VERMONT

Department of Disabilities, Aging and Independent Living
Division of Licensing and Protection
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AGENCY OF HUMAN SERVICES

February 10, 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 **January 14, 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 01/14/2026

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 one facility reported incident, including reports # 2694372 on 1/14/26 to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. The following regulatory deficiencies were identified: F0602 Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is NOT MET as evidenced by: 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	F0000 F0602	The facility wishes to have this plan of correction stand as its written plan of compliance. Our date of compliance is 2/27/26. Preparation and/or execution of this does not constitute an admission or agreement with the existence of or scope and severity of the cited deficiencies. This plan is prepared and/or executed to ensure compliance with regulatory requirements. Plan of Correction – F0602 Free from Misappropriation/Exploitation - CFR(s): 483.12 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The ten residents identified in the facility investigation (Residents #1–10) were assessed immediately for any change in condition related to missed or diverted controlled medications. All reported receiving medications upon request and as prescribed and that their pain was controlled. The involved LPN was removed from the schedule on 12/15/25, placed on administrative leave, and later separated from employment and is ineligible for re-hire. The suspected drug diversion was reported to Licensing and Protection, Adult protective services, local law enforcement, and the Office of Professional Regulation in compliance with state law and facility policy. Controlled medication counts for all affected residents were reconciled, and all discrepancies were documented and reported. Residents or their insurance companies will be reimbursed for lost medications at the facility's expense. 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 buildingwide audit of all controlled medication logbooks, controlled substance proofs-of-use, and MARs was conducted by the DON, ADONs, and Acting Administrator. No additional residents were found to have unexplained missing doses or altered documentation beyond the ten already identified. All residents receiving controlled medications were	

F0602 SS = E

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 NBA LNHA	Administrator	2/9/2026

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F0602 SS = E	Continued from page 1 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 Vermont 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 an	F0602	considered potentially 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? All licensed nurses were reeducated on the Required immediate reporting procedure for any count discrepancy or documentation irregularity and facility policies titled, Medication Administration Methods, Controlled Substances Inventory Policy/Storage, and Nursing Documentation Standards by the DON/designee. The facility will continue changeofshift controlled medication counts performed jointly by oncoming and outgoing nurses. A weekly supervisory audit process will be implemented to include random audits of two carts per week to review MAR documentation, and count reconciliation and a review of narcotic book sign for verification of legible, sequential, and accurate documentation and any discrepancy or triggers will immediate investigation by DON/Administrator. The LPN involved in misappropriation was terminated and will not be eligible for rehire. The facility now verifies active licensure status for all nurses monthly, and licensed staff will not be allowed to work without a current, active license. Staff access to controlled substances is limited to licensed nurses assigned to the unit. 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? The corrective action will be monitored through weekly audits of at least two medication carts to verify proper controlled substance documentation, MAR consistency, and no outofsequence, altered, or overwritten entries. Any staff found noncompliant will receive progressive counseling/discipline and retraining. Any discrepancies will be reported immediately to the Administrator and corrected. The audits will continue weekly for three months, then monthly for three months or until substantial compliance is obtained. Findings will be reported to the quality assurance committee at the schedules meeting for a minimum of 3 months.	

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F0602 SS = E	Continued from page 2 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 Burlington Police Department, and an investigation is in progress with the Office of Professional Regulations.	F0602	The dates corrective action will be completed? The facility will achieve full compliance with this Plan of Correction by February 27, 2026. The Director of Nursing is responsible for this **Tag F 602 POC accepted on 2/10/26 by S. Davies/S. Stem** Plan of Correction- F0659 Qualified Persons - CFR(s): 483.21(b)(3)(ii) What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The involved LPN was removed from the schedule on 12/15/25, placed on administrative leave, and later separated from employment and is ineligible for re-hire. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?	
F0659 SS = D	Qualified Persons CFR(s): 483.21(b)(3)(ii) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to ensure that 1 of 5 nursing staff had an active Vermont 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 Vermont license to	F0659	All residents who received care from the LPN had the potential to be affected. A facilitywide license verification audit was completed on 12/16/25 for all licensed nurses (LPNs and RNs). The audit confirmed that there were no additional RN or LPN staff with expired licenses. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?	

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F0659 SS = D	Continued from page 3 practice. The nurse's multistate compact license (a license with the authority to practice in multiple member states), which permitted practice in Vermont, had expired on 10/31/25. A request for an updated license was made to the Administrator on 1/14/26 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 Vermont. 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 Vermont. 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 10/31/25 to 12/15/25, with 6 shifts administering medications as an LPN. During an interview on 1/15/26 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 12/16/25, was completed, and that it was determined the suspected LPN was the only staff member noted to have an expired Vermont license. The Administrator stated the expected process is for staff to renew their licenses to practice in Vermont, 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 Vermont 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 1/15/26 at 11:26 AM with the former Director of Nursing (DON), who resigned on 1/13/26, she revealed that during a review of the suspected LPN's personnel file, the facility identified that the LPN's	F0659	A centralized, electronic spreadsheet of all licensed staff is now updated upon hire/ termination of any new RN or LPN and monthly with licensure renewals. The Administrator/designee will complete monthly audits of this log and notify any employee with an expiration date within 30 days and will prevent them from being scheduled following the expiration date until their new license is verified as active. All licensed nurses will be re-educated on the requirements for active licensure in Vermont or Compact Licensure. Al licensed nurses were reeducated on the required immediate reporting procedure for any count discrepancy or documentation irregularity and facility policies titled, Medication Administration Methods, Controlled Substances Inventory Policy/Storage, and Nursing Documentation Standards by the DON/designee. The facility will continue changeofshift controlled medication counts performed jointly by oncoming and outgoing nurses. A weekly supervisory audit process wil be implemented to include random audits of two carts per week to review MAR documentation, and count reconciliation and a review of narcotic book sign for verification of legible, sequential, and accurate documentation and any discrepancy or triggers will immediate investigation by DON/Administrator. The LPN involved in misappropriation was terminated and will not be eligible for rehire. The facility now verifies active licensure status for all nurses monthly, and licensed staff will not be allowed to work without a current, active license. Staff access to controlled substances is limited to licensed nurses assigned to the unit.	

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F0659 SS = D	Continued from page 4 Vermont 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.	F0659	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? A weekly audit of the license tracking worksheet will be completed by the Administrator or Designee weekly X 4 weeks then Monthly. License verifications will be completed for all LPN and RN staff upon hire, documented on the tracking sheet and filed as appropriate. Monthly license verification will be completed for all RNs and LPNs. Nurses will be notified of an upcoming expiration date and any RNs or LPNs with expired licensure will not be allowed to work until license is renewed and verified. Findings will be reported to the quality assurance committee at the schedules meeting for a minimum of 3 months. The dates corrective action will be completed? The corrective action will be completed by February 27, 2026. The Director of Nursing is responsible for this corrective action. **Tag F 602 POC accepted on 2/10/26 by S. Davies/S. Stem** Plan of Correction - F0755 Pharmacy Srvcs/Procedures/Pharmacist/Records - CFR (s): 483.45(a)(b)(1)-(3) What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The involved LPN was removed from the schedule on 12/15/25, placed on administrative leave, and later separated from employment and is ineligible for re-hire.	
F0755 SS = D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is NOT MET as evidenced by: 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	F0755		

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F0755 SS = D	Continued from page 5 was raised on 12/15/25 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 12/16/25, it was revealed that the LPN suspected of failing to follow medication administration procedures had an expired nursing license in Vermont. Per interview with the Administrator on 1/14/26 at approximately 12:00 PM, confirmed the LPN was working without a current Vermont State license. The facility policy titled "Controlled Substances Inventory Policy/Storage", last modified 11/13/24, 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 1/25/24, 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 11/21/25, 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 1/14/26 at 1:38 PM with the	F0755	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 who received care from the LPN had the potential to be affected. A facilitywide license verification audit was completed on 12/16/25 for all licensed nurses (LPNs and RNs). The audit confirmed that there were no additional RN or LPN staff with expired licenses. A buildingwide audit of all controlled medication logbooks, controlled substance proofs-of-use, and MARs was conducted by the DON, ADONs, and Acting Administrator. No additional residents were found to have unexplained missing doses or altered documentation beyond the ten already identified. All residents receiving controlled medications were considered potentially 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? A centralized, electronic spreadsheet of all licensed staff is now updated upon hire/ termination of any new RN or LPN and monthly with licensure renewals. The Administrator/designee will complete monthly audits of this log and notify any employee with with an expiration date withing 30 days and will prevent them from being scheduled following the expiration date until their new license is verified as active. All licensed nurses will be re-educated on the requirements for active licensure in Vermont or Compact Licensure. All licensed nurses were reeducated on the required immediate reporting procedure for any count discrepancy or documentation irregularity and facility policies titled, Medication Administration Methods, Controlled Substances Inventory Policy/Storage, and Nursing Documentation Standards by the DON/designee. The facility will continue changeofshift controlled medication counts performed jointly by oncoming and outgoing nurses. A weekly supervisory audit process will be implemented to include random	

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F0755 SS = D	Continued from page 6 Administrator, she confirmed that the LPN had been assigned the task of medication administration without the required Vermont 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 1/15/26 at 11:26 AM with the former Director of Nursing (DON), who resigned on 1/13/26, she revealed that during a review of the suspected LPN's personnel file, the facility identified that the LPN's Vermont 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.	F0755	audits of two carts per week to review MAR documentation, and count reconciliation and a review of narcotic book sign for verification of legible, sequential, and accurate documentation and any discrepancy or triggers will immediate investigation by DON/Administrator. The LPN involved in misappropriation was terminated and will not be eligible for rehire. The facility now verifies active licensure status for all nurses monthly, and licensed staff will not be allowed to work without a current, active license. Staff access to controlled substances is limited to licensed nurses assigned to the unit. 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? The corrective action will be monitored through weekly random audits of at least two medication carts to verify proper controlled substance documentation, MAR consistency, and no outofsequence, altered, or overwritten entries. Any staff found noncompliant will receive progressive counseling and retraining, and discrepancies will be reported immediately to the Administrator and corrected. The audits will continue weekly for three months, then monthly for three months or until substantial compliance is obtained. Additionally, License verifications will be completed for all LPN and RN staff upon hire, documented on the tracking sheet and filed as appropriate. Monthly license verification will be completed for all RNs and LPNs. Nurses will be notified of an upcoming expiration date and any RNs or LPNs with expired licensure will not be allowed to work until license is renewed and verified. A weekly audit of the license tracking worksheet will be completed by the Administrator or Designee weekly X 4 weeks then ongoing monthly. Findings will be reported to the quality assurance committee at the schedules meeting for a minimum of 3 months. The dates corrective action will be completed? The corrective action will be completed by February 27, 2026. The Director of Nursing is responsible for this corrective action. **Tag F 755 POC accepted on 2/10/26 by S. Davies/S. Stem**	