VERMONT

Department of Disabilities, Aging and Independent Living
Division of Licensing and Protection
280 State Drive/HC 2 South
Waterbury, VT 05671-2060
www.dlp.vermont.gov

[phone] 802-241-0344
[fax] 802-241-0343

AGENCY OF HUMAN SERVICES

July 29, 2026

Ms. Sabrina Neal, Administrator
Elderwood at Burlington
98 Starr Farm Rd.
Burlington, VT 05408

Provider ID #: 475030

Dear Ms. Neal:

Enclosed is a copy of your acceptable plans of correction for the complaint investigation conducted on **July 1, 2026.** Please post this document in a prominent place in your facility.

We may follow up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M Cota RN
Pamela M. Cota, RN, BS
Assistant Division Director
State Survey Agency Director

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475030	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/01/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS The Division of Licensing and Protection conducted an unannounced, onsite investigation of 2 complaints and 1 FRI (facility-reported incident), including reports #3053948, #3053362, and #3052276 on6/26/26 and 6/30/26 with offsite record review on 6/25/26 and 6/29/26, and 7/1/26, exiting remotely on 7/1/26 to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. The following regulatory deficiencies were identified:	F0000	Elderwood at Burlington wishes to have this plan of correction stand as its written plan of compliance. The preparation and/or execution of this plan does not constitute an admission or agreement with the allegations set forth in the statement of deficencies. This plan is prepared and/or executed as evidence of the facilities continued compliance with appliciable state and federal regulatory requirements.	
F0684 SS = D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and record review the facility failed to provide quality care to 1 of 3 sampled residents (Resident #3) related to skin assessment, and non-pressure wound care. Findings include: 1.) Resident #3 is a long term resident of the facility with diagnoses including lymphedema (swelling caused by fluid build up), chronic venous insufficiency (veins in the legs do not work well resulting in blood buildup), diabetes, chronic pain, depression and anxiety. Per interview with Resident #3 on 6/24/2026 at 10:45 AM, s/he stated that his/her legs have been "unwrapped for days." S/he reported that the bandages were removed earlier in the week before his/her shower and that they have not been replaced. S/he voiced concern about the "open	F0684		

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 reverse for further 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
Sabrina Neal RN BSN MBA LNHA	Administrator	7/22/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475030	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/01/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0684 SS = D	Continued from page 1 areas" on his/her legs and stated they "hurt a lot." Per observation of Resident #3's lower legs at the time of his/her interview, legs were open to air, both lower extremities were reddened, a dime sized blister could be seen on the inner aspect of his/her lower leg, and 2 open areas of skin on both of his/her shins. Per review of Resident #3's physician orders there is an order for knee high compression to bilateral lower extremities with kerlix, coban, and tubigrip (all are types of bandages used in wound care). Per review of the facility's skin assessment policy, the resident's physician orders and the resident's care plan on 7/1/2026, systemic skin assessments are to be conducted weekly and as needed. According to Resident #3's medical record his/her last skin assessment was performed on 6/12/2026. Per interview with a Licensed Practical Nurse (LPN) on 6/24/2026 at 12:30 PM, she stated that she was the nurse who removed the bandages from Resident #3's lower legs on Monday 6/22/2026. She observed that Resident #3's lower legs were swollen with a blister on his/her left leg and skin breakdown on both lower legs. She stated that she was unsure if this was a change in condition so reported it to leadership several times over the next 2 days with a request that a skin assessment be completed before rebandaging. The LPN reported the following: 6/22/2026 – the nurse noted the condition of Resident #3's legs and reported her findings to the day shift supervisor. 6/22/2026 – the nurse noted that Resident #3's skin assessment had not been completed and reported her findings to the night shift supervisor. 6/23/2026 – the nurse noted that Resident #3's skin assessment had not been completed, and his/her legs were not bandaged. She reported her findings to an Assistant Director of Nursing (ADON)/unit manager, wound care nurse and the facility's nurse educator. 6/24/2026 – the nurse noted that Resident #3's skin assessment had not been completed, and his/her legs were not bandaged. She reported her findings to the Director of Nursing (DON). Per interview with the Unit Manager on 6/24/2026 at 2:15 PM, she stated that they were waiting for orders from the wound care team. She confirmed that a skin assessment had not been completed	F0684	F0684 SS = D CFR(s): 483.25 What corrective action will be accomplished for those residents found to have been affected by the deficient practice; Resident #3 skin assessment was completed on 6/24/2026, provider notified and new orders obtained. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; A full house audit of all resident skin checks will be completed, and any residents with a newly identified skin condition will have a skin assessment completed and notification made to the provider for orders. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and, All nurses will receive reeducation on the policies and procedures; Pressure Ulcer, Pressure Injury & Other Skin Conditions: Initial Assessment, Care Planning, Ongoing Evaluation and Management SNF and Acute change in condition interact. All skin checks and change in condition notifications will be reviewed daily for any newly identified areas, and any new skin conditions will be assessed immediately, and new treatment orders obtained. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. An audit of all skin checks and change in condition notifications will be completed daily x 4 weeks then weekly x 3 months or until substantial compliance is obtained. The dates corrective action will be completed. The director of nursing is responsible for this corrective action. This corrective action will be completed by August 7, 2026. **Tag F0684 POC accepted on 7/29/26 by D. Hoffman/S. Stem**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475030	A. BUILDING B. WING	07/01/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0684 SS = D	Continued from page 2 since 6/12/2026, and should have been based on facility policy, the resident's physician orders, and care plan. She confirmed that an assessment should have taken place after the nurse's report of alteration in the resident's skin integrity. Per interview with the Director of Nursing (DON) and a wound care nurse on 6/24/2026 at 2:40 PM, the DON reported that they were in the process of doing a skin assessment on Resident #3 and getting new orders for wound care. She confirmed that the last skin assessment was completed on 6/12/2026 (12 days previous) and that a skin assessment should have been completed on Resident #3 weekly and after the staff nurse reported her findings.	F0684	F0689 SS = D CFR(s): 483.25(d)(1)(2) What corrective action will be accomplished for those residents found to have been affected by the deficient practice; The two staff members involved received immediate education and competency for Arjo use was completed on 06/19/2026. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All residents requiring mechanical lift are at risk.	
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to ensure that 1 of 3 sampled residents (Resident #2) remained as free from fall-related accidents as possible by failing to ensure that direct care staff properly use an assistive device and prevent an avoidable accident from occurring. Findings include: A facility policy titled, "Safe Patient Handling Program," last modified on 1/16/20, states "All employees responsible for resident movement shall attend a Safe Patient Handling Training Program and demonstrate competency in resident transfers, lifts and positioning /repositioning of residents... A full-body mechanical lift will be used by those residents who have no weight-bearing abilities and/or other indicated medical conditions...Two (2) or more caregivers must be present." A review of the facility fall investigation revealed that Resident # 2 sustained a witnessed fall from the mechanical lift on 6/19/26. A statement from the	F0689	What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and, All nursing staff will receive re-education on the resident safe handling program and will receive repeat competency and training on the Arjo mechanical lift use. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. An initial audit of all current nursing staff will be completed for competencies of Arjo mechanical lift use by POC date; any staff without verified competencies will receive re-education and competency verification. An audit of all newly hired nursing staff will be completed weekly to verify competency completion for Arjo use prior to completion of orientation and then monthly audits will be completed for all nursing staff to maintain annual re-education and competency thereafter. The dates corrective action will be completed. The Director of Nursing will be responsible for this plan of correction and corrective action will be completed by August 7, 2026. **Tag F0689 POC accepted on 7/29/26 by D. Hoffman/S. Stem**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475030	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/01/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0689 SS = D	Continued from page 3 supervising Registered Nurse reveals that LNA #1 and the Support Aide were present in the room at the time of the fall. A review of a provider's progress note dated 6/19/26 indicates that Resident #2 is being evaluated following a fall from a Hoyer lift during a transfer from a chair to a bed by two staff members. The nurse reports that the resident is experiencing pain in the right upper extremity and bilateral hips and that Resident #2 also sustained a head strike. Per interview on 6/24/26 at 12:13 PM, Resident #4 stated s/he was in the room when the fall from the lift occurred. S/he stated that an LNA (Licensed Nursing Assistant) and the person "who can bring things like water and towels" attempted to move his/her roommate (Resident #2) from the chair to the bed using a lift machine, and that they dropped him/her on the floor. S/he reported that the LNAs often transfer using the mechanical lift with only one person. Per the medical record, Resident #4 has a BIMS of 15 (Brief Interview for Mental Status) (A tool used to assess cognitive status), suggesting that s/he is cognitively intact. A facility job description titled "Support Aide," last revised on 1/25, section "Essential Job Functions," does not include transferring residents with mechanical lifts. Per interview with LNA #1 on 6/24/26 at 1:50 PM, she revealed she had asked the Support Aide to assist her with transferring Resident #2; she did not know the Support Aide was unable to help her transfer the resident using the mechanical lift. On 6/24/26 at 1:58 PM, an interview with the Support Aide revealed that she occasionally assists the Licensed Nursing Assistants (LNAs) with Hoyer lift transfers. She explained that she was not sure how Resident #2 fell because she wasn't looking at her, as she was not there to help, but she was just watching as another person. She stated that she has not received any training from the facility on how to transfer or assist in transferring a resident and "knows now" that she isn't supposed to assist with transfers. Employee education records for LNA #1 and the Support Aide do not include competencies evaluating the use of a mechanical lift. For more information, see F726. Per interview with the facility Educator on 6/26/26 at 4:01 PM, she stated that the role of the Support	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475030	A. BUILDING B. WING	07/01/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0689 SS = D	Continued from page 4 Aide does not include transferring residents or assisting with transfers, especially with the use of a mechanical lift or any form of personal care. All direct care staff are required to complete specific training and undergo an annual competency assessment to operate a mechanical lift. The lift requires two trained staff; she confirmed that LNA #1 had no evidence of having completed the mechanical lift competencies.	F0689	F0726 SS = D CFR(s): 483.35 (a)(3)(4)(c) What corrective action will be accomplished for those residents found to have been affected by the deficient practice; The two staff members involved received immediate education and competency for Arjo use was completed on 06/19/2026.	
F0726 SS = D	Competent Nursing Staff CFR(s): §483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is NOT MET as evidenced by: Based on employee file review, record review, and interviews, the facility failed to ensure that direct care staff had the specific competencies, and skill	F0726	How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All residents requiring mechanical lift are at risk. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and, All nursing staff will receive re-education on the resident safe handling program and will receive re-competencies training on the Arjo mechanical lift use. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. An initial audit of all current nursing staff will be completed for competencies of Arjo mechanical lift use by POC date; any staff without verified competencies will receive re-education and competency verified. An audit of all newly hired nursing staff will be completed weekly to verify competency completion for Arjo use prior to completion of orientation and then monthly audits will be completed for all nursing staff to maintain annual re-education and competency thereafter. The dates corrective action will be completed. The Director of Nursing will be responsible for this plan of correction and corrective action will be completed by August 7, 2026. **Tag F0726 POC accepted on 7/29/26 by D. Hoffman/S. Stem**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475030	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/01/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0726 SS = D	Continued from page 5 sets necessary to meet residents' needs related to the use of a mechanical lift for 1 of 4 sampled Licensed Nursing Assistant (LNA) [LNA#1]. Findings include: A review of the facility fall investigation revealed that Resident # 2 sustained a witnessed fall from the mechanical lift on 6/19/26. A statement from the supervising Registered Nurse reveals that LNA #1 and the Support Aide were present in the room at the time of the fall. A review of a provider's progress note dated 6/19/26 indicates that Resident #2 is being evaluated following a fall from a Hoyer lift during a transfer from a chair to a bed by two staff members. The nurse reports that the resident is experiencing pain in the right upper extremity and bilateral hips, and reports that Resident # suffered a head strike as well. See F689 for more information. A review of the "Facility Assessment", last updated 11/11/25, reveals that the residents who reside in the facility have various care needs, such as catheter care, transfer assistance with a mechanical Hoyer lift, dressing, toileting, and bathing assistance. The assessment describes a service offered as Mobility and fall/fall with injury prevention, which includes transfers, ambulation, and restorative nursing. The facility assessment indicates that staff will be trained and evaluated for competencies related to assistance with lifts. A review of 4 LNA training files confirmed that one file (LNA #1) lacks documented training or competency for operating a mechanical Hoyer lift. On 6/24/26, at 1:58 PM, an interview with the Support Aide revealed that she occasionally assists the Licensed Nursing Assistants (LNAs) with Hoyer lift transfers. She stated that she has not received any training from the facility on how to transfer or assist in transferring a resident. Per interview with the facility Educator on 6/26/26 at 4:01 PM, she stated that the role of the Support Aide does not include transferring residents or assisting with transfers, especially with the use of a mechanical lift or any form of personal care. All direct care staff are required to complete specific training and undergo an annual competency assessment to operate a mechanical lift. The lift requires two trained staff; she confirmed that LNA #1 had no evidence of having completed the mechanical lift competencies and the Support Aide does not receive training on any type of transfer or mechanical lifts.	F0726		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475030	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/01/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0800 SS = D	Provided Diet Meets Needs of Each Resident CFR(s): 483.60 §483.60 Food and nutrition services. The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to communication and coordination between the staff with all departments special dietary for 1 of 1 sampled residents (Resident #1). Findings include: Per record review, Resident #1 has diagnoses that include diabetes type 2, disorders of phosphorus metabolism, stage 5 chronic kidney disease, and is on a Monday, Wednesday, Friday schedule for dialysis. Per review of Resident #1 medical record, s/he had dialysis nutrition labs dated 6/12/26 that revealed a Phosphorus level at 7.8 and a note requesting to encourage the resident to avoid ice cream. Per record review Resident #1, they have been partaking in dairy products since the recommendation from dialysis was sent to the facility on 6/12/26, to encourage the resident to not eat ice cream. The resident was noted to have eaten ice cream, yogurt, and milk since 6/12/26. Resident's orders or care plan do not reflect the recommendation. Per interview on 6/30/26 with the Unit Manager at 2:50 PM, verbalized that when a resident returns from dialysis they have a dialysis book they take with them for any new orders or recommendations. She verbalized that staff would then communicate any dietary changes thru their Diet Order and Communication slip. This could be used for new diet orders, recommendations, or short-term diet adjustments such as nothing by mouth (NPO). Also stated that the nurses and dietary staff at dialysis at times communicate with them via a call or email. Per interview on 6/30/26 with Dietary Manager at	F0800	F0800 SS = D CFR(s) 483.60 What corrective action will be accomplished for those residents found to have been affected by the deficient practice; Resident #1 discharge from the facility on 6/16/2026. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All residents have the potential to be affected. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and, All nursing staff will be re-educated on order verification and procedure for dietary communication slips for any dietary order changes. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. An audit of all provider orders will be reviewed daily X 4 weeks then weekly x 3 months for any new order changes and for dietary communication completion for any dietary orders. Any discrepancies will be rectified immediately. The dates corrective action will be completed. The Director of Nursing will be responsible for this plan of correction and corrective action will be completed by August 7, 2026. **Tag F0800 POC accepted on 7/29/26 by D. Hoffman/S. Stem**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475030	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/01/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0800 SS = D	Continued from page 7 3:13 PM, he was not able to locate a Diet Order or Communication slip for Resident #1 for the month of June. Per interview on 6/30/26 with the Dietary Tech at 3:15 PM, when shown the Dialysis Nutrition Labs from 6/12/26 with the Phosphorus levels at 7.8 and the comment noted with it requesting to encourage the resident to avoid ice cream. The Dietary Tech verbalized that she did not know about this and that this was not communicated to her. She stated that if she or the Dietary Manager had seen the recommendation, they would have put it in the system. She confirmed that it was not in the system and that it should have been in the system.	F0800		