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	01/14/2026

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews and record reviews, the facility failed to ensure that 10 of 10 residents sampled (#1, 2, 3, 4, 5, 6, 7, 8, 9, and 10) were free from misappropriation of 6 different types of controlled medications identified by the facility audit. Findings include:Per review of the facility's reported investigation, a concern was raised on 12/15/25 regarding documentation of resident #1 receiving an as-needed (prn) medication. The assigned medication nurse reported that resident #1 hadn't received the medication for 3 months, which they confirmed with the resident. The facility conducted audits of all Control Medication logbooks (record-keeping systems used by facilities to track the inventory, administration, and disposal of controlled substances) and the medication administration records of residents who were to receive these medications. It was found that on 2 separate occasions, for ten different residents (#1, 2, 3, 4, 5, 6, 7, 8, 9, and 10) in the facility and on two units, a Licensed Practical Nurse (LPN) had not followed the procedure for administering medications as evidenced by two logbooks having entries overwritten, out-of-sequence entries, and potentially fraudulent entries all with the removal and not administered medications. These medications included pain medications: Oxycodone, Tramadol, Morphine, Percocet, and Butalbital/Acetaminophen/Caffeine. During the process of conducting the facility's internal investigation, the facility found irregularities with the Controlled Medication logbook, which included, per the facility, falsified sign-outs, forged staff signatures, altered dates, and removals without corresponding MAR (medication administration record) documentation. Nursing staff handwriting samples were obtained to compare with the logbooks. Upon conclusion, the facility investigation verified the LPN's alleged medication diversion. Per interview with Administrator on 1/14/26 at approximately 12:00 PM, she stated that the handwriting sample provided by the suspected LPN was compared to documentation in the logbook, and it was determined that she had made the entries in the logbook. The Administrator confirmed the LPN was involved in ten incidents of removing medications that are believed not to have been administered to the prescribed residents. The Administrator confirmed that there was a failure to protect residents from the suspected LPN's misappropriation of medications at the facility, and confirmed the LPN doesn't hold an active [NAME] nursing license (see citation F659 for additional information). Per interview on 1/14/26 at 1:00 PM with one of the nurses who initiated the report, she confirmed that when completing a change of shift count of the controlled medications, she noted a resident's count of a prn medication had drastically changed in one day since her previous shift, and she noticed her documentation had been altered. She reported her concerns to the Director of Nursing (DON) and began reviewing the logbook for discrepancies by comparing its entries with the individual residents' MARs, which identified additional errors. She stated the medication count in the logbook was correct, but the altered documentation in the logbook indicated an issue that needed to be reported. Per interview on 1/15/26 at 11:26 AM with the former Director of Nursing (DON), who resigned on 1/13/26, she confirmed receiving a report on 12/15/25 regarding (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

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	an issue with the logbooks for two of six medication carts. One of the Assistant Directors of Nursing (ADON) informed her that there was something wonky, something weird with the logbooks after a nurse assigned to one of the medication carts noticed that a PRN medication had been used for a resident who hadn't taken the medication for an extended period. Upon review of the logbooks, it was found that the count numbers weren't off, but the signatures didn't match the staff who had worked the past couple of shifts, and the dates were out of sequence for signing out the identified medications. On 12/15/25, the DON had the staff assigned to the medication carts meet with her and provide a sample of their writing. The suspected LPN was visibly shaky during the interview and, while providing the writing sample, questioned which numbers she should write on the paper. The DON stated that after the meeting with the suspected LPN, the LPN didn't return to her assigned unit immediately. When the LPN returned to the unit, she completed a change-of-shift count with the oncoming nursing staff. The DON stated she quickly went to the medication cart and reviewed the logbook, which revealed handwriting matching the entries believed to be fraudulent. The LPN was brought to the office for further questioning, and the DON states the LPN didn't actually deny it, and was placed on administrative leave pending further investigation. The DON confirmed that the incident has been reported to the [NAME] Police Department, and an investigation is in progress with the Office of Professional Regulations.

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F 0659 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care by qualified persons according to each resident's written plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that 1 of 5 nursing staff had an active [NAME] license to practice. Findings include:A review of credentials for a Licensed Practical Nurse (LPN) investigation for misappropriation of medications (see citation F602 for additional information) revealed that the LPN lacked an active [NAME] license to practice. The nurse's multistate compact license (a license with the authority to practice in multiple member states), which permitted practice in [NAME], had expired on [DATE]. A request for an updated license was made to the Administrator on [DATE] at 12:00 PM, and nursys.com (the national nurse licensure and disciplinary database) was used to search for it. The search confirmed the LPN's license was only active in North Carolina, a single-state license, and was no longer valid for [NAME]. The Administrator stated, I asked her to fix this. She was asked who she was referring to, and she stated she had spoken to the LPN by phone regarding the LPN's active single-state LPN license for North Carolina, rather than a multistate compact license that previously included [NAME]. Per the administrator, the LPN had clicked the wrong button during renewal. Review of the nurse's timecard showed that after the multistate compact license expired, the individual worked 11 shifts from [DATE] to [DATE], with 6 shifts administering medications as an LPN. During an interview on [DATE] at 2:00 PM with the Administrator, she stated that the facility has had a vacant Human Resources position and that a spreadsheet hadn't been updated with staff's license expiration dates. She continued by saying that an audit of all licensed staff, dated [DATE], was completed, and that it was determined the suspected LPN was the only staff member noted to have an expired [NAME] license. The Administrator stated the expected process is for staff to renew their licenses to practice in [NAME], and if this task isn't completed, they will not work at the facility until they have an active license. The Administrator confirmed that the LPN had worked a total of 11 shifts during the period without a valid [NAME] license. The LPN Team Leader job description for the employee, last revised 1/2025, requires credentials as a Licensed Practical Nurse with a current state license in good standing for the state of employment. An essential job function listed is administering medications and treatments. Per interview on [DATE] at 11:26 AM with the former Director of Nursing (DON), who resigned on [DATE], she revealed that during a review of the suspected LPN's personnel file, the facility identified that the LPN's [NAME] nursing license had expired, which is needed for the LPN position. The DON stated that the Administrator had taken on the task of researching the expired license.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to implement a system to ensure nursing staff members administering medications maintain ongoing qualifications for 1 of 5 nursing staff sampled. Findings include:Per the facility's reported investigation, a concern was raised on [DATE] when the oncoming shift medication nurse reported that a resident hadn't received an as-needed (prn) medication for 3 months, a claim the nurse confirmed with the resident. The facility conducted audits of all Control Medication logbooks (record-keeping systems used by facilities to track the inventory, administration, and disposal of controlled substances) and the medication administration records of residents who were to receive these medications. It was found that on 2 separate occasions, for ten different residents in the facility and on two units, a Licensed Practical Nurse (LPN) had not followed the procedure for administrating medications as evidence identified by the facility as irregularities with the logbook, which included, per the facility, falsified sign-outs, forged staff signatures, altered dates, and removals without corresponding MAR (medication administration record) documentation. The medications suspected of being taken and not administered to the prescribed residents were pain medications: Oxycodone, Tramadol, Morphine, Percocet, and Butalbital/Acetaminophen/Caffeine. During the facility investigation on [DATE], it was revealed that the LPN suspected of failing to follow medication administration procedures had an expired nursing license in [NAME]. Per interview with the Administrator on [DATE] at approximately 12:00 PM, confirmed the LPN was working without a current [NAME] State license. The facility policy titled Controlled Substances Inventory Policy/Storage, last modified [DATE], states that the change of shift controlled substance count procedure process is, The oncoming licensed nurse . will count remaining doses of each medication and the outgoing licensed nurse.will verify the amount. Per facility policy titled Medications Administration Methods, last modified [DATE], states A Licensed Nurse.per state regulations will be responsible for passing medications according to techniques and procedures that meet current practice standards and are in compliance with State Codes, Rules and Regulations and other applicable state and federal laws. The facility policy titled Nursing Documentation Standards, last modified [DATE], states Corrections must be made by the original author: .Handwritten records: draw one line through the error, write omit, initial, and date. During an interview on [DATE] at 1:38 PM with the Administrator, she confirmed that the LPN had been assigned the task of medication administration without the required [NAME] nursing license and had fraudulently removed controlled medications by failing to follow procedures for administering and documenting accurately in the logbooks per facility policies. Per interview on [DATE] at 11:26 AM with the former Director of Nursing (DON), who resigned on [DATE], she revealed that during a review of the suspected LPN's personnel file, the facility identified that the LPN's [NAME] nursing license had expired, which is needed for the LPN position. The DON stated that the Administrator had taken on the task of researching the expired license. See citations F602 and F659 for additional information.