VERMONT

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

April 23, 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 recertification survey conducted on **March 25, 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, 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 03/25/2026

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
E0000	Initial Comments An unannounced on-site re-certification survey was conducted by the Division of Licensing and Protection on 3/23/26 to 3/25/26 including Emergency Preparedness Requirements for 42 CFR Part 483 requirements for Long Term Care Facilities. The result of the Emergency Preparedness Survey identified no regulatory violations.	E0000	The facility wishes to have this plan of correction stand as its written plan of compliance. Our date of compliance is 2/20/26. 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. F645 PASARR screening	
F0000	INITIAL COMMENTS The Division of Licensing and Protection conducted an unannounced, onsite recertification survey from 3/23/2026 through 3/25/2026 to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. The following regulatory deficiencies were identified:	F0000	What corrective action(s) will be accomplished for those Residents found to have been affected by the alleged deficient practice? Resident #20 received a Post Admission PASARR screening	
F0645 SS = D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph	F0645	How will you identify other residents having the potential to be affected by the same deficient practice? House audit of all residents requiring a PASARR screening was conducted; any findings of deficient practice will be corrected at the time of discovery. What measures will be put into place, or what systemic changes will you make to ensure that the deficient practice does not recur? Reeducation on PASARR regulatory compliance and completion was conducted with the social work team to ensure understanding of requirements of preadmission screen being in place and ongoing of PASARR screening. How will the corrective action be monitored to ensure the deficient practice will not recur? Auditing will be conducted weekly for a period of 12 weeks to ensure proper PASARR screening is conducted within the proper time frame, on all new admissions. This audit will be conducted by the Social Services Director and reported to the QAPI team for review at the regularly scheduled meeting. Date of compliance is May 9, 2026, the Director of Social Services is responsible for this corrective action.	

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	4/17/26

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F0645 SS = D	Continued from page 1 (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is NOT MET as evidenced by:	F0645	**Tag F0645 POC accepted on 4/23/26 by R. Desrochers/S. Stem**	

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F0645 SS = D	Continued from page 2 Based on staff interview and record review, the facility failed to assure that a PASARR (Pre-Admission Screening and Resident Review) was conducted for 1 applicable resident (Resident #20), who was admitted with a 30-day exemption and has exceeded the expected 30-day stay. Findings include: Per record review, Resident #20 had a PASARR Level 1 exception form signed and dated by a physician on 4/15/2025 that stated, "If the individual is found to meet the conditions of this exemption, the individual may be admitted to a nursing facility without further screening. Hospital Discharge for Short-Stays (30 days or less) less) Is this individual being admitted to a nursing facility directly following an acute hospitalization for treatment of a condition that he/she was hospitalized for? (The attending physician must certify by signing below, before admission, that the individual is likely to require less than 30 days in the nursing facility to qualify for this exemption.)If it is later decided the individual will exceed the 30 days, another Level 1 form screening for serious mental illness (SMI) and intellectual/developmental disability (IDD/DD) and/or a related condition (RC) must be completed by the admitting nursing home and submitted to the Department of Mental Health. Please be sure to send completed copies of this form to the hospital of record, nursing facility, and individual/legal guardian(s)." There is no evidence in Resident #20's medical record that a Level 1 PASARR was completed prior to admission and there is no evidence of further screening after the 30 days exemption. Resident #20 has diagnoses including but not limited to, Post Traumatic Stress Disorder, Unspecified, Adjustment Disorder with Mixed Anxiety and Depressed Mood, and insomnia. Per interview on 3/24/26 at approximately 3:10 PM, the Director of Nursing confirmed that the PASARR screening had not been updated since the initial 30-day period and the resident still resides in the facility.	F0645		
F0658 SS = D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is NOT MET as evidenced by:	F0658		

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F0658 SS = D	Continued from page 3 Based on interview and record review, the facility failed to follow the providers' orders in administering a medication for one of eight residents (Resident #64). Per record review, Resident #64 has the medical diagnosis of cellulitis of left lower limb, Methicillin Resistant Staphylococcus Aureus infection (MRSA), and pain in their left leg. On 2/19/26, a telehealth provider created a treatment plan including "Start linezolid 600 mg BID for five days to cover for MRSA". A second progress note on 2/24/26 by a provider identified that the Resident had been prescribed linezolid on 2/19/26 and that they could not see that it was ever obtained or administered. Per interview on 3/25/26 at 4:05 PM with the infection preventionist (IP) nurse, she provided a text message with the provider that asked if Resident #64 had been given the linezolid per the telehealth orders and indicated that linezolid would have been a good choice. When asked who enters the orders for telehealth providers, she stated that typically it's whoever calls the telehealth provider, but the telehealth provider or the nurse can do it. Per interview on 3/25/26 at 5:01 PM with the infection preventionist (IP) nurse, she confirmed that they don't have a policy specific to nurses putting in orders. Per interview on 3/25/26 at 5:11 PM with the infection preventionist (IP) nurse and the Unit Manager (UM), the UM confirmed that the order was not transcribed over and that it wasn't given to the Resident #64 as ordered. Lippincott Williams & amp; Wilkins. 2023. Lippincott Nursing Procedures - 9th Ed. Philadelphia. Lippincott Williams & Wilkins.	F0658	F658 Quality of care Resident #64 What corrective action(s) will be accomplished for those Residents found to have been affected by the alleged deficient practice? Resident # 64 is no longer resides at Elderwood of Burlington discharge occurred on 3/30/26 How will you identify other residents having the potential to be affected by the same deficient practice? A whole house audit will be conducted retrospectively to include the past 30 days to review all notes for follow up confirmation. Any findings of deficient practice will be corrected at the time of discovery. What measures will be put into place, or what systemic changes will you make to ensure that the deficient practice does not recur? Licensed nurses will be reeducated on order entry and order verification process pertaining to orders received and follow up documentation of received orders. All Nurses will be educated on the Electronic Physician Orders (Create, Confirm, Processing Orders) policy. How will the corrective action be monitored to ensure the deficient practice will not recur? An audit will be completed weekly for four weeks, then monthly for three months to show all telephone orders receive proper follow-up. The results of the audits will be reported to the quality assurance committee at the scheduled meeting. Date of compliance is May 9,2026, the Director of nursing is responsible for this corrective action	
F0698 SS = E	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is NOT MET as evidenced by:	F0698	**Tag F0658 POC accepted on 4/23/26 by R. Desrochers/S. Stem**	

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F0698 SS = E	Continued from page 4 Based on observation, interview, and record review, the facility failed to ensure that residents who require dialysis (A life-sustaining medical treatment that filters waste, toxins, and excess fluids from the blood when the kidneys have failed.) receive services consistent with professional standards of practice for one of two residents (Resident #112). Findings include: Per review of the facility policy and procedure titled "Dialysis- Care of Resident Receiving Off Site Dialysis", revised on 7/6/18, it revealed that vital signs, including weights, should be performed as ordered by the provider. Per record review, Resident #112 was admitted to the facility on 3/6/26 with diagnosis that include end stage renal (kidney) disease, anemia (low red blood cells) in chronic kidney disease, chronic diastolic heart failure (CHF), and pulmonary edema (fluid in lungs). The Resident has a central catheter (a soft plastic tube, tunneled under the skin and placed in a vein in the neck, chest, or groin, which enters a central vein that leads to the heart). Review of Resident #112's care plan reveals a focus area of "I require hemodialysis r/t End Stage Renal Disease" with the intervention of monitoring for vital signs as needed, initiated on 3/7/26. An additional focus area is Resident #112s Respiratory Status which states "I have a potential for alteration in respiratory status r/t CHF, fluid overload, Shortness of Breath" with an intervention of monitor vital signs/pulse oximetry as needed/ordered, initiated on 3/7/26. Per review of the dialysis binder for Resident #112, there are two dialysis center communication record forms that are missing various information, like the patient identifier, the Resident's weight, how much fluid was removed, and the dialysis centers recommendations. Per interview on 3/25/26 at 2:39 PM with the nurse supervisor, she reported that the dialysis communication binder goes to dialysis and that it isn't always filled out. She confirmed that the patient identifier should be filled out, any recommendations from dialysis, pre and post vitals, weights, how much fluid they took off, and the date of treatment. Per observation on 3/25/26 at approximately 4:25 PM, there were no clamps observed in Resident #112's room. Per interview on 3/25/26 at 4:30 PM, the Unit Manager confirmed that Resident #112 should have clamps in the	F0698	F698 Dialysis services Resident #112 What corrective action(s) will be accomplished for those Residents found to have been affected by the alleged deficient practice? Resident #112 dialysis communication binder/epic was reviewed, and the identified areas of concern of missing information were identified. Resident identifier was updated, resident weights will be ongoing as per protocol surrounding dialysis appointments, Resident fluid removal amounts will be monitored as recorded on the form, and dialysis recommendations will be reviewed. Resident #112 clamps for emergency use of the dialysis port have been ordered. Resident #112 care plan was updated to ensure that the dialysis port with location is listed How will you identify other residents having the potential to be affected by the same deficient practice? Current in-house dialysis of residents' binders was reviewed, and no other findings of missing communication information was found. Current in-house dialysis residents were reviewed, and clamps were ordered for all residents on dialysis. Current in-house dialysis of residents' care plans was reviewed to ensure that ports were listed on care plans. What measures will be put into place, or what systemic changes will you make to ensure that the deficient practice does not recur? Nursing staff was educated on the need for communication forms to be reviewed on resident return from treatment for the following: vitals, fluid removal amounts, as well as recommendations made by Dialysis services. Nursing staff were educated on the need for available clamps issued to all dialysis patients. Nursing staff were educated on ensuring care plans are updated to show port and location. How will the corrective action be monitored to ensure the deficient practice will not recur? An audit will be conducted weekly for 4 weeks then monthly for 3 months to ensure communication tools are utilized, and communication between the facility and the contractor is complete. This audit will include ensuring clamps are readily available for all dialysis residents. and ensure any residents who admit that require dialysis are issued a care plan that includes dialysis port location. The results of the audits will be reported to the quality assurance committee at the scheduled meeting. Date of compliance is May 9,2026, the Director of nursing is responsible for this corrective action. **Tag F0698 POC accepted on 4/23/26 by R. Desrochers/S. Stem**	

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F0698 SS = E	Continued from page 5 room for use in case of an emergency, and that there were not any in the room. The Unit Manager then went to get clamps from the medication room but could not find them. The Unit Manager then found the clamps in the Clean Utility room and stated that he would make sure the clamps go in Resident #112's room. Per interview on 3/25/26 at 4:51 PM, the Unit Manager confirmed that Resident #112 has a central line, not a shunt per the treatment plan. The Unit Manager also confirmed that the care plan should indicate central line.	F0698	F730 Nurse Aid Performance Review What corrective action(s) will be accomplished for those Residents found to have been affected by the alleged deficient practice? No residents were identified as having been affected by the alleged deficient practice. How will you identify other residents having the potential to be affected by the same deficient practice All residents have the potential to be affected by the alleged deficient practice. All currently employed Licensed Nurse Aids having been employed for greater than 12 months were reviewed for completion of a performance review. Any further findings of noncompliance to the requirement will be completed. What measures will be put into place, or what systemic changes will you make to ensure that the deficient practice does not recur? The Leadership Nursing team will be reeducated to ensure understanding of the regulatory requirements to ensure Nurse Aids are given a performance review every 12 months and these records are maintained in the employee file. How will the corrective action be monitored to ensure the deficient practice will not recur? The Human Resources Director will audit employee files to ensure that all licensed nursing aids have had their performance review no later than twelve months from employment. This audit will be done monthly x3 months, the findings will be shared with the QAPI team at the scheduled meeting. Date of compliance is May 9th, the Director of Nursing is responsible for this corrective action. **Tag F0730 POC accepted on 4/23/26 by R. Desrochers/S. Stem**	
F0730 SS = F	Nurse Aide Perform Review – 12Hr/Year In service CFR(s): §483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to complete a performance review of every nurse aide at least once every 12 months or provide regular in-service education based on the outcome of these reviews for 4 of 4 sampled employee files. Findings include: A review of 4 employee files indicated that Licensed Nursing Assistant (LNA) #1 was hired on 10/1/2024, LNA #2 with a hire date of 7/18/2023, LNA # 3 with a hire date of 7/24/2025, and LNA #4 with a hire date of 12/17/2018 did not have evidence of performance reviews for 2025 in their employee files. Per the interview with the Administrator on 3/25/26 at 2:40 PM, she confirmed that the 2025 employee reviews had not been completed.	F0730		
F0761 SS = F	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted	F0761		

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F0761 SS = F	Continued from page 6 professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on observation and interview, the facility failed to ensure expired medications were stored or disposed of properly for 3 of 3 units. This is a repeat deficiency for this facility, with violations cited during the previous two recertification surveys dated 4/2/25 and 1/11/24. Findings include: Per review of the facilities policy titled "Medications Administration Methods" dated 1/25/24, it states that medication expiration dates are checked prior to administration. Per observation and interview on 3/24/26 at 10:30 AM, the Chittenden medication room had seven cases, 69 packs of nystatin oral suspension packs 500,000 units/5ml (a medication used to treat fungal infections), that had expired in 2025. A nurse confirmed this medication was expired. Per observation and interview on 3/24/26 at 11:12 AM of a medication treatment cart on the Champlain Unit, a medication called Benzonatate 100 mg tablets (a medication used to help alleviate coughing) expired on 10/31/25 along with Aspirin 325mg (a medication used to make the blood thinner) with an expiration date of 1/26. A nurse confirmed these medications were expired. Per observation and interview on 3/24/26 at 11:31 AM in	F0761	F761 Storage of Drugs and Biologics What corrective action(s) will be accomplished for those Residents found to have been affected by the alleged deficient practice? No residents were identified as having been affected by the deficient practice. How will you identify other residents having the potential to be affected by the same deficient practice? All residents have the potential to be affected by deficient practices. None were identified. Expired medications found during the survey were immediately removed from use. House wide audits were conducted of all medication carts and medication storage areas, and no other expired medications were identified. What measures will be put into place, or what systemic changes will you make to ensure that the deficient practice does not recur? All nursing staff will be re-educated on the policy " medication administration methods" specific to medication expiration dates and removal from use if expired. How will the corrective action be monitored to ensure the deficient practice will not recur? Auditing of unit storage and medication carts/treatment carts will be conducted weekly for 4 weeks, then monthly, for all three units. The results of the audits will be reported to the quality assurance committee at the scheduled meeting. Date of compliance is May 9, 2026, the Director of nursing is responsible for this corrective action **Tag F0761 POC accepted on 4/23/26 by R. Desrochers/S. Stem**	

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F0761 SS = F	Continued from page 7 the Mansfield medication room, a medication called Ipratropium bromide and albuterol sulfate inhalation solution .5mg/3mg (a medication to help open the airways) expired on 12/25. A nurse confirmed this medication had expired.	F0761	F812 Food procurement Storage and prepare What corrective action(s) will be accomplished for those Residents found to have been affected by the alleged deficient practice? No residents were identified as having been affected by the deficient practice. How will you identify other residents having the potential to be affected by the same deficient practice? All residents have the potential to be affected by deficient practices. The Dietary Director removed all identified expired food items immediately from the kitchenette refrigerator. A house audit was conducted to ensure no other items past expiration date were found. None were identified. What measures will be put into place, or what systemic changes will you make to ensure that the deficient practice does not recur? All dietary and nursing staff will be educated on the policy of proper food storage which includes expiration dates, removal of expired items, and labeling of food items. How will the corrective action be monitored to ensure the deficient practice will not recur? Auditing of all kitchenettes will be conducted daily to ensure that all items are labeled and dated appropriately with open/expiration dates and to ensure expired items are removed. This audit will be done under the direction of the Dietary Director. The findings will be provided to the QAPI team for a period of 3 months or until substantial compliance is obtained. Date of Compliance is May 9, 2026 and the Director of Dietary services will be reposible for this corrective action. **Tag F0812 POC accepted on 4/23/26 by R. Desrochers/S. Stem**	
F0812 SS = D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review the facility failed to store food in accordance with professional standards for food service safety for 1 applicable unit. Findings include: Per observation of the kitchenette #1 refrigerator on the Mansfield unit on 3/23/26 at 11:21 AM there was a can of Redi-whip that expired on 3/16/26. There were (2) 32-ounce bottles of milk that expired on 3/19/26. In the freezer there were three packs of two donuts with no label or date. An interview was conducted with the Kitchen Manager on 3/23/26 at approximately 11:30 AM. The Kitchen Manager confirmed the items in the fridge were expired stating, "I'll throw these [items] away." He confirmed that the	F0812		

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(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
F0812 SS = D	Continued from page 8 packs of donuts had no label or date on them stating, "I don't know what these are from." Per review of the facility's "Dietary, Food and Supply Orders-Storage" policy [last revised 10/26/18] it states, "1. Food and non-food items are removed from storage areas by kitchen personnel, as needed on a per meal basis. 2. Before use, all items are checked for spoilage. 3. If a food is partially used, the item is labeled with name and date and covered before being put back in storage."	F0812		
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported;	F0880	F880 Infection Prevention What corrective action(s) will be accomplished for those Residents found to have been affected by the alleged deficient practice? Resident #14 was reviewed and there were no identified effects of the alleged deficient practice of nurse failing to Don PPE. How will you identify other residents having the potential to be affected by the same deficient practice? A whole house audit was conducted on PPE use on residents identified as needing Barrier precautions; no findings of residents affected were identified. All staff that were found to be in noncompliance have been reeducated and provided disciplinary action if warranted. What measures will be put into place, or what systemic changes will you make to ensure that the deficient practice does not recur? All staff were reeducated to the use of PPE and infection control practices for Barrier precautions. How will the corrective action be monitored to ensure the deficient practice will not recur? Random Audits will be conducted biweekly x12 weeks to ensure the use of PPE when caring for residents on Barrier Precautions. Findings of this audit will be reported to the QAPI team for review. Individuals not adhering to policy will be reeducated and or disciplined. Date of compliance is May 9th,2026, the Director of nursing is responsible for this corrective action **Tag F0880 POC accepted on 4/23/26 by R. Desrochers/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 03/25/2026

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F0880 SS = D	Continued from page 9 (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review the facility failed to implement appropriate infection control practices during medication administration via tube feed for one sampled resident (Resident #14). This is a repeat deficiency for this facility, with violations cited during the previous two recertification surveys dated 4/2/25 and 1/11/24. Findings include: 1. Medication administration via a tube feed was observed on 3/25/26 at approximately 8:45 AM for Resident #14 by LPN#2. Per observation, Resident #14 had an "Enhanced Barrier Precautions" sign outside of	F0880		

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F0880 SS = D	Continued from page 10 their room. Per record review, Resident #14 has an order stating "Precautions: Maintain barrier precautions r/t [related to] hx [history] of MRSA [Methicillin-resistant Staphylococcus aureaus, a bacterium that is resistant to many antibiotics], PEG [Percutaneous Endoscopic Gastrostomy] tube use." Per observation, LPN#2 did not don PPE [Personal Protective Equipment] prior to going into the room. Per review of the facility's "Transmission Based Precaution Levels (Type of Infectious Condition, Techniques and Documentation) SNF" policy [last revised 6/6/24] it states, "Enhanced Barrier Precautions: Enhanced barrier precautions involve gown and glove use during high contact resident activities for residents known to be colonized or infected with an MDRO [Multidrug-Resistant Organism, an organism resistant to many antibiotics] as well of those who at increased risk of MDRO acquisition." An interview was conducted with LPN#2 on 3/25/26 at 8:55 AM. She confirmed she did not put on PPE prior to entering the resident's room to administer medications via a PEG tube. She stated, "I'm not sure if we need to wear PPE [for tube feeding]." She confirmed tube feeding is on the EBP sign stating, "We'll have to look into that." An interview was conducted with the Infection preventionist on 3/25/26 at 9:22 AM. The Infection Preventionist confirmed that PPE should be worn for EBP residents with a PEG tube.	F0880		
F0883 SS = D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time	F0883		

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F0883 SS = D	Continued from page 11 period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interviews, the facility failed to document for 1 of 6 residents (Resident #124) whether the resident was offered, educated, and received or declined the influenza and pneumococcal	F0883	F883 Influenza and Pneumococcal Immunizations What corrective action(s) will be accomplished for those Residents found to have been affected by the alleged deficient practice? Resident # 124 was offered the influenza and pneumococcal vaccine and was declined due to historical immunization. How will you identify other residents having the potential to be affected by the same deficient practice? A whole house audit of current residents was conducted indicating any other residents identified as without consent or declination or in need of immunization and will be rectified to show compliance. What measures will be put into place, or what systemic changes will you make to ensure that the deficient practice does not recur? All licensed Nursing staff will be reeducated on obtaining consent/declinations for immunizations, administration and documentation practices of immunizations. How will the corrective action be monitored to ensure the deficient practice will not recur? House wide audit of immunization status will be ongoing weekly x 4 weeks then monthly for 3 months to ensure all new admissions are included showing receipt of Influenza and Pneumococcal immunization documentation or declination. A report of audit findings will be provided to the QAPI team for review. Date of compliance is May 9, 2026,, the Director of Nursing is responsible for this corrective action **Tag F0883 POC accepted on 4/23/26 by R. Desrochers/S. Stem**	

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F0883 SS = D	Continued from page 12 vaccinations. Findings include: Per record review on 03/25/2026, Resident #124 was admitted on 10/3/25, and no documentation was located in the electronic medical record (EMR) to indicate the resident, or their representative had been educated, offered, and received or declined vaccinations. The Immunizations Report generated from the EMR indicates Resident #124's influenza status is "historical," but lacks documentation of the immunization. The report doesn't indicate whether the resident received the pneumococcal vaccination. Per interview on 3/25/2026 at approximately 11:39 AM, the Infection Preventionist was asked to provide the "Vaccination Review: Consent/Declination SNF Resident Form" for Resident #124. Per interview on 3/25/2026 at approximately 4:05 PM, the Infection Preventionist confirmed documentation of offering, educating, and either receiving or declining the influenza and pneumococcal vaccinations were not available. Review of the facility policy titled, "Influenza Immunization (Residents) Policy," last modified 6/2025, notes: "Annually...Prior to administration, residents and/or responsible parties will be educated regarding the risks and benefits of the influenza vaccine." The policy further states, "the resident Influenza Vaccination Consent/Declination form will then be completed," and once consent is obtained, the vaccination may be ordered and administered. Review of facility policy titled "Pneumococcal Vaccination (Resident)," last modified August 2023, states: "Documentation of immunization will be placed in the individual's record at the facility. If a resident is not immunized, the reason will be documented."	F0883		
F0887 SS = D	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80 Infection control §483.80(d)(3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following:	F0887		

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F0887 SS = D	Continued from page 13 (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects, associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses. (v) The resident or resident representative, has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; and (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident, or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal. (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and	F0887	F887 Covid 19 immunizations What corrective action(s) will be accomplished for those Residents found to have been affected by the alleged deficient practice? Resident # 124 was offered the Covid-19 immunization and consented to immunization and the vaccination was ordered for administration. Resident #124 will recieve the vaccination upon reciept of vaccine from pharmacy. How will you identify other residents having the potential to be affected by the same deficient practice? A house wide audit of current residents was conducted indicating any other residents identified as without consent or declination of covid immunization or in need of immunization, and all will be rectified to show compliance. What measures will be put into place, or what systemic changes will you make to ensure that the deficient practice does not recur? All licensed Nursing staff will be reeducated on obtaining consent/declinations for immunizations, administration, and documentation practices of immunizations. In addition, all nurses will be educated on the the immunization policies. How will the corrective action be monitored to ensure the deficient practice will not recur? A house wide audit of immunization status will be ongoing weekly x4 weeks then monthly x3 months to ensure all new admissions are included showing receipt of covid immunization documentation or declination. Any areas of concern for noncompliance will be followed by reeducation and or disciplinary action. A report of audit findings will be provided to the QAPI team for review. Date of compliance is May 9, 2026, the Director of **Tag F0887 POC accepted on 4/23/26 by R. Desrochers/S. Stem**	

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F0887 SS = D	Continued from page 14 (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review the facility failed to include documentation in the electronic medical record (EMR) for 1 of 6 residents (Resident #124) whether the resident was offered, educated, received, or declined the COVID-19 vaccinations. Findings include: Per record review on 03/25/2026, Resident #124 was admitted on 10/3/25, and no documentation was located in the EMR to indicate the resident or their representative had been educated, offered, received, or declined the COVID-19 vaccinations. The Immunizations Report generated from the EMR indicates Resident #124's COVID-19 status is "historical" with a date of receiving it on 12/5/24, however it lacks documentation of the immunizations. Per interview on 03/25/2026 at approximately 11:39 AM, The Infection Preventionist was asked to produce the "Vaccination Review: Consent/Declination SNF Resident Form" for Resident #124. Per interview on 3/25/2026 at approximately 4:05 PM, the Infection Preventionist confirmed documentation of offering, educating, and either receiving or declining the COVID-19 vaccinations were not available. Review of the policy entitled "COVID-19 Policy (Resident)", Last Modified 9/2025 notes: "For residents who decline to be vaccinated for COVID-19, the facility will obtain a written affirmation for signature indicating that the resident was offered and declined the opportunity for the facility to arrange for a COVID-19 vaccination..." "...Vaccination fact sheets will be made available to residents and resident representatives prior to administration. Informed consent either written or verbal will be obtained from all individuals being vaccinated."	F0887		