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	08/11/2025

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Per interview and record review, the facility failed to ensure one of four residents (Resident #2) was free from chemical restraints by prescribing an as needed psychotropic medication with no stop date of 14 days. Findings include:Per review of Resident #2's medical record, Resident #2 has major diagnoses of vascular dementia [a form of dementia associated with impaired reasoning, planning, judgment, and memory caused by brain damage from impaired blood flow to your brain], Stage 2 chronic kidney disease, and COPD [Chronic Obstructive Pulmonary Disease]. Resident #2 had a BIMS [Brief Interview of Mental Status] score of 9 as of 7/17/25. A BIMS score of 9 indicates that Resident #2 is cognitively impaired. Per record review of a physician order dated 7/23/25 states, Lorazepam tablet 0.5 mg [milligram]: Give one tablet by mouth every 6 hours as needed for itching and anxiety. There was no documented stop date of 14 days on this order. Resident #2 was administered the Lorazepam 8 times from 7/23/25 to 8/11/25.An interview was conducted with the DON [Director of Nursing] on 8/11/25 at 11:45 AM. The DON confirmed that the order for Lorazepam did not include a stop date of 14 days. Works CitedVascular Dementia. Mayo Clinic. https://www.mayoclinic.org/diseases-conditions/vascular-dementia/symptoms-causes /syc-20378793. Accessed 8/12/25.

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Per interview and record review the facility's failed to prevent significant medication errors for one of four residents [Resident #1] sampled. Findings include:Per review of Resident #1's medical record, s/he had major diagnoses of Type II Diabetes, Alzheimer's Disease with late onset, Schizoaffective Disorder [a mental illness where the person experiences symptoms of both schizophrenia and a mood disorder], and anxiety. Resident #1 has a BIMS [Brief Interview of Mental Status] score of 4 as of 6/27/25. A BIMS score of 4 indicates Resident #1 was cognitively impaired. Per record review of the Resident #1's July 2025 MAR [Medication Administration Record] a medication order on the MAR states, Lisinopril [a medication used to treat high blood pressure] tablet 40 mg [milligrams] Give one tablet buy mouth in the morning for hypertension. Hold for SBP [systolic blood pressure] <100 [under 100] mmHg [millimeters of mercury] and notify provider. The MAR shows that the medication was ordered on 6/27/25.Per record review of Resident #1's nurse progress note written on 7/20/25 at 7:00 AM states, Resident found on the floor by CNA [Certified Nursing Assistant] sitting with [his/her] buttocks, with legs and arms extended. This writer assessed the resident, [s/he] is alert and oriented times 3, upper and lower extremities ROM [range of motion] OK [okay], no pain, no bruises at time of fall. [His/Her] head had no bumps. [S/he] said that [s/he] didn't hit [his/her] head [s/he] hit [his/her] buttocks. A nursing note at 7/20/25 at 11:50 AM states, Resident noted to have hypotensive during routine vitals at 7:22 AM BP [blood pressure] 77/45 at 9:18 AM 89/54 at 11:27 [AM]: 77/45. APN [Advanced Practice Nurse] orders resident to be transferred to ED [Emergency Department].Per record review of a physician order note dated 7/20/25 at 5:50 AM states, Assess pain per protocol, Fall precautions per facility protocol, Monitor with neurochecks [a neurological assessment] per facility protocol. Notify a clinician of any change in condition [sic] cbc [complete blood count], cmp [comprehensive metabolic panel]. Give 8 ounces of broth followed by 200 mL [milliliters] of fluid. Recheck BP [blood pressure] in 2 hours, notify provider if SBP < 100 mm hg [systolic blood pressure under 100 millimeters of mercury] Hold am [morning] lisinopril dose today [sic] Ice to back of head x 15 minutes [every fifteen minutes] as tolerated. Per record review of a physician order dated 7/20/25 at 10:15 AM states, Transfer to Emergency Department establish IV [intravenous access]/ give 500ml [milliliters] of 0.9 NS [normal saline] provide via NC [nasal cannula] or simple mask PRN [as needed] spo2 95-99% [Oxygen saturation 95-99%].Per record review of the facility's Medication Error Reporting Policy [last modified 7/6/18] states, The Medication Error Report is completed by a licensed nurse, and will be categorized and defined as follows:.2. Omission or wrong drug:. Medication given without order: Dose given to resident without physician's order.Note: A significant medication error means one that causes the resident discomfort or jeopardizes his/her life or safety.Per record review of Resident #1's MAR, Lisinopril was administered by Licensed Nurse #1 during the 7:00 AM to 10:00 AM medication pass. The blood pressure at the time of the Lisinopril administration was documented in the MAR as 89/54 mmHg [millimeters of mercury]. The systolic blood pressure recorded was too low to have Lisinopril administered as the systolic blood pressure needed to be over 100 mmHg [millimeters of mercury]. There was no documentation on the July 2025 MAR showing that normal saline via IV was administered to Resident #1.An interview was conducted with the DON [Director of Nursing} on 8/11/25 at 11:45. The DON confirmed that the MAR was documented as the medication administered with the blood pressure of 89/54 mmHg [millimeters of mercury]. She stated, I'm doing a med [medication] error report with the nurse who signed off the medication. The DON confirmed the blood pressure of the resident decreased to 77/45 mmHg at 11:27 AM and 11:56 AM. She confirmed Resident #1 was never administered normal saline or IV access prior to going to the hospital.Works Cited:Schizoaffective Disorder. Mayo Clinic. https://www.mayoclinic.org/diseases-conditions/schizoaffective-disorder/symptoms-causes/syc-20354504. Accessed 8/12/25.