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	03/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elderwood at Burlington	98 Starr Farm Rd Burlington, VT 05408

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0622 Level of Harm - Potential for minimal harm Residents Affected - Many	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. 46135 Based on interview and record review, the facility failed to ensure that when a transfer and/or discharge of a resident was necessary, the physician's documentation in the medical record specified the needs of the resident that could not be met, attempts to meet the needs, and the service available at the receiving facility for 4 applicable residents (Resident #1, #2, #3, and #4). Findings include: Record review reveals that Resident #1 was acutely transferred from the facility to the hospital on 2/16/23, Resident #2 acutely transferred from the facility to the hospital on 12/27/22, Resident #3 was acutely transferred from the facility to the hospital on 2/21/2023, and Resident #4 was acutely transferred from an appointment to the hospital on 1/9/2023. There was no evidence in the above residents' medical records that their physician documented the specific needs that the facility could not meet, the facility efforts to meet those needs, and the specific services the receiving facility would provide to meet the needs of the residents' which could not be met at the current facility. On 3/17/2023 at 2:41 PM, the Director of Nursing confirmed that Resident #1, #2, #3, and #4's physician did not document the required information about their transfer in their medical record.

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Many	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 46135 Based on staff interviews and record review the facility failed to notify the resident and/or resident's representative in writing of a transfer/discharge; and send a copy of the notice to the Ombudsman (public official appointed to investigate complaints people make against government and/or public organizations) for 4 applicable residents (Resident #1, #2, #3, and #4). Findings include: Record review reveals that Resident #1 was acutely transferred from the facility to the hospital on 2/16/23, Resident #2 acutely transferred from the facility to the hospital on 12/27/22, Resident #3 was acutely transferred from the facility to the hospital on 2/21/2023, and Resident #4 was acutely transferred from an appointment to the hospital on 1/9/2023. Residents #1, #2, #3, and #4 do not have social service progress notes about the emergency transfers to the hospital in their medical record and there is no evidence that these residents and/or representatives were provided a notice of transfer. Facility policy titled Discharge Planning and Notice of Discharge/Transfer Policy, last revised on 2/13/2019 states: Following notification of an emergency discharge or planned transfer/discharge, the director of social services/designee sends to the responsible party a notice of transfer/discharge. A copy is kept on file in the social services department. In the event the social worker is unavailable to complete the Notice of Transfer/Discharge form, a licensed nurse will prepare the form and provide a copy for the responsible party. The original is given to the director of social services/unit social worker. The facility will send a copy of the notice to a representative of the Office of the State Long Term Ombudsman with every transfer or discharge. The unit social worker enters a summary note in the Social Services Progress Notes in the resident's medical record that includes the name of the hospital, reason for hospitalization , and whether the bed is on reserve at this facility. On 3/17/2023 at approximately 2:45 PM, the Director of Nursing stated that the facility policy did not address emergency transfers requirement clearly and transfer notices were not being sent to residents, their representatives, or the state Long Term Ombudsman when residents were sent out on emergency transfer to the hospital. S/He confirmed that Residents #1, #2, #3, and #4 did not receive written transfer notices when being sent to the hospital.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46135 Per interview and record review, the facility failed to provide treatment to an existing pressure injury for 3 applicable residents [Residents #1, #2 and #4] consistent with facility policy and professional standards of practice. Facility policy titled Skin Conditions, Wounds and Pressure Ulcers (Assessment and Monitoring Program), last modified on 2/3/2023 states Identified skin conditions and/or wounds will be reassessed weekly by a registered nurse until the presence of the condition is resolved, and The medical provider will review and assess the progress of skin conditions and/or wounds during required visits, or when necessary, and document in the medical record. 1. Record review reveals Resident #4 was readmitted to the facility with diagnoses that include congestive heart failure, end stage renal disease (ESRD), type 2 diabetes, history of spinal fusion, emphysema, and need for assistance with personal care on 9/14/22 following a hospital stay related to septic shock and pneumonia. Resident #4's care plan includes the following care plan focus: Skin integrity: I [Resident #4] am at risk for impaired skin integrity related to Activity Intolerance, Deconditioning, Immobility, actual skin breakdown r/t [related to] decline in status/refusal of repositioning 9/6/22, initiated on 6/13/2022. Interventions include conduct systemic skin inspections weekly and as needed. Document findings, initiated on 07/26/2022, and monitor skin condition daily and report any signs of skin breakdown, initiated on 06/13/2022. Review of Resident #4's wound evaluations on 11/23/2022 reveal a stage 2 pressure ulcer [partial-thickness skin loss with exposed dermis] on the right ischial tuberosity [sit bone located in the buttock] measuring 1.1 cm x 0.5 cm and an abscess on the spine [surface intact] measuring 1.9 cm x 0.6 cm. Resident #4's Minimum Data Set (MDS; a comprehensive assessment used as a care-planning tool), dated 12/3/2022, reveals that Resident #4 is at risk for developing pressure ulcers/injuries and has one stage 2 pressure ulcer. Review of Resident #4's wound evaluations on 12/6/2022 reveal a stage 2 pressure ulcer on the right ischial tuberosity measuring 2.5 cm x 1.3 cm. There are no additional wounds identified during this evaluation. There are no wound evaluations for Resident #4 from 12/7/2022 through 1/5/2023. Review of Resident #4's wound evaluations on 1/6/2023 reveal a stage 2 pressure ulcer on the right buttock measuring 2.5 cm x 1.3 cm, a stage 2 pressure ulcer on the left buttock measuring 5.1 cm x 2.6 cm, and a stage 2 pressure ulcer on the left buttock measuring 3.9 cm x 3.3 cm. Resident #4's discharge MDS, dated [DATE], reveals that Resident #4 has one stage 2 pressure ulcer, one stage 3 pressure ulcer [full thickness skin loss], and one stage 4 pressure ulcer [full thickness skin and tissue loss]. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	There is no evidence in Resident #4's medical record that the provider was notified of the worsening and/or developing of Resident #4's pressure ulcers and no documentation that the medical provider reviewed and assessed Resident #4's skin condition and/or wounds. Review of Resident #4's physician's orders reveal the following: Cleanse right ischial tuberosity wound with NSS [normal saline solution], pat dry, cover with Allevyn foam [foam dressing] every shift for skin condition start date 11/26/22. There are no treatment orders for the other two identified pressure ulcers from readmission on 11/23/2022 through hospital transfer on 1/9/2023, or evidence that wound care was completed. A hospital note dated 1/10/2023 states that Resident #4 is found to be in likely septic shock from acute [and] chronic SSTI [skin and soft tissue infections] of [his/her] back/buttocks in setting of baseline chronic hypotension. The provider note reveals the following about Resident #4's clinical condition: Over the past 24 hours, there has been a high probability of sudden, clinically significant or life threatening deterioration in the patient's condition, which include the following diagnoses which I have managed: Active problems: ESRD, septic shock, decubitus skin ulcer [bedsore], wound infection complicating hardware, sequela, delirium. 2. Record review reveals Resident #2 was admitted to the facility on [DATE] with diagnosis that include end stage renal disease, chronic pressure ulcers, type 2 diabetes, osteomyelitis [bone infection], history of MRSA [Methicillin-resistant Staphylococcus aureus; antibiotic resistant infection] infection, paraplegia, and need for assistance with personal care. A 12/14/2023 provider note reveals that Resident #2 is complaining of heel wounds. The provider exam reveals a left heel PU [pressure ulcer] and left lateral distal foot PU noted and significant. These notes also reveal additional known pressure ulcers and a recent wound infection. Review of Resident #2's wound evaluations show the last wound evaluations for December 2022 were completed on 12/14/2022. There are multiple entries in the SWIFT system [wound photograph evaluation documentation system] prior to 12/14/2022. These entries are not labeled, and some wounds are tracked on multiple wound assessment entries. There is no way to accurately determine a comprehensive report of Resident #2's skin based on review of the SWIFT evaluations and there is no comprehensive skin evaluation documentation in Resident #2's medical record. Physician orders reveal that Resident #2 was being treated for skin injuries of the left heel, coccyx, left thigh, and right shin in December 2022. The treatment administration record reveals the following order: skin examination report to RN and document in Medical Record if new skin condition is identified every day shift every Tuesday start date 10/25/2022. The treatment record reveals that Resident #2's skin assessment was not completed between 12/14/2022 and 12/27/2022 as ordered. A 12/27/2023 progress note reveals that Resident #2 was transferred to the hospital due to showing signs of sepsis. There is no documentation of the condition of his/her skin at this time. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A 1/26/2023 transfer of care note from the hospital reveals that Resident #2 was admitted to the hospital on 12/27/2022 related to heel ulcers and ultimately septic shock. The provider writes that Resident #2 presented from the facility with AMS [altered mental status] and fever. In the ED [s/he] was found to have worse LE [left extremity] ulcers and a known sacral ulcer. Orthopedics evaluated the patient with concerns for osteomyelitis due to bedside debridement with probing to bone of his L [left] calcaneus [heel bone] . was started on cefepime and vancomycin for osteomyelitis causing septic shock and was admitted to the MICU. 3. Record review reveals Resident #1 was admitted to the facility on [DATE] with diagnoses that included complete paraplegia [paralysis of the legs and lower body], type 2 diabetes, morbid obesity, and a bed confinement status. Resident #1's care plan includes the following care plan focus: Skin integrity: I [Resident #1] am at risk for impaired skin integrity related to 5 (or more) medications, DM [diabetes], cardiac disease, paralysis, Immobility and an ostomy [surgical opening in the abdomen to allow stool to exit the body], initiated on 4/27/2021 with an intervention to monitor skin condition weekly and report any signs of skin breakdown, initiated on 4/27/2021. Resident #1's care plan does not address an actual wound until 1/25/2023. Review of Resident #1's wound evaluations on 12/14/2022 reveal a stage 2 pressure ulcer on the right calf measuring 1.0 cm x 0.6 cm. Resident #1's 1/27/2023 wound evaluations on reveal a stage 2 pressure ulcer on the right calf measuring 1.4 cm x 0.7 cm. There are no wound evaluations for this wound from 12/15/2022 through 1/26/2023. Review of Resident #1's physician's orders reveal the following: cleanse right calf lateral wound with NSS, pat dry, apply bacitracin and cover with Allevyn border foam every evening shift, with a start date of 11/25/2022. Resident #1's treatment administration record reveals that wound care was not documented as complete or refused for 12 days between 12/14/2022 through 1/19/2023. 4. On 3/21/2023 at approximately 3:00 PM, the Director of Nursing stated that there is no way to find comprehensive documentation of a Residents' skin injuries and/or wounds after a weekly skin assessment. Nursing staff check that it has been completed on the treatment record and any new wounds will be documented in a wound assessment. S/He stated s/he became aware of these problems in January 2023 and confirmed that the skin assessment and monitoring policy had not been followed for Residents #1, #2, and #4. Record review and interview with the Director of Nursing on 3/21/2023 at 3:30 PM reveal that the facility implemented corrective action for the above deficiencies. The facility completed a house wide audit of skin to ensure all wounds were identified and all wounds had treatment orders, hired new staff including a Registered Nurse to review wound evaluations weekly, implemented a new admission check list to ensure wound assessments were documented, and completed education with direct care staff. The facility continues to review skin and wound conditions for all residents with wounds weekly at a customer at risk meeting. Based on corrective actions completed by 2/17/2023, prior to the onsite investigation, this citation is designated as past non-compliance.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 46135 Based on interview and record review, the facility failed to keep all information in the resident's records confidential for 1 applicable resident (Resident #5). Findings include: Per interview on 3/17/23 at 3:35 PM, Resident #3's spouse reported that at the time Resident #3 was being transferred to the hospital by ambulance, s/he requested a list of medications and later discovered that s/he received Resident #5's orders instead. These records were sent to the Division of Licensing and Protection, confirming that Resident #3's spouse was given the order summary report for Resident #5 by facility staff. On 3/17/23 at approximately 2:30 PM, a Licensed Nurse confirmed that s/he handed Resident #3's spouse a list of medications, which s/he thought to be for Resident #3. On 3/17/23 at 2:42 PM the Director of Nursing stated that the unit secretary, who is responsible for giving medical records to emergency medical technicians during acute transfers, would require a request for medical records form be filled out to anyone else requesting medical information. S/He confirmed that Resident #5's medical records were not kept confidential.