i		1
		g and 16 of the 42 residents	Ļ.	÷.		8
1		bers to assist with some or	1 Contraction	- L		1
	all of their activities of		2	25		
	On Unit B, 3 of the 38		I.			1
	assistance with eating	50	1			
	required 2 staff mem	80	1			
	all of their ADLs.			÷		
	On Unit C, 1 of the 14	hereon streets 1	90			
		g and 3 of the 14 residents	ł.	ļ		4
i		bers to assist with some or	1 1	1		
				:		1
	Per a joint interview v	vith 3 LNAs on 8/10/24 at	i			2. D
	6: 43PM, LNA #1 stel	ted that the facility is really	1			1
	short staffed and has	been since they reopened	τ.			( <b>1</b> )
	the rehab unit. S/He	explained that there were	i i	Ť.		
	°only 3 LNAs on Unit 8	3 at that moment, and to do	1 Xe	τ.		4
	a good job, there sho	uld be 5. S/He explained				÷
		ny residents that require 2		a		9. <b>.</b> 9
		re. S/He explained that it is	80	1		
		r work done and it takes a				
13		ents the help they need. LNA	1			
i	#2 and #3 agreed wit	h the above.		1		1
				1		1
		/24 at approximately 4:45				
		plained that there has been				1
		shifts and not getting shifts				
		e frequently has to work as a				
	ποοr nurse and is una Unit Manager.	able to do his/her role as the				
	Onit Manager.		ł.	1		
	On 8/13/24 at 4-07 D	M, the Scheduler expleined	I	1		
		a lot of call outs for direct				
		mes it is hard to fill shifts		1		
		le stated that the direct care				
		ected all call-outs and shift				
		prifimed that they accurately	8			

FORM CMS-2587(02-09) Previous Versions Obsolete

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Facility ID: 478030

if continuation sheet Page 17 of 23

		ID HUMAN SERVICES MEDICAID SERVICES		ON	FORM APPROVED IB NO. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 475030			(X2) MULTIPLE CONSTRUCTION A. BUILDING		DATE SURVEY COMPLETED
		B. WING		08/15/2024	
NAME OF PR	OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
elderwo	OD AT BURLINGTON			98 STARR FARM RD BURLINGTON, VT 05408	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING IN <b>P</b> ORMATION)	id Prefox Tag	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-ALFEVENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	was later confirmed b review of direct care a through 8/12/24 reve- unfilled shifts, and rea- licensed nurse shifts were not refilled or re that were scheduled i reassigned. 10 licens reassigned were work unit managers or the licensed nurse shifts 8/2/24, three on 8/5/2 8/8/24) that were eith	me worked by staff, which by the DON at 5:06 PM. A staff schedules from 8/1/24 aled multiple call outs, assignments. There were 12 that were scheduled that bassigned and 29 LNA shifts that were not filled or bed nurse shifts that were ked by nursing supervisors, Director of Nursing and 9 (one on 8/1/24, two on 24, two on 8/7/24, one on ber short a licensed nurse or	F 725		
	the unit manager or s Free from Unnec Psy CFR(s): 483.45(c)(3)	chotropic Meds/PRN Use	F 75	i F758 Specific Corrective Action 1 1. The corrective action for this	1
	affects brain activities processes and behave but are not limited to, categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic	hotropic drug is any drug that s associated with mental dor. These drugs include, drugs in the following ensive assessment of a		<ul> <li>alleged deficient practice was an art to ensure an AIMs assessment has been completed for all residents affected by this alleged deficient practice. Side-effect monitoring was put in place for all affected resident and care plans reviewed and updat as needed for all residents affected this alleged deficient practice.</li> <li>Residents #5, #9, and #25 continue reside at the facility and had no ill effecte from this alleged deficient practices.</li> </ul>	s s æd lby
	psychotropic drugs a unless the medication	ents who have not used re not given these drugs n is necessary to treat a diagnosed and documented	- - 	2. To identify other potential deficie practice, all residents receiving a psychotropic medication are at risk this alleged deficient practice.	

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Facility ID: 475030

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	F DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIP	OMB NO. 0938-03 (X3) DATE SURVEY		
	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED	
					l c	
475		475030	B. WING		08/15/20	0.04
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP		JZĄ
	WIDER OR OUT FLIER			96 STARR FARM RD		
ELDERWO	OD AT BURLINGTON					
				BURLINGTON, VT 05408		
(X4) D		TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL		PROVIDER'S PLAN O		(X8) VPLETICH
PREFIX TAG	<b>1</b>	LSC IDENTIFYING INFORMATION)	PREFOX TAG	CROSS-REFERENCED TO		DATE
		_	1	DEFICIEN	NCY)	
			1			
F 758	Continued From pag	je 18	j F 75	F758 continued		
	§483.45(e)(2) Resid	ents who use psychotropic				
		al dose reductions, and	1	3. Providers will be e		
	behavioral interventi			appropriate use of pa		
1		n effort to discontinue these	1	medications. Nursing		
	drugs;		1	educated on side effe	ect monitoring of	
			1	psychotropics		
	§483.45(e)(3) Resid	ents do not receive				
		oursuant to a PRN order	1	4. The corrective act	ion will be	
		on is necessary to treat a		monitored through w	eekly audit x4	
1		ondition that is documented	4	weeks and then mon	thly x2 months to	
	in the clinical record;		1	ensure substantial co	ompliance is	
			1	maintained. The DOI		
	§483.45(e)(4) PRN (	orders for psychotropic drugs		be responsible for th	is corrective	
		s. Except as provided in		action. Audits will be		
		attending physician or		QAPI for further revie		
	prescribing practition			recommendations		
		RN order to be extended	1	1		
	•• •	or she should document their	1	Date of completion: (	19/27/24	
	• • •	ent's medical record and	1		1	
	indicate the duration	for the PRN order.	12	t	1	
	1			Tag F 758 POC acce	pted on 9/23/24 by	
	§483.45(e)(5) PRN (	orders for anti-psychotic		S. Stem/P. Cota	1	
:		14 days and cannot be		1	ĩ	
		attending physician or			•	
		ner evaluates the resident for		1		
	the appropriateness		1	29.0	1	
		T is not met as evidenced		1		
	by:		2			
		on, record review and	1	I		
		failed to monitor 3 out 3				
		or the adverse side effects		1		
	•	olc medications (Resident's				
	#5, #9, and #10). Fir		*			
	(4) D	- D14440		l I		
		w Resident #9 was admitted	1	İ	1	
		Include Alzheimer's, dementia	į			
		irbances. S/He has the			£	
		orders written by the		i		
	Advance Registered	Practice Nurse (APRN):	1			

Facility ID: 475030

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		ID HUMAN SERVICES				PRINTED: 09/05/2024 FORM APPROVED OMB NO. 0938-0391
STATEMENT O	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) ML A. BUILI	ILTIPLE CONSTRUCTION	N	(X3) DATE SURVEY COMPLETED
		475039	8. WIN	3		C
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS	S, CITY, STATE, ZIP CODE	08/15/2024
				98 STARR FARM	RD	
ELDERWO	OD AT BURLINGTON			BURLINGTON,	VT 05408	
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	l c	) Í Pf	ROVIDER'S PLAN OF CORRECTION	N (205)
PREFIX TAG	•	Y MUST BE PRICEDED BY FULL LSC IDENTIFYING INFORMATION)	PRE TA		CH CORRECTIVE ACTION SHOULD S-REFERENCED TO THE APPROPR	
				1	DEFICIENCY)	
			1	1		
F 758			F	758		
		t 2 milligrams (mg) give one				
	•	mes a day for agitation,		î		
3		o treat schizophrenia)		2		i
	(Schizophrenia is a so	how people think, feel and				
1		2024), Lorazepam oral		ł		j –
		ablet by mouth at bedtime				
3		oral tablet 5 mg give one		î		
2		moming for agilization and				i
		n the evening for behaviors.	10			1
	(Zyprexa is an antips)	ychotic used to treat				
1		lanufacturers warning for		1		3
		am, and Zyprexa, all have		I.		i i
	the significant side ef			ा. इ.		
	<sup>1</sup> drowsiness/sleepines	s. (Drugs.com, 2024).		£		:
	There is no document	ted evidence that Resident	T	5		1
		adverse effects prior to	1			
		ation. Per review of the	i	L		4
		ministration record Resident		£		
	#9 received schedule	d doses of his/her	i			
	medication including	antipsychotics for the	1			
	months of July and A	ugust 2024.	1.09	·		
	Destaudurstans-					ß
	, i i i i i i i i i i i i i i i i i i i	n of Resident #9 in his/her	i	f.		
		) AM on 08/13/2024, s/he n his/her bed in the same	1	I.		
		During observation this	0.0	2		
	0 •	sident #9's door several	5 <b>1</b> .5	1		
		d attempt to speak on one	385	2		
	<sup>1</sup> occasion but was not	able to or stay awake.	5 <b>4</b> (			
	i Destato					
		Nursing Assistant #1 (LNA)				1
5	at 4:45 PM on 08/13/	2024 s/ne stated that 5 sleepy, often sleeps				
		itatied when Resident #9 is	343 34	ĸ		1
	awake she frequently			×		
	andro ono noquotiny		3•0			
	Per further record rev	iew of Resident #9's	1	•		1
FORM CMS-258	7(02-99) Previous Versions Obs	ciele Evert ID; DLD	Jt1	Facility ID: 475030	If cant	inuation sheet Page 20 of 23

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DEPARTI	FORM APPROVE				
	<u>S FUR MEDICARE &amp;</u> DF DEFICIENCIES	MÉDICAID SERVICES	(X2) MULTIPLE C		OMB NO. 0938-035 (X3) DATE SURVEY
		IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED
		475030	B. WING	· · · · · · · · · · · · · · · · · · ·	C 08/16/2024
NAME OF P	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP	
			38	STARR FARM RD	
ELDERWO	DOD AT BURLINGTON		BU	RLINGTON, VT 05408	
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	Ð	PROVIDER'S PLAN OF	CORRECTION (23)
PRÉFIX TAG		Y MUST BE PRIFCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE DATE DATE
F 758	Continued From page	a 20	F 758		l.
			: 100		1
		2/09/2024, 03/08/2024, and			
8	08/02/2024 the psychiatry notes document in their				4
		#9 complained to the	1		1
		of being more tired. However,			
			i I		1
5	, there is no evidence in the medical record that providers were notified, or that symptoms were		i i		i
	monitored or address				ļ
	According to the medical record for Resident #9		1 1		i
					T
		to psychiatric facility for			
		nent on 05/24/2024 and			2ª 1
		y on 05/25/2024. According			
	•	on 05/26/2024 "Primary Chief			
		ggressive Behavior History	1, 4 1		
		io LTC resident of EW at or a psych evaluation for	1 1		1
	_	haloperidol and quetlapine	1 1		.1.
		r note ineffectiveness and	1 1		1
	Abilify was started. P		c Į		
		tions in hydromorphone.			
		sed by 2.5mg every 4-5 days			
		y per recommendation			
		cal record, there is no			
		e that recomendatinos were			:
	*	nt #9 was restarted on	1 1		
	antipsychotic medica		ļ I		
	2. Resident #5 hee #	ne following orders written by	i		1
		12/20/2023, "RisperiDONE	i		1
		ablet by mouth every	. 1		
		me for agitation/behaviors."			
		nted evidence in his/her			191
		cumentation that s/he was			(2)
		side effects or adverse	8 8		
	•	o documented evidence that	1 1		** *1
		luated for adverse effects	! .		16
		dministration of psychotropic	¥:		
		rting medication 12/20/2023.			
RM CMS-266	37(02-99) Previous Versions Ob	solde Event ID: DLD.	j11 Faci	Ity ID: 478030	If continuation sheet Page 21 of

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PRINTED: 09/05/2024 FORM APPROVED OMB NO. 0938-0391

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	(X2) MULTE A. BUTUDIN	PLE CONSTRUCTION		(X3) DATE SURVEY
		475030	B. WING	h	•	C 08/15/2024
NAME OF PE	ROMDER OR SUPPLIER			STREET ADDRESS, CITY, STA	TE, ZIP CODE	
ELDERWO	OOD AT BURLINGTON			98 STARR FARM RD BURLINGTON, VT 05408		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENCE	PLAN OF CORRECTION TIVE ACTION SHOULD B CED TO THE APPROPRIA EFICIENCY)	
F 758	Continued From page	21	F 7	58		
	Oral Tablet 0.5 MG (L mouth four times a da Tablet 100 MG (Serth mouth in the morning tabs=200mg." There in the medical record she/he was monitored medication administra of an IDT meeting or medical record. Per the Facility policy revised 05/16/2023 " that those residents p drugs will receive only doses and for the dur treat the resident's as o Monitoring the effici consequences o Preventing, identify adverse consequence drugs." Per interview with the on 8/14/2024 at 9:15/ expectation that each psychotropic medicat interdisciplinary team comprehensive care for side effects related medications and they with the Director of N	on by APRN "LORazepam orazepam) Give 0.75 mg by ay for Anxiety, Zoloft Oral aline HCI) Give 2 tablet by for Depression 2 is no documented evidence of an assessment in that d for adverse effects prior to ation. There is no evidence quarterly AIMS in his/her titled "Psychotropic Drugs" it is the policy of this facility rescribed psychotropic y those medications, in ation clinically indicated to sessed condition acy and aciverse ing, and responding to as related to psychotropic Oirector of Nursing (DON) AM s/he stated it is the resident receiving ions would have an meeting and a plan that includes monitoring d to use of psychotropic don't. Follow up interview ursing on 08/15/2024 at				
	evidence of monitorin	here was no documented g for Residents #5, #9, and	ţ			
	#10 for adverse effec			 	<b>10</b>	
r Untern UMIQ+230	7(02-99) Previous Versions Obs			Fecility ID; 475030		uation sheet Page 22 of 23

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED C	
		475030	B. WING			
NAME OF PROVIDER OR SUPPLIER ELDERWOOD AT BURLINGTON			98	IREET ADDRESS, CITY, STATE, ZIP CODE Is starr farm RD URLINGTON, VT 05408	08/15/2024	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFORENCED TO THE APPROPS DEFICIENCY)	BE COMPLETIO	
F 758	Continued From page	ə 22	F 758		1	
3	medications.		1		1	
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## PRINTED: 09/05/2024 FORM APPROVED

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION DENTERCATION NUMBER: 476030		(X1) PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	•	(X3) DATE SURVEY COMPLETED	
		476030	B. WING		C 08/15/2024	
IAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, ST/	ATE, 27P CODE	-	
		98 STARR	FARM RD			
	DOD AT BURLINGTON	BURLINGT	FON, VT 05404	8		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEPICIENCIES CY MUST BE PRECEDED BY FULL LSC (DENTIFYING INFORMATION)	id Priefix Tag	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		
\$320 \$\$ <b>¤</b> F	7.13 (d)(1) QUALITY LEVELS	OF CARE - STAFFING	S320	S320 Specific Corrective Action		
	T 40 4044 TI - 6			1. What corrective action will be		
		ty shall maintain staffing		accomplished for those residents		
	levels adequate to m	ieet resident needs.		found to have been affected by the		
	at Ataminimum nu	rsing homes must provide:		deficient practice; The daily PPD	for	
		ang nomes must provide.		the last 30 days was reviewed to	1	
	i. no fewer than thre	e (3) hours of direct care per		ensure that the PPD was not less	<b>i</b>	
	resident per day, on a weekly average, including			than 2.0 for LNA hours	1	
	nursing care, personal care and restorative					
	nursing care, but not	t including administration or		2.To identify other potentially alle	and 1	
	supervision of staff;	and		deficient practice, a daily audit wi		
				completed for the last 30 days to		
	ii. of the three hours of direct care, no fewer than			review the daily LNA PPD hours.		
	two (2) hours per resident per day must be , assigned to provide standard LNA care (such as			residents have the potential to be		
I		tance with ambulation,		affected.	I.	
		ned by LNAs or equivalent			1	
		ng meal preparation, physical				
	therapy or the activit			3.To ensure this alleged deficient		
1	i i i i i i i i i i i i i i i i i i i	. •		practice does not continue, a dail		
	I			PPD call has been started effecti		
'				August 19, 2024 to review staffin		
ŝ		T is not met as evidenced		needs and implement strategies and implement s		
	by:	•		2.0 for LNA and overall PPD of 3		
		niew and record review, the		An audit of the daily PPD will be	.0.	
		tain the required minimum w for 2.0 hours of direct care		completed daily. Supplemented	·	
	•	(PPD) on a weekly average		staffing and shifting of responsibil	lities	
		Assistants (LNAs) for 1 of 8		to areas of need will be implement		
	sampled weeks. Find			when indicated. (i.e. Nurses wor		
	·	•		as LNAs, therapist providing ADL		
		the daily nursing hours		care). Recruitment of staff will		
		eduler, the hours of direct		continue with weekly recruitment	and	
		r day by LNA staff fell below		retention IDT meetings.		
	•	per day minimum for the		The facility will recruit staff as ne		
		24 by averaging 1.89 hours of ent. On 8/13/24 at 10:08 AM,		to maintain LNA staffing levels of		
	•	med that the PPD was below	9	less than 2.0 with an overall 3.0 I	~PU	
	1	On 8/13/24 at 5:06 PM, the		daily.	1	
sion of Lic	ensing and Protection			al an an an an an an an an an an an an an		
ORATORY	DIRECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNATURE			(X8) DATE	
V-V	9111/4/24	RAL		(Link)	(9 17 dz	

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## PRINTED: 09/05/2024 FORM APPROVED

Division of Licensing and Protection STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION 478030			CONSTRUCTION QC	(X3) DATE SURVEY COMPLETED				
			A. BUILDING:		6			
		B. WING		C 08/15/2024				
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE								
DERWO	OD AT BURLINGTON		IR FARM RD GTON, VT 05408					
(X4) ID REFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES SY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY)	(XS) Comple Date			
<b>\$320</b>	Continued From pag		S320	S320 continued				
	Director of Nursing confirmed that the schedules and calculated PPD were eccurate.			<ul> <li>4. The corrective action will be monitored through continued daily PPD calls to include the facility administration and governing body and auditing of PPD daily x 4 weeks and then weekly x2 months to ensure substantial compliance is maintained. The DON/Designee is responsible for this corrective action. Audits will be reviewed at QAPI for further review and recommendations</li> <li>Date of Compliance 09/27/2024</li> </ul>				
1				Tag S 320 POC accepted on 9/23/ S. Stem/P. Cota	24 Dy .			
1					•			
1								
					Ì			