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	12/07/2022

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 46442 Based on observation, resident and staff interview and medical record review the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment including injuries of unknown source and misappropriation of resident property, are reported immediately, but no later than 2 hours after the allegation is made to the appropriate State Agencies for 1 of 27 sampled residents (Resident #80). Findings include: On 12/5/22 at 1:10 pm, interview with resident #80 stated that the resident felt s/he had been abused during a shower by 2 Licensed Nursing Assistants (LNA) in September of this year. S/He indicated that s/he was handled roughly, and as a result refuses to go the shower and only will allow bed baths. On 12/5/22 at 2:30 pm, interview with facility Administrator indicates that the allegation of abuse was investigated in the facility and found that there was no evidence to support the allegation of abuse. Administrator further indicated that because the facility did not find evidence of abuse, the allegation was not reported to the appropriate state agency. On 12/5/22, review of facility policy regarding Abuse Prevention, Identification, Investigation, Protection and Reporting reveals the following: The facility Administrator or designee will report all alleged violation to state agencies immediately, but no later than 2 hours after the allegation of abuse, mistreatment and as required to all other required agencies (e.g., law enforcement, adult protective services, licensing authorities, state nurse aide registries., when applicable) within specified timeframes.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475030	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/07/2022
NAME OF PROVIDER OR SUPPLIER Elderwood at Burlington		STREET ADDRESS, CITY, STATE, ZIP CODE 98 Starr Farm Rd Burlington, VT 05408	

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46135 Based on record review and staff interviews, the facility failed to develop a baseline care plan within 48 hours of admission for 1 of 27 sampled residents [Resident #302] related to pain management and skin integrity. Findings include: Per record review, Resident #302 was admitted to the facility on [DATE] for subacute rehab with multiple orthopedic injuries and fractures following a motor vehicle accident. Review of Resident #302's care plan does not include a care area focus for pain, pain management goals, or interventions for pain management; or a care area focus for skin, skin integrity goals, or interventions to maintain/improve skin integrity. Per observation and interview on 12/5/2022 at 9:35 AM, Resident #302 reported that his/her pain is not being managed. Resident #302 reported to have a 9/10 pain level during interview and was observed moaning with a distorted face multiple times during the interview. Resident was able to reposition self in bed slightly but with increased pain. Resident #302 stated that s/he had problems with his/her skin from being in bed so much and sometimes his/her bottom is painful. Per interview on 12/07/22 at 7:40 AM, the Unit Manager [UM] stated that Resident #302 had skin break down before being admitted to the nursing facility. The UM confirmed Resident #302 should have a care plan for pain management and skin integrity. Per interview on 12/7/2022 at 8:20 AM, the Director of Nursing [DON] confirmed that Resident #302 should have a care plan for pain management and skin integrity.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 46442 Based on observation, interview and medical record review, the facility failed to ensure a care plan was implemented regarding oxygen therapy for 1 of 26 sampled residents. (Resident #1) Review of medical record for Resident # 1 reveals the resident was admitted to the facility 4/11/22 with diagnosis that included Type 2 Diabetes Mellitus (A condition that results from insufficient production of insulin causing unstable blood sugar), End stage renal disease stage 5 (the last stage of kidney disease in which the kidneys cannot function any longer, they are unable to keep up with the daily needs of the body), Renal dialysis (The process of removing waste products and excess fluid from the body. Dialysis is necessary when the kidneys are not able to adequately filter the blood). The resident had been also recently diagnosed with Heart failure (Heart failure is a chronic, progressive condition in which the heart muscle is unable to pump enough blood to meet the body's needs for blood and oxygen). Per observation of resident #1 on 12/06/22 at 09:09 AM, resident has oxygen in place via nasal cannula (The nasal cannula is a device used to deliver supplemental oxygen), at 2 liters/per minute. Medical record review for resident #1's Physician orders reveals an order for oxygen @ 2L PRN- Keep Oxygen saturation between 88-96% (Oxygen saturation is a measure of how much oxygen the blood is carrying). Review of Resident #1 care plan reveals there is no care plan in place for Oxygen therapy. Per interview with the Director of Nursing (DON) on 12/07/22 at 11:48 AM, s/he confirms that s/he would expect that resident #1 would have a care plan for oxygen therapy and that there is no care plan in place for oxygen therapy in the medical record for resident #1.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25757 Based on staff interview and record review, the facility failed to revise the care plan for 3 applicable residents (Residents # 35, #198 & #51) to reflect changing goals, preferences and needs of the residents. Findings include: 1.) Resident # 35's care plan for Activities of Daily Living (ADL) states - Personal Hygiene - Independent / Setup help only. Per Licensed Nursing Assistant (LNA) task documentation since 11/7/22 , resident # 35 has required the following assist with personal hygiene: Independent - 0 occasions; Supervision - 6 occasions; Limited assist - 9 occasions; Extensive assist - 1 occasion; Total dependence - 19 occasions. Per interview with a unit LNA familiar with Resident #35's care, the resident is not independent with personal hygiene and requires at least limited assist. On 12/6/22 at 12:33 PM, the Unit Manager confirmed that Resident #35's care plan had not been revised to reflect his/her actual personal hygiene needs. 29776 2.) Review of Res. #198's medical record revealed the resident had a history of falls and after a fall on 7/10/22, a Fall Risk Assessment was conducted. The scoring on the Fall Risk scale lists a score of 45 or higher as High Risk for falls. Res. #198's score is recorded as 100. Per review of Nurses Notes dated 9/26/22, Alerted to room via call light and Licensed Nurse Aide. Roommate signaled to make us aware that resident had fallen unto the floor. Upon entering room, [Res. #198] was seen lying on back with neck and shoulders slightly elevated against chair in room. Resident was visibly shaken .Alerted to neck and back pain via resident. Per Occupational Therapy [OT] notes dated the day after the fall [Res. #198] had a fall on 9/26/22 before midnight .This morning, [Res. #198] found seated in chair by OT yelling out and crying in pain. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's 'Prevention and Reporting of Accidents and Incidents for Residents' policy includes An Incident Report is completed immediately after the incident is discovered' and 'the Immediate Intervention to Prevent Re-occurrence is documented in the Incident Report and the Care Plan. Review of the Incident Report for Res. #198's fall on 9/26/22 under 'Immediate Action Taken' records the resident was checked for neurological issues and 'body checked for any signs of damage': there are no interventions documented to prevent re-occurrence of a fall. Review of Res. #198's Care Plan revealed the resident was identified as at risk for falls related to history of falls with fractures. Review of Care Plan interventions regarding falls revealed no new interventions added to prevent future falls after the fall on 9/26/22. Further review of Res. #198's medical record revealed that 22 days later, on 10/18/22, Res. #198 fell again. Nurses Notes record Writer heard yells of help coming from room .Entered bathroom, resident noted propped up on left side on floor, head in between rails and toilet . Behind left ear, small open area noted. Complained of lower back and left hip pain. Res. #198 was sent to the hospital and diagnosed with a fracture of pubic ramus. According to 'Medical Experts.CO.UK': Fractured pubic rami injuries are not very common, but they are very serious and can be an extremely painful experience. This is especially the case with a pubic rami fracture in elderly patients, which could be highly dangerous. (https://www.medicalexperts.co.uk/fractured-bones/fractured-pubic-rami/) Per interview with the acting Director of Nursing [DON] on 12/7/22 at 12:38 PM, the DON confirmed that there was no documentation that Res. #198's Care Plan was reviewed or revised after a fall on 9/26/22. The DON confirmed there were no new interventions added to prevent future falls, and 22 days later Res. #198 fell again, resulting in a pelvic fracture. 46135 3. Review of Resident #51's medical record revealed that the resident had been admitted to the facility on [DATE] with a Foley catheter [a tube inserted into the bladder to drain urine]. Progress notes revealed that the catheter had been removed after a visit with a Nurse Practitioner on 10/24/2022. As of 12/7/2022, Resident #51's care plan indicates that s/he still has a Foley catheter. Per interview on 12/7/2022 at 7:50 AM, the Unit Manager confirmed that Resident #51 no longer has a Foley catheter and the resident's care plan was not revised and should have been revised to reflect the change.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45667 Based on interviews, observations and record review the facility failed to ensure residents who are unable to carry out activities of daily living receive the necessary services to maintain good personal hygiene for 3 (Residents # 31, #51 & #68) of 26 sampled residents. Findings include: 1. During interview with Resident #31 on 12/5/22 at approximately 11 AM he/she stated he/she had not received a bath for two weeks. Resident #31 has diagnosis including acute pulmonary edema (excessive liquid accumulation in the tissue and air spaces of the lungs), hypertension with heart failure, acute and chronic respiratory failure. A review of Resident #31's care plan revealed he/she required limited physical assistance of one person to complete upper body hygiene and extensive physical assistance of one person to complete his/her lower body hygiene. The Task Administration Record was reviewed and revealed Resident #31 is to receive assistance with bathing in the AM and PM daily and a has a bath scheduled every Monday evening. Record review demonstrated Resident #31 had received the required assistance with a bath on 11/25/22 and not again until 12/5/22 which was an 11 day period without receiving the assistance required for a bath. This was confirmed by the Director of Nursing on 12/5/22 at 12:45 PM. 46135 2. Record review reveals that Resident #51 was admitted to the facility on [DATE] with upper and lower extremity weakness and atrophy [wasting away of a body part]. Resident #51's care plan indicates that s/he requires total dependence on staff for personal hygiene and bathing. Per interview on 12/6/2022 at 8:10 AM, Resident #51 stated that s/he was upset because s/he is not getting showered regularly. S/he said that staff will tell her/him that they will shower him/her but most of the time they don't follow through with it. Resident #51's spouse stated that s/he had asked staff for 8 days straight for his/her spouse to be showered and it wasn't until the eighth night at midnight that Resident #51 was finally showered. Review of Licensed Nursing Aide (LNA) task documentation and progress notes since Resident #51 was admitted on [DATE] reveal only two days that Resident #51 was showered: 11/22/2022 and 12/6/2022. Per interview on 12/7/2022 at 7:50 AM, the Unit Manager [UM] stated that Resident #51 was on the showering schedule and can receive a shower anytime they request one. The UM confirmed that there was no documentation that Resident #51 was being showered regularly. Per review of the shower schedule for the unit, Resident #51 is scheduled to receive showers on Fridays. Per interview on 11/7/2022 at 1:36 PM, an LNA stated that they try to follow shower schedules as best they can but sometimes they do not always get all the showers done because sometimes they do not have enough staff. 46544 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Per interview on 12/05/22 at 3:00 PM, Resident #68's representative stated that this resident appears poorly groomed with greasy hair. S/he is concerned that Resident #68 is not being provided with showers twice weekly according to the resident's care plan and that this resident is receiving only sponge baths. Review of Resident #68's care plan reveals showers are scheduled to be provided on Tuesday evenings, Saturday mornings, and as needed. Resident requires total assistance with showers and grooming per resident record. Review of October and November's Intervention and Task sheets indicates showers were provided twice in November on the 3rd and 22nd. One shower was provided for the month of October on the 24th. There is no documentation in the resident's record to indicate refusal of showers and there is no evidence that this resident was unavailable for showers for any reason. Per interview with the Director of Nursing (DNS) on 12/06/22 at 3:10 PM, the DNS confirms showers should be provided according to the care plan on Tuesday evenings and Saturday mornings, and they were provided only once in October and twice in November.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. 46544 Based on observations, interviews, and record review the facility failed to provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community, for 2 residents (Resident #68 and Resident #86) of 26 sampled residents. Findings include: #1) Per interview on 12/05/22 at 3:00 PM, Resident #68's representative stated this resident is often in the resident room when s/he visits, and this resident does not seem to be included in group activities or engaged in one-on-one activities in accordance with the resident's choices. The resident representative stated concern that this resident may be isolated too much and even the simplest of enjoyable activities preferred by the resident, such as music playing in the room, does not seem to happen. Observations were made of resident #68 over the course of three days on December 5th, 6th, and 7th of 2022 at different times of the day. Resident #68 was observed outside of the resident room once in this timeframe. On December 06 resident #68 was observed sitting in one of the unit's common areas interacting with a private duty caregiver who is provided to the resident by the family; this caregiver is not facility staff. There were two other residents putting a puzzle together at a table in the common area. There was no group activity happening at that time in the common area. Music was playing in the resident's room on 12/07 in the afternoon, prior to that there was no music playing in the resident's room at the time of observations. There is a radio on the resident's bedside nightstand. Nursing staff were observed in the resident's room only at mealtimes and when providing care, but no one-on-one activities were observed. Review of the resident's care plan indicates that this resident enjoys many activities to include low stimulus group activities, holiday parties, happy hour, socials, listening to music of many types, nature topics, comfort animals, everyday events and listening to others talk. Review of the resident's activity offerings and attendance according to the Resident Program Detail sheets show that Resident #68 was included in activities for the month of October for a total of 5 times, on the 2nd, 11th, 18th, 24th, and 28th. This resident attended one activity in November on the 22nd. There were no documented refusals of activities. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	#2) Per resident interview on 12/05/22 at 2:00 PM, Resident #86 stated that s/he is frustrated and bored because s/he has been kept in the resident room for days. Resident #86 stated that s/he wants to attend activities but has not been allowed to because the roommate of this resident was quarantined. S/he stated staff come in the room only to deliver food or provide personal care. This resident stated enjoyment in many activities, to include bingo especially, but states staff has not offered activities of any kind either inside or outside of the room. Resident #86 stated s/he is going a little stir crazy. This resident also offered to wear a mask outside of the room if asked, though the resident states s/he has no symptoms or diagnosis of illness. During observations over the course of three days on December 5th, 6th, and 7th of 2022 at different times of the day, this resident was not engaged in activities either in or outside of the resident's room. Record review of the resident's care plan includes a wide variety of activity preferences to include social gatherings, art programs, cognitive and educational programs and games, a variety of music, trivia games and reading the newspaper. Resident Program Detail sheets show that Resident #86 has had no activities offered to date for the month of December. November records show 8 activities were provided in total on the dates of the 11th, 16th, twice on the 18th, once on the 21st, 23rd, 24th, and 25th. October shows 5 activities were provided on the 11th, 19th, twice on the 24th, and once on the 31st. No refusals were documented in the records. Per interview with the Director of Nursing (DNS) on 12/06/22 at 3:50 pm, the DNS confirmed that Resident #86 and Resident #68 should have been offered activities in accordance with the resident's care plans and that this had not been done as evidenced by the Resident Program Detail sheets, and refusals would be documented on the detail sheets if they occurred. The DNS stated there is no facility policy requiring that Resident #86 should have been required to stay in the resident room regardless of the roommate's need for isolation.

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 25757 Based on staff interview and record review, facility staff failed to ensure that 3 applicable residents (Resident # 35, Resident #16, & Resident #198) received treatment and care in accordance with professional standards of practice. Findings include: Facility staff did not document the provision of care for Resident # 35's Foley catheter as ordered by the physician. There is a physician order dated 8/1/22 for urinary Foley catheter care every shift for infection control and as needed. Per review of the Treatment Record (TAR), catheter care was not documented as done on 7 occasions in October 2022 and on 7 occasions in November 2022. There is a physician order for urinary output - verify documentation and notify provider if output is less than 100 ml (milliliter) per shift every shift for output. Review of the TAR indicates that urinary output was not documented as done on 25 occasions in October and 23 occasions in November 2022. The above was confirmed by the Unit Manager on 12/6/22 at 3:36 PM. 45667 2.) Resident #16 required emergent care related to having the retention balloon of the Foley catheter overfilled. Per record review Resident #16 has diagnosis including unspecified dementia and neuromuscular dysfunction of the bladder requiring the use of a Foley catheter. A Foley catheter is a semi-rigid but flexible tube used to drain the bladder while blocking the urethra. A practitioner inserts the catheter through the urethra to the bladder then inflates the circumferential collar (located at the tip of the catheter) called the retention balloon to keep the catheter from being expelled. On 11/12/22 it was noted that Resident #16 had bloody urine in the Foley catheter collection bag. Two nurses attempted to remove the catheter to change it but due to resistance they were unable to remove it, per instructions from the physician Resident #16 was sent to the emergency room . The emergency department notes stated, There was resistance to deflating the catheter balloon, but with some pressure and patience it was able to start being emptied. Shockingly, there ended up being over 90 cc of water in the balloon. Once this was fully emptied, the catheter was able to be removed. New catheter was placed, and urine analysis did show evidence of infection. This could have contributed to the dysfunction, though the large amount of fluid in the balloon certainly was part of the issue. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Facility procedure protocol entitled Catheterization, Insertion of Indwelling Catheter for [gender removed] Residents with an approval date of 01/23/2018 reviewed. Step 15 states .insert catheter an additional 1 to 2 inches beyond the point at which urine began to flow and inflate balloon lumen of catheter with sterile water. USE WATER AMOUNT SPECIFIED IN PHYSICIANS'S ORDER. Step 23 states Nurse: Document required or pertinent information in appropriate records, and consult immediate supervisor, if necessary. DOCUMENT SIZE OF CATHETER, CONDITION OF GENITAL AREA, TYPE OF DRAINAGE SYSTEM. NOTE AMOUNT, COLOR AND ODOR OF URINE. Per record review Resident #16 had the following provider order: 16 French (#16 refers to the size of the catheter to be used) to gravity for neurogenic bladder, change monthly for maintenance, bladder scan if UOP (urinary output) < 200 cc, notify provider if residual =/> 200 cc or if UOP <100 cc. It is noted the order does not contain an amount of water to be used to inflate the balloon. Further record review revealed there was no documentation from the nurse as required by the facility's written procedure protocol. On December 7, 2022, at approximately 2 PM a facility #16 French foley catheter and catheter insertion kit was requested for viewing, the RN Supervisor provided the requested catheter and confirmed this was the type used throughout the facility. In addition to being marked with 16 Fr (#16 French) it was also marked 30mL/cc which indicates how much fluid the retention balloon should be filled with. The contents of the insertion kit were viewed a syringe prefilled with 30 mL/cc was included in the kit to be used when inflating the retention balloon. Without a complete Provider order and with the lack of nursing documentation the standard of care as outlined in the Facility Procedure Protocol was not met resulting in an emergent transport of Resident #16. 3.) Review of Res. #198's medical record revealed on 7/10/22 the resident suffered a fall at 4:55 PM. The next morning, on 7/11/22, Nursing Notes record Resident complaining of aching right hip pain, 10/10 [on a scale of 0 to 10, 0= no pain, 10 = worst pain] . Resident unable to stand on her right leg due to her right hip pain. She did not want to attempt range of motion with writer because it hurts too much. Nursing Notes later the same day record Resident was seen by Nurse Practioner status post fall related to nursing reports of right hip pain and decreased ability to bear weight on right side. New order received and entered to obtain x-ray 2 views of right hip and pelvis. Further review of Nurses Notes reveal no further notes regarding the ordered x-ray for Res. #198's hip pain on 7/11, 7/12, and 7/13/22. Review of orders for Trident Care, the facility's Radiology service, reveal an order for a radiology exam dated 7/14/22, 3 days after the Nurse Practioner order for an x-ray was entered. A notation on the Trident Care order reads not done. Nurses Notes on 7/14/22 record Writer spoke with Nurse Practioner to update on resident status .Order received to send to emergency room for evaluation and treatment if unable to obtain right hip x-ray today related to decreased ability to bear weight status post fall. Review of Res. #198's medical record regarding the emergency room visit reveals the resident was diagnosed with 'a closed, non-displaced greater trochanteric fracture' [bony protrusion on the femur (thighbone)]. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	An interview was conducted with the acting Director of Nursing [DON] on 12/7/22 at 12:38 PM. The DON confirmed there was no documentation regarding why the x-ray ordered on 7/11/22 was not completed for 3 days until the resident was sent to the Emergency Department, and no documentation that the Nurse Practioner was notified that the x-ray was not completed as ordered for 3 days after the order was written.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475030	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/07/2022
NAME OF PROVIDER OR SUPPLIER Elderwood at Burlington		STREET ADDRESS, CITY, STATE, ZIP CODE 98 Starr Farm Rd Burlington, VT 05408	

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F 0690 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45667 Based on interview and record review the facility failed to properly manage the care of a Foley catheter for one applicable resident (Resident #16). Resident #16 is an [AGE] year old person with diagnosis including unspecified dementia and neuromuscular dysfunction of the bladder requiring the use of a Foley catheter. A Foley catheter is a semi-rigid but flexible tube used to drain the bladder while blocking the urethra. A practitioner inserts the catheter through the urethra to the bladder then inflates the circumferential collar (located at the tip of the catheter) called the retention balloon to keep the catheter from being expelled. Physician orders include an order to flush the catheter twice daily with 120 cc of normal saline to maintain patency and prevent urine related debris from collecting and resulting in a blockage. A Foley catheter has two ports that are accessable to the practitioner. One port is used to inflate the balloon with water using the syringe provided in the catheritization kit, the other port is to be used to irrigate the catheter. The irrigant is pushed via a syringe into the specified port, the irrigant then drains into the collection bag along with the urine being drained from the bladder. On 11/12/22 Resident #16 was emergently sent to the hospital after two facility nurses were unable to remove the catheter for replacement. The emergency department notes stated, There was resistance to deflating the catheter balloon, but with some pressure and patience it was able to start being emptied. Shockingly, there ended up being over 90 cc of water in the balloon. Once this was fully emptied, the catheter was able to be removed. New catheter was placed, and urine analysis did show evidence of infection. This could have contributed to the dysfunction, though the large amount of fluid in the balloon certainly was part of the issue. Per record review Resident #16 had the following provider order: 16 French (#16 refers to the size of the catheter to be used) to gravity for neurogenic bladder, change monthly for maintenance, bladder scan if UOP (urinary output) < 200 cc, notify provider if residual =/> 200 cc or if UOP <100 cc. It is noted the order does not contain an amount of water to be used to inflate the balloon. Further record review revealed there was no documentation from the nurse as required by the facility's written procedure protocol. On December 7, 2022, at approximately 2 PM a facility #16 French foley catheter and catheter insertion kit was requested for viewing, the RN Supervisor provided the requested catheter and confirmed this was the type used throughout the facility. In addition to being marked with 16 Fr (#16 French) it was also marked 30mL/cc which indicates how much fluid the retention balloon should be filled with. The contents of the insertion kit were viewed a syringe prefilled with 30 mL/cc was included in the kit to be used when inflating the retention balloon. On 12/7/22 at 12:10 PM the DON confirmed knowledge of this event and revealed it was suspected that someone had attempted to flush the catheter using the incorrect access port resulting in the balloon being significantly overfilled. Refer also to F684.

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

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45667 Based on observation, interview and record review the facility failed to ensure 1 applicable resident (Resident #31) received respiratory care as ordered by a physician. Resident #31 was not provided supplemental oxygen per physician orders. Resident #31 is a [AGE] year old person with diagnosis including acute pulmonary edema (excessive accumulation of liquid in the tissue and air spaces of the lungs) with acute and chronic respiratory failure. Resident #31 receives supplemental oxygen of 3 liters per minute via nasal cannula per physician orders. On 12/2/22 the following order was written: Check 02 tank (TO BE FULL) on back of chair when in day room (MUST HAVE). On 12/6/22 Resident #31 was in the day room working on a puzzle wearing a nasal cannula attached to a portable oxygen tank on the back of his/her wheelchair, the oxygen tank was empty. At 12:35 PM the unit manager confirmed the tank was empty.

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46135 Based on observation, record review, and staff interviews, the facility failed to provide pain management in accordance with the resident's preferences for 1 of 27 sampled residents [Resident #302]. Findings include: Findings include: Per record review, Resident #302 was admitted to the facility on [DATE] for subacute rehab with multiple orthopedic injuries and fractures following a motor vehicle accident. Resident #302 has a physician order for OxyCODONE HCl Tablet 15 MG Give 1 tablet by mouth every 4 hours as needed for pain -Start Date-11/30/2022. Resident #302's care plan does not include a care area focus for pain, pain management goals, or interventions for pain management. Per observation and interview on 12/5/2022 at 09:35 AM, Resident #302 reported that his/her pain is not being managed. S/he stated that s/he has asked the nursing staff to wake him/her up at night to give administer his/her PRN [as needed] oxycodone but they won't wake him/her up to give it to him/her and because of that, s/he is unable to manage their pain throughout the rest of the day. Resident #302 reported to have a 9/10 pain level during interview and was observed moaning with a distorted face multiple times during the interview. A provider note dated 12/5/22 states Patient endorses chronic discomfort, moderately well managed with current regimen. Patient verbalizes pain at baseline today mildly increased with movement secondary to acetabular fracture, however, a social service note dated 12/5/22 states [Patient]states that [his/her] pain meds are still not right. Feels [s/he] is not being given in a timely manner. Worried that [s/he] won't get if falls asleep as they are prn. Per interview on 12/6/2022 at 3:00 PM, a Licensed Practical Nurse [LPN] stated s/he was aware the resident #302 wanted to be woken up for his/her PRN medication at night but nursing staff won't wake him/her up for PRN medications because there is a policy not to wake up residents and s/he has a history of drug seeking. Per interview on 12/07/22 at 7:40 AM, the Unit Manager stated that Resident #302 should have a care plan for pain and that nursing staff should not wake up a resident to administer PRN medications, even if they ask. Per interview on 12/7/2022 at 8:20 AM, the Director of Nursing [DON] stated that there was not a policy prohibiting nursing staff from waking up a resident on request for PRN medications and nursing should follow his request to wake him up. The DON confirmed that there should be a care plan for pain.

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25757 Based on observation, staff interview and record review, the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety. Findings include: On 12/05/22 at 06:05 AM during the initial tour of the kitchen, the following observations were made: 1. Two fans operating in the walk-in refrigerator are heavily soiled with dust. The dust was observed flying off the fans into the refrigerator space. 2. There are 2 blender bases on a food prep table soiled with dust and grease. 3. A tray containing 6 cooked chicken tenders (as identified by staff) in the reach-in refrigerator is uncovered and unlabeled. 4. There are 2 staff (a cook and a dietary aide) working with food in the kitchen not wearing head coverings. All observations were confirmed by the cook at the time of the observations. During a follow-up visit to the kitchen on 12/6/22 at 9:50 AM, accompanied by the Food Service Director (FSD), the following additional observations were made: 1. The walk-in freezer temperature was 10 degrees Fahrenheit (F). The posted temperature from this morning was 2 degrees F. The FSD stated there has not been any deliveries today and that the high temperature has been an ongoing issue. The refrigerator/freezer temperature record states to maintain freezer at 0 F or below. 2. There is a scoop inside a bulk bin of cocoa powder. 3. A utensil rack hung from the ceiling over the steam table is heavily soiled with dust and grease. Per review of facility documentation on 12/6/22, the following issues regarding refrigerator and freezer temperatures between July - November 2022 were noted: 1. In the walk-in freezer, temperatures were above 0 degrees F or not documented on 31 occasions in July; 11 in August; 21 in September; 31 in October and 30 in November. 2. In the reach-in refrigerator in the kitchen, temperatures were above 40 degrees F or not documented on 22 occasions in July; 27 in August; 22 in September; 26 in October and 5 in November. (continued on next page)

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	475030	A. Building B. Wing	12/07/2022

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3. In the [NAME] refrigerator, temperatures were above 40 degrees F or not documented on 12 occasions in July; 11 in August; 9 in September; 15 in October and 10 in November. 4. In the walk-in refrigerator, temperatures were above 40 degrees F or not documented on 8 occasions in July; 17 in August; 18 in September and 31 in October. 5. In the reach-in refrigerator near dry storage, temperatures were above 40 degrees F or not documented on 31 occasions in July; 3 in August; 6 in September and 19 in October. The above was confirmed by the FSD on 12/6/22 at 12:53 PM

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46135 Based on observation and interview, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Findings include: 1. Per observation on 12/5/2022 at 6:20 AM, room [ROOM NUMBER] had a personal protective equipment [PPE] bag hanging from the doors. There was no signage indicating what type of transmission-based precautions [TBP] should be used to enter the room. Per interview on 12/5/2022 at 6:30 am, an Licensed Practical Nurse [LPN] stated that there should be signage on room [ROOM NUMBER] stating the resident is on contact precautions. Per interview on 12/7/22 at 8:20 AM, the Director of Nursing confirmed that signs should be posted on doors for the residents requiring precautions. 2. Per observation on 12/5/2022 at 6:20 AM, room [ROOM NUMBER] had a personal protective equipment [PPE] bag hanging from the door. There was no signage indicating what type of TBP should be used to enter the room. Per interview on 12/5/2022 at 6:30 am, an LPN stated that there should be signage on room [ROOM NUMBER] stating the resident is on droplet precautions. Per observation on 12/06/22 at 1:20 PM, an LNA entered room [ROOM NUMBER] to deliver a meal tray. This LNA was not wearing any PPE in addition to a mask. Per interview on 12/6/22 at 1:22, the Unit Manager [UM] confirmed that staff are to be wearing eye protection, a gown, gloves, and a mask to enter the room even if they are dropping off a tray, especially since the resident is still coughing a lot. 3. Per observation on 12/5/22 at 11:05 AM room [ROOM NUMBER] had a PPE bag hanging from the door. There was no signage indicating what type of TBP should be used to enter the room. Per interview on 12/5/22 at 11:06 AM, an LPN observed that there was no signage indicating what type of precautions the resident in room [ROOM NUMBER] was on and stated that the resident was on precautions for MRSA [contact precautions]. Per interview on 12/2/22 at approximately 11:10 AM, the UM confirmed that there needs to be a precautions sign on room [ROOM NUMBER]'s door. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	4. Per observation on 12/5/22 at 12:29 PM, a Licensed Nurses Aide [LNA] entered room [ROOM NUMBER] carrying a lunch tray for one of the residents. The LNA was not wearing infection prevention equipment to include; disposable gloves, disposable gown, or eye protection. Per observation, outside of room [ROOM NUMBER] were 2 posted notices, identifying the room as an 'isolation' room requiring all staff and visitors who enter to don Personal Protective Equipment [PPE] including gloves, gowns, and eye protection. The LNA was further observed to exit the room without hand washing or any hand hygiene, pick up another lunch tray, and return to the room, again without gloves, gown, or eye protection. The LNA was observed exiting the room again, and again did not perform any hand hygiene. Per interview with Unit Manager [UM] on 12/05/22 2:39 PM, the UM confirmed that room [ROOM NUMBER] was an isolation room, and to prevent infection all staff and visitors entering the isolation room should be gowned, gloved, and with eye protection, and perform hand hygiene when exiting the room.