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	08/15/2024

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 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** 46135 Based on observation, resident and resident representative interview, staff interview, and record review, the facility failed to ensure that a resident who is unable to carry out activities of daily living (ADLs) without assistance receives the proper level of assistance for 8 of 11 sampled residents (Residents #1, #4, #5, #6, #7, #8, #9, and an anonymous resident). Findings include: 1. Per record review, Resident #7's care plan states that s/he has an alteration in bladder/bowel elimination [related to] impaired mobility, initiated on 3/18/19 and that s/he has a deficit in ADL function/mobility related to cerebral palsy and schizoaffective disorder, revised on 4/28/24. Care plan interventions include total dependence for toileting hygiene, revised on 3/20/24, maximum assistance for transferring, revised on 5/23/24, and for staff to provide 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). 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 soiled him/herself in bed that morning 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 late 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 observed on at 11:18 AM. When asked, Resident #7 said that staff had still not helped him/her clean up from the accident this morning and now s/he needs to urinate again, for which s/he had put their call light on a bit ago to get help. Resident #7's call light was not answered until 11:47 AM. 2. Per record review, Resident #10's care plan states s/he is always incontinent of bowel and bladder. [Interventions include] provide prompt incontinent care, revised on 12/29/2021 and requires one assist for incontinent care, revised on 03/10/2023. Per observation and interview on 08/13/2024 at 10:30 AM, Resident #10 stated s/he does not receive timely incontinent care. S/He stated that s/he requested incontinent care at 8:00 AM on the morning of interview and was still waiting. Resident #10 stated that s/he sometimes waits for hours for his/her care. During observation, Resident #10 pressed his/her call light a total of 6 times starting at 10:43 AM and ending at 11:40 AM. During the time of observation, 6 people answered the light and instead of providing her care, they told the resident his/her LNA would return to provide his/her care. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Per interview with the Licensed Nursing Assistant #4 (LNA) who answered the call light on 08/13/2024 at 10:45 AM s/he stated that Resident #10 requested to be changed. LNA #4 further explains that Resident #10 requires assistance for incontinent care and is not on his/her list for the day. Per LNA #4 s/he stated that s/he had not assisted in caring for Resident #10 since the start of his/her shift at 6:00 AM. Per interview with LNA #5 on 08/13/2024 at 10:58 AM, s/he confirmed that s/he is assigned to Resident #10 and s/he had not provided incontinent care to Resident #10 since start of his/her shift at 6:00 AM. Per interview on 08/13/2024 at 11:50 AM, LNA # 6, who was scheduled to work central supply that day, rather than do patient care, stated that s/he provided incontinent care to Resident #10 alone on 08/13/2024 at 11:40 AM. S/he also confirmed that Resident #10 was incontinent of urine and feces. 3. Per record review, Resident #1's care plan states that s/he has a deficit in ADL function/mobility related to cerebral palsy, blindness, revised on 2/24/24. Interventions include total dependence for eating and I should be out of bed for meals, revised on 4/9/24, and 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 5:06 PM, the Director of Nursing confirmed that Resident #1 should be out of bed for dinner every night. 4. 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 [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 because s/he had to go so bad, s/he went to the bathroom on his/her own even though s/he knew s/he needed staff assistance. Once s/he returned to his/her bed, s/he sat on the bed and then slid off landing on the floor. S/he explained that it was about 15 more minutes before the staff helped him/her back into bed. There was no documentation in the LNAs' POC (point of care; electronic documentation system for LNAs) that Resident #8 had assistance being transferred to the toilet during the evening or night shift on 8/12/24. 5. Per record review, Resident #4's care plan states that s/he has a deficit in ADL function/mobility related to surgical amputation secondary to gangrene, revised on 11/6/23, with interventions that include assistance for bed to wheelchair transfer, needing slide board and wheelchair placement to get out of bed, revised on 12/12/23. On 6/5/24 Resident #4 was assessed to have a BIMS of 15. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Per interview on 8/10/24 at 6:14 PM, Resident #4 stated that response time is very long due to lack of staff. S/He explained that s/he likes to get out of bed after lunch and needs staff to help as s/he can't do it on his/her own. S/He explained that s/he has to wait until 4:00 PM to get up or they don't get him/her up at all because they are so busy. S/He revealed that it is about 2-3 times a week that s/he can't get up when s/he wants to because there are not enough staff to help. 6. Per record review, Resident #5's care plan states that s/he has a deficit in ADL function/mobility related to recent amputation surgery, revised on 5/27/24, with an intervention for a 2 person physical assist with mechanical lift for transferring, initiated on 12/22/24. On 5/29/24 Resident #5 was assessed to have a BIMS of 15. Per observation and interview on 8/13/24 at 10:23, Resident #5 was lying in bed and stated that s/he would like to be out of bed right now. S/He explained that s/he was out of bed earlier, had asked to go back to bed but would like to be up now and was told that there are not enough staff to help him/her since s/he needs a Hoyer (mechanical lift operated by staff) to get out of bed. 7. Per a confidential interview on 8/12/24 at 10:26 AM, a resident, stated that s/he does not get showered as often as s/he should because there are not enough aides to help. S/He explained because staffing is short and s/he misses his/her showers, s/he is [NAME], and doesn't like that feeling. This resident was able to understand all questions asked of him/her by giving reasonable responses that demonstrated that s/he was alert and orientated to person, place, and time. 8. Per interview with Resident's #11 Power of Attorney (POA) on 08/13/2024 at 3:15 PM, s/he stated that s/he goes to the facility every day and frequently has to provide care for Resident #11. S/He stated that Resident #11 has missed two showers in the past two weeks. S/He stated that there is not enough staff do address Resident #11 needs, and less staff on the weekends. S/He stated when s/he is at the facility the Nurse Mangers are frequently working the medication cart or working as a Licensed Nursing Assistant. S/He stated that s/he feels if s/he did not go to the facility every day, Resident #11 would not receive the ADL care s/he needed. 9. Per a joint interview with 3 LNAs on 8/10/24 at 6:43 PM, LNA #1 stated that the facility is really short staffed and has been since they reopened 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 39 residents needed assistance with eating and 15 of the 39 residents required 2 staff members to assist with some or all of their ADLs. 50336

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. 50336 Based on staff interview and record review, the facility failed to ensure that physicians and other providers (as delegated to per regulation) review the residents' total program of care, including medications and treatment plan at each visit as required for 1 of 3 sampled residents (Resident's #9). Findings include: Physician note dated 6/4/2024 under section titled Assessment and Plans reads ALZHEIMER'S DISEASE, UNSPECIFIED - G30.9-With behaviors, [s/he] has episodes of screaming out, restlessness and agitation. [S/he] currently is on Seroquel Haldol and Ativan without behavior changes continue meds for now . Per record review Seroquel was discontinued 05/23/2024. Per review of Resident #9's physician orders starting on 4/3/2024 shows that Resident #9 was taking the following medication at the time of regulated visit: Haloperidol oral tablet 2 milligrams (mg) give one tablet by mouth two times a day for agitation, Lorazepam oral tablet 0.5 mg give 1 tablet by mouth at bedtime for anxiety, A Physician note dated 7/20/2024 Assessment and Plans ALZHEIMER'S DISEASE, UNSPECIFIED - G30.9-With behaviors, [s/he] has episodes of screaming out, restlessness and agitation. [S/he] currently is on Seroquel Haldol and Ativan without behavior changes continue meds for now . A review of Resident #9's physician orders 7/20/2024 shows that s/he is was taking the following medication: Haloperidol oral tablet 2 milligrams (mg) give one tablet by mouth two times a day for agitation, Lorazepam oral tablet 0.5 mg give 1 tablet by mouth at bedtime for anxiety, Zyprexa oral tablet 5 mg give one tablet by mouth in the morning for agitation and one tablet by mouth in the evening for behaviors. Per an Advance Practiced registered Nurse (APRN) note dated 8/5/2024 section titled Assessment and Plans ALZHEIMER'S DISEASE, UNSPECIFIED - G30.9 Without change on Aricept and Seroquel still has behaviors. [S/he] also can get Haldol. A review of Resident #9's physician orders on 2024 8/5/2024 shows that s/he was taking the following medication: Haloperidol oral tablet 2 milligrams (mg) give one tablet by mouth two times a day for agitation, Lorazepam oral tablet 0.5 mg give 1 tablet by mouth at bedtime for anxiety, Zyprexa oral tablet 5 mg give one tablet by mouth in the morning for agitation and one tablet by mouth in the evening for behaviors. There is no order for Seroquel Per interview with the Director of Nursing on 8/14/2024 at 9:15 AM s/he confirmed the provider visits above, were regulatory visits, did not reflect the actual medications that Resident #9 had orders for at the time of visit, and did not accurately review the resident total program of care and it should have.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46135 Based on observation, resident and staff interviews, and record review, the facility failed to ensure there are a sufficient number of skilled licensed nurses, nurse aides, and other nursing personnel to provide care and respond to each resident's basic needs and individual needs as required by the resident's diagnoses, medical condition, or plan of care, potentially impacting all residents of the facility. Findings include: 1. Observations and interviews reveal that ADL care (activities of daily living) was not provided in a timely manner. a. Per record review, Resident #7's care plan states that s/he has an alteration in bladder/bowel elimination [related to] impaired mobility, initiated on 3/18/19 and that s/he has a deficit in ADL function/mobility related to cerebral palsy and schizoaffective disorder, revised on 4/28/24. Care plan interventions include total dependence for toileting hygiene, revised on 3/20/24, maximum assistance for transferring, revised on 5/23/24, and for staff to provide 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). 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 soiled him/herself in bed that morning 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 late 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 observed on at 11:18 AM. When asked, Resident #7 said that staff had still not helped him/her clean up from the accident this morning and now s/he needs to urinate again, for which s/he had put their call light on a bit ago to get help. Resident #7's call light was not answered until 11:47 AM. b. Per record review, Resident #10's care plan states s/he is always incontinent of bowel and bladder. [Interventions include] provide prompt incontinent care, revised on 12/29/2021 and requires assistance for incontinent care, revised on 03/10/2023. Per observation and interview on 08/13/2024 at 10:30 AM, Resident #10 stated s/he does not receive timely incontinent care. S/He stated that s/he requested incontinent care at 8:00 AM on the morning of interview and was still waiting. Resident #10 stated that s/he sometimes waits for hours for his/her care. During observation, Resident #10 pressed his/her call light a total of 6 times starting at 10:43 AM and ending at 11:50 AM. During the time of observation, 6 people answered the light and instead of providing her care, they told the resident his/her LNA would return to provide his/her care. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Per interview with the Licensed Nursing Assistant #4 (LNA) who answered the call light on 08/13/2024 at 10:45 AM s/he stated that Resident #10 requested to be changed. The LNA, #4 further explains that the Resident #10 requires assistance for incontinent care and is not on his/her list for the day. Per LNA #4 s/he stated that s/he had not assisted in caring for Resident #10 since the start of his/her shift at 6:00 AM. Per interview with LNA #5 on 08/13/2024 at 10:58 AM, s/he confirmed that s/he had not provided incontinent care to Resident #10 since start of his/her shift at 6:00 AM. Per interview on 08/13/2024 at 11:50 AM, LNA # 6, who was scheduled to work central supply that day, rather than do patient care, stated that s/he provided incontinent care to Resident #10 alone S/he confirmed that Resident #10 was incontinent of urine and feces. c. Per record review, Resident #1's care plan states that s/he has a deficit in ADL function/mobility related to cerebral palsy, blindness, revised on 2/24/24. Interventions include total dependence for eating and I should be out of bed for meals, revised on 4/9/24, and 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 5:06 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 [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 because s/he had to go so bad, s/he went to the bathroom on his/her own even though s/he knew s/he needed staff assistance. Once s/he returned to his/her bed, s/he sat on the bed and then slid off landing on the floor. S/he explained that it was about 15 more minutes before the staff helped him/her back into bed. There was no documentation in the LNAs' POC (point of care; electronic documentation system for LNAs) that Resident #8 had assistance being transferred to the toilet during the evening or night shift on 8/12/24. e. Per record review, Resident #4's care plan states that s/he has a deficit in ADL function/mobility related to surgical amputation secondary to gangrene, revised on 11/6/23, with interventions that include assistance for bed to wheelchair transfer, needing slide board and wheelchair placement to get out of bed, revised on 12/12/23. On 6/5/24 Resident #4 was assessed to have a BIMS of 15. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Per interview on 8/10/24 at 6:14 PM, Resident #4 stated that response time is very long due to lack of staff. S/He explained that s/he likes to get out of bed after lunch and needs staff to help as s/he can't do it on his/her own. S/He explained that s/he has to wait until 4:00 PM to get up or they don't get him up at all because they are so busy. S/He revealed that it is about 2-3 times a week that s/he can't get up when s/he wants to because there are not enough staff to help. f. Per record review, Resident #5's care plan states that s/he has a deficit in ADL function/mobility related to recent amputation surgery, revised on 5/27/24, with an intervention for a 2 person physical assist with mechanical lift for transferring, initiated on 12/22/24. On 5/29/24 Resident #5 was assessed to have a BIMS of 15. Per observation and interview on 8/13/24 at 10:23, Resident #5 was lying in bed and stated that s/he would like to be out of bed right now. S/He explained that s/he was out of bed earlier, had asked to go back to bed but would like to be up now and was told that there are not enough staff to help him/her since s/he needs a Hoyer to get out of bed. g. Per a confidential interview on 8/12/24 at 10:26 AM, a resident stated that s/he does not get showered as often as s/he should because there are not enough aides to help. S/He explained because staffing is short and s/he misses his/her showers, s/he is [NAME], and doesn't like that feeling. This resident was able to understand all questions asked of him/her by giving reasonable responses that demonstrated that s/he was alert and orientated to person, place, and time. h. Per interview with Resident's #11 Power of Attorney (POA) on 08/13/2024 at 3:15 PM, s/he stated that s/he goes to the facility every day and frequently has to provide care for Resident #11. S/He stated that Resident #11 has missed two showers in the past two weeks. S/He stated that there is not enough staff do address Resident #11 needs, and less staff on the weekends. S/He stated when s/he is at the facility the Nurse Mangers are frequently working the medication cart or as a License Nursing Assistant. S/He stated that s/he feels if s/he did not go to the facility every day, Resident #11, would not receive the ADL care s/he needed. 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 aides 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 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. 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. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3. Additional staff interviews and record review reveal that the facility does not always have enough direct care staff to provide the care needed. Per review of resident lists with LNAs from each unit on the evening of 8/10/24 showed the following: On Unit A, 4 of the 42 residents needed assistance with eating and 16 of the 42 residents required 2 staff members to assist with some or all of their activities of daily living (ADLs). On Unit B, 3 of the 39 residents needed assistance with eating and 15 of the 39 residents required 2 staff members to assist with some or all of their ADLs. On Unit C, 1 of the 14 residents needed assistance with eating and 3 of the 14 residents required 2 staff members to assist with some or all of their ADLs. Per a joint interview with 3 LNAs on 8/10/24 at 6:43 PM, LNA #1 stated that the facility is really short staffed and has been since they reopened 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. Per interview on 8/12/24 at approximately 4:45 PM, a Unit Manger explained that there has been trouble staffing all the shifts and not getting shifts filled. As a result, s/he frequently has to work as a floor nurse and is unable to do his/her role as the Unit Manager. On 8/13/24 at 4:07 PM, the Scheduler explained that there have been a lot of call outs for direct care staff and sometimes it is hard to fill shifts due to vacations. S/He stated that the direct care schedules above reflected all call-outs and shift substitutions. S/He confirmed that they accurately reflected the actual time worked by staff, which was later confirmed by the DON at 5:06 PM. A review of direct care staff schedules from 8/1/24 through 8/12/24 revealed multiple call outs, unfilled shifts, and reassignments. There were 12 licensed nurse shifts that were scheduled that were not refilled or reassigned and 29 LNA shifts that were scheduled that were not filled or reassigned. 10 licensed nurse shifts that were reassigned were worked by nursing supervisors, unit managers or the Director of Nursing and 9 licensed nurse shifts (one on 8/1/24, two on 8/2/24, three on 8/5/24, two on 8/7/24, one on 8/8/24) that were either short a licensed nurse or the unit manager or supervisor filled in. 50336

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	08/15/2024

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50336 Based on observation, record review and interview the facility failed to monitor 3 out 3 residents sampled for the adverse side effects related to psychotropic medications (Resident's #5, #9, and #10). Findings include: (1.) Per record review Resident #9 was admitted with diagnoses that include Alzheimer's, dementia with behavioral disturbances. S/He has the following medication orders written by the Advance Registered Practice Nurse (APRN): Haloperidol oral tablet 2 milligrams (mg) give one tablet by mouth two times a day for agitation, (Antipsychotic used to treat schizophrenia) (Schizophrenia is a serious mental health condition that affects how people think, feel and behave. Mayo Clinic 2024), Lorazepam oral tablet 0.5 mg give 1 tablet by mouth at bedtime for anxiety, Zyprexa oral tablet 5 mg give one tablet by mouth in the morning for agitation and one tablet by mouth in the evening for behaviors. (Zyprexa is an antipsychotic used to treat schizophrenia). Per Manufacturers warning for Haloperidol, Lorazepam, and Zyprexa, all have the significant side effect of drowsiness/sleepiness. (Drugs.com, 2024). There is no documented evidence that Resident #9 was evaluated for adverse effects prior to medication administration. Per review of the facility medication administration record Resident #9 received scheduled doses of his/her medication including antipsychotics for the months of July and August 2024. Per hourly observation of Resident #9 in his/her room starting at 10:00 AM on 08/13/2024, s/he was observed lying on his/her bed in the same position until 4:30 PM. During observation this writer knocked on Resident #9's door several times. Resident #9 did attempt to speak on one occasion but was not able to or stay awake. Per Interview License Nursing Assistant #1 (LNA) at 4:45 PM on 08/13/2024 s/he stated that Resident #9 is always sleepy, often sleeps through meals. LNA stated when Resident #9 is awake she frequently hollers out. Per further record review of Resident #9's medical record, on 02/09/2024, 03/08/2024, and 08/02/2024 the psychiatry notes document in their assessment Resident #9 as lethargic and on 08/02/2024 Resident #9 complained to the psychiatric provider of being more tired. However, there is no evidence in the medical record that providers were notified, or that symptoms were monitored or addressed. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the medical record for Resident #9 s/he was transfered to psychiatric facility for medication management on 05/24/2024 and returned to this facility on 05/25/2024. According to the provider note on 05/26/2024 Primary Chief Complaint : Psych: Aggressive Behavior History Present Illness : 80 y/o LTC resident of EW at [NAME] sent out for a psych evaluation for non-stop screaming haloperidol and quetiapine were discontinued for note ineffectiveness and Abilify was started. Psych is strongly recommending reductions in . hydromorphone. Abilify can be increased by 2.5mg every 4-5 days to a max of 10mg/day per recommendation notes. Per the medical record, there is no documented evidence that recomendatinos were followed, and Resident #9 was restarted on antipsychotic medications 05/26/2024. 2. Resident #5 has the following orders written by the APRN starting on 12/20/2023, RisperiDONE Tablet 1 MG Give 1 tablet by mouth every morning and at bedtime for agitation/behaviors. There is no documented evidence in his/her medical record or documentation that s/he was being monitored for side effects or adverse reactions. There is no documented evidence that Resident #5 was evaluated for adverse effects prior to medication administration of psychotropic medication since starting medication 12/20/2023. 3. Per record review Resident #10 has the following orders written by APRN LORazepam Oral Tablet 0.5 MG (Lorazepam) Give 0.75 mg by mouth four times a day for Anxiety, Zoloft Oral Tablet 100 MG (Sertraline HCl) Give 2 tablet by mouth in the morning for Depression 2 tabs=200mg. There is no documented evidence in the medical record of an assessment in that she/he was monitored for adverse effects prior to medication administration. There is no evidence of an IDT meeting or quarterly AIMS in his/her medical record. Per the Facility policy titled Psychotropic Drugs revised 05/16/2023 It is the policy of this facility that those residents prescribed psychotropic drugs will receive only those medications, in doses and for the duration clinically indicated to treat the resident's assessed condition . o Monitoring the efficacy and adverse consequences . o Preventing, identifying, and responding to adverse consequences related to psychotropic drugs. Per interview with the Director of Nursing (DON) on 8/14/2024 at 9:15AM s/he stated it is the expectation that each resident receiving psychotropic medications would have an interdisciplinary team meeting and a comprehensive care plan that includes monitoring for side effects related to use of psychotropic medications and they don't. Follow up interview with the Director of Nursing on 08/15/2024 at 12:45 PM confirmed there was no documented evidence of monitoring for Residents #5, #9, and #10 for adverse effects of psychotropic medications.