

Division of Licensing and Protection
103 South Main Street
Waterbury, VT 05671-2306
<http://www.dail.vermont.gov>
Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
Fax (802) 871-3318

August 13, 2015

Ms. Susan Biondolillo, Administrator
Starr Farm Nursing Center
98 Starr Farm Rd
Burlington, VT 05408-1396

Dear Ms. Biondolillo:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **July 15, 2015**. 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
Licensing Chief



07

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/28/2015
FORM APPROVED:
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475030	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/15/2015
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NAME OF PROVIDER OR SUPPLIER STARR FARM NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 98 STARR FARM RD BURLINGTON, VT 05408
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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)	DATE COMPLETED
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F 000 INITIAL COMMENTS

A unannounced onsite investigation of 2 entity self-reports and 1 complaint concerning care and services was conducted by the Division of Licensing and Protection on 7/14-7/15/15. The following regulatory violations were identified:

F 225 483 13(c)(1)(i)-(iii), (c)(2) - (4)
SS=C INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS

The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.

The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).

The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.

The results of all investigations must be reported to the administrator or his designated

F 000 Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the alleged facts or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of federal and state law require it.

08/18/2015

LABORATOR, DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Susan B. Beondolillo</i>	TITLE Executive Director	DATE 8-4-2015
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 30 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.

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F 225 Continued From page 1
representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken

This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview and record review, staff failed to report bruising of unknown source immediately to the nursing supervisor or administration through established procedures so that the bruising could be investigated for 1 of 3 applicable residents. (Resident #2) Findings include

On 7/14/15 at 9:40 AM Resident #2 was observed sitting in his/her wheelchair by the nurse's station. A large area of deep purple and red bruising was noted on his/her bilateral dorsal forearms extending from just above the resident's wrists to just below the elbows. The resident was not able to communicate how the bruising occurred. The bruises were brought to the attention of the Unit Manager (UM) at 9:50 AM.

On 7/14/15 at 10:08 AM, LNA #1 reported that the bruises were present on Resident #2 during AM care, but had not been reported to the nurse. S/he reported that the last time s/he had provided care to the resident was approximately 3 weeks ago and the bruises were not present at that time. On 7/14/15 at 11:19 AM, an agency nurse reported s/he had not noticed the bruises on Resident #2 during the morning medication pass to the resident. On 7/14/15 at 4:05 PM, LNA #2 reported that s/he had noticed the bruises a few

Flag 225

F 225 Resident # 2 bruises of unknown etiology were reported to State survey and certification agency and investigated. The facility identified the cause of bruises and new plan of care has been revised, updated and implemented.

08/18/2015

The facility completed skin assessments on residents in house to ensure no other residents were affected by this practice.

Re-education to facility staff was provided by the staff development coordinator on the facility abuse prevention policy/procedure. This included a focus on treating any injury of unknown etiology including bruises to follow this abuse prevention procedure. (Identify report, investigate and monitor).

Random skin check audits will be completed by the DNS/Designee weekly x 30 days then monthly x 60 days to ensure compliance with abuse prevention policy/procedure. The results of these audits will be presented monthly to the Quality Assurance Performance Improvement Committee for 3 months for further review.

*ADC audits 8.13.15
SDJ SA*

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 225 Continued From page 2

days to a week ago and remembered talking to a nurse about it. At the same time LNA #3 reported that s/he thought the skin was discolored and not bruised. On 7/15/15 at 11:25 AM, a staff nurse reported that Resident #2 had bruising on the forearms in May and didn't notice that these bruises were different/new. Per review of a 5/23/15 skin condition report, the resident had a 10 x 5 cm reddish-purple bruise on his/her left wrist and a 6.0 cm x 6.2 cm reddish-purple bruise on his/her right wrist. The staff nurse confirmed that a 7/2/15 weekly skin check form documented that the bruising to the right and left arm were "... getting lighter in color. No skin issues."

On 7/15/15 at 2:07 PM, the facility Director of Nursing (DNS) reported that the resident's family had seen the forearm bruises on the past weekend and had asked staff about them.

On 7/14/15 at approximately 12:00 PM, the UM completed 2 weekly non-pressure skin condition reports documenting a "new Non-pressure area" bruise on the left arm between wrist and elbow measuring 14.5 cm x 15.0 cm that was dark purple/brownish color, and on the right arm between the wrist and elbow, a bruise measuring 15.0 cm x 15.0 cm that was dark red/brownish color.

Per review, the facility's policy titled, Identification of an Event that May Constitute Abuse, states its rationale is to "Identify events, such as suspicious bruising of residents, occurrences, patterns, and trends that may constitute abuse (e.g., bruises of unknown origins...) Under Procedure, staff are directed to 1. Report a suspicious injury or an injury unknown source to the charge nurse 2. Immediately notify the Executive Director,

F 225

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F 225 Continued From page 3
Director of Nursing Services (DNS) and Social Services

On 7/15/15 at 10:29 AM, the UM reported that residents in the facility have weekly skin checks. If a bruise is identified, staff are interviewed to determine a cause. If staff cannot determine how a bruise occurred, an event form is completed and an investigation is started looking back at the prior 72 hours for causation. Staff statements are taken and the bruise is monitored on the TAR (Treatment Administration Record). The UM confirmed that Resident #2's bilateral forearm bruises had not been reported and no event form had been completed prior to their identification by the surveyor
(Refer F281)

F 225

F 281 483.20(k)(3)(i) SERVICES PROVIDED MEET
SS=D PROFESSIONAL STANDARDS

The services provided or arranged by the facility must meet professional standards of quality.

This REQUIREMENT is not met as evidenced by:
Based on direct observation, staff interview and record review, the facility failed to assure that nurses met professional standards of nursing practice regarding the identification, monitoring and reporting of changes in skin condition for 1 of 3 applicable residents (Resident #2). Findings include:

On 7/14/15 at 9:40 AM, Resident #2 was observed sitting in his/her wheelchair by the nurse's station. A large area of deep purple and red bruising was noted on his/her bilateral dorsal

F 281

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F 281 Continued From page 4

forearms extending from just above the resident's wrists to just below the elbows. The resident was not able to communicate how the bruising occurred. The bruises were brought to the attention of the Unit Manager (UM) at 9:50 AM.

On 7/14/15 at 10:08 AM, LNA #1 reported that the bruises were present on Resident #2 during AM care, but had not been reported to the nurse. S/he reported that the last time s/he had provided care to the resident was approximately 3 weeks ago and the bruises were not present at that time.

On 7/14/15 at 11:19 AM, an agency nurse reported s/he had not noticed the bruises on Resident #2 during the morning medication pass to the resident. On 7/14/15 at 4:05 PM, LNA #2 reported that s/he had noticed the bruises a few days to a week ago and remembered talking to a nurse about it. At the same time, LNA #3 reported that s/he thought the skin was discolored and not bruised. On 7/15/15 at 11:25 AM, a staff nurse reported that Resident #2 had bruising on the forearms in May and thought that these were the same bruises that had been present and were not different/new. Per review of a 5/23/15 skin condition report, the resident had a documented 10 x 5 cm reddish-purple bruise on his/her left wrist and a 6.0 cm x 6.2 cm reddish-purple bruise on his/her right wrist. The staff nurse confirmed that a 7/2/15 weekly skin check form documented that the bruising to the right and left arm were "getting lighter in color. No skin issues." Per review of 6/11, 6/18, and 6/25/15 weekly skin check sheets and weekly non-pressure skin condition reports, the original bruises identified on 5/23/15 were not remeasured and all of the above reports document that the bilateral forearm bruising was getting lighter in color and that there was no new skin issues.

Ftag 281

Resident # 2 bruises of unknown etiology were reported to State survey and certification agency and investigated. The facility identified the cause of bruises and new plan of care has been revised, updated and implemented.

The facility completed skin assessments on residents in house to ensure no other residents were affected by this practice.

Re-education was provided by the staff development coordinator on the facility abuse prevention policy/procedure. This included a focus on treating any injury of unknown etiology including bruises to follow this abuse prevention procedure. (Identify report, investigate and monitor).

Random skin check audits will be completed by the DNS/Designee weekly x 30 days then monthly x 60 days to ensure compliance with abuse prevention policy/procedure. The results of these audits will be presented monthly to the Quality Assurance Performance Improvement Committee for 3 months for further review.

*Pbc center 8-13-15
SD/SL*

08/18/2015

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F 281 Continued From page 5

On 7/15/15 at 2:07 PM, the facility Director of Nursing (DNS) reported that the resident's family had seen the forearm bruises on the past weekend and had asked staff about them.

On 7/14/15 at approximately 12:00 PM, the UM completed 2 weekly non-pressure skin condition reports documenting a "new Non-pressure area" bruise on the left arm between wrist and elbow measuring 14.5 cm x 15.0 cm that was dark purple/brownish color and on the right arm between the wrist and elbow, a bruise measuring 15.0 cm x 15.0 cm that was dark red/brownish color.

On 7/15/15 at 10:29 AM, the UM reported that residents in the facility have weekly skin checks; if a bruise is identified, staff are interviewed to determine a cause. If staff cannot determine how a bruise occurred, an event form is completed and an investigation is started looking back at the prior 72 hours for causation. Staff statements are taken and the bruise is monitored on the TAR (Treatment Administration Record). The UM confirmed that Resident #2's bilateral forearm bruises had not been reported and no event form had been completed prior to their identification by the surveyor
(Refer F225)

F 282 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN

The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.

F 281

F 282

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F 252 Continued From page 6

This REQUIREMENT is not met as evidenced by

Based on observation, interview and record review, the facility failed to provide services in accordance with the plan of care for 1 of 4 residents (Resident #3). Findings include:

On 7/14/15 at 12:30 PM, Resident #3 reported that s/he had an exercise program set up by Physical Therapy (PT) and Occupational Therapy (OT) to have Range of Motion (ROM) exercises done by licensed nursing assistants (LNAs) each morning with his/her care. The resident reported that the exercises are done at most 2 times/week. The resident reported that the exercises are essential to keep him/her functional so s/he can continue to feed him/herself, reach with his/her arms/hands and support his/her body in the wheelchair.

Per medical record review, Resident #3 had diagnoses of muscle weakness, paraplegia and spasticity related to a diagnosis of cerebral palsy (CP). A nursing maintenance program plan of care for passive ROM was present in the LNA care binder. It stated that Resident #3 "... requires daily ROM of legs due to cerebral palsy ... Interventions: 1. ROM to both legs daily 2. Resident benefits from slow passive range of both legs in a m prior to getting in chair." An OT discharge summary dated 6/11/15 states that "The patient will participate in a BUE [bilateral upper extremity] maintenance ROM program for hands through shoulders with LNAs to prevent contracture, prevent further hypertonicity, and maintain joint health, skin integrity and BUE use during self feeding, wc [wheelchair] mobility and leisure interests."

F 282

Ftag 282

Resident # 3 is receiving range of motion per his current plan of care.

08/18/2015

House audit was completed on residents with a plan of care of range of motion to ensure no other residents were affected by this practice.

The SDC/designee re-educated license nurses, licensed nursing assistants and therapy staff on following/communicating the residents' plan of care on range of motion. (Re-education was inclusive of the facility range of motion policy/procedure).

Random audits of residents with a plan of care with range of motion will be completed by the DNS/designee weekly x 30 days then monthly x 60 days. The results of these audits will be presented monthly to the Quality Assurance Performance Improvement Committee for 3 months for further review.

Plc auto 8-18-15
SD [Signature]

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F 282 Continued From page 7

F 282

On 7/14/15 at 1 21 PM, LNA #1 reported that s/he assisted Resident #3 with his/her AM care but was unaware that the resident needed ROM exercises done with his/her care. On 7/15/15 at 2 07 PM, LNA #2 reported that ROM exercises were not done this AM as there was no time. S/he also reported that s/he was not aware of the need for upper body exercises as listed by the OT.

On 7/15/15 at 10 42 AM, the nurse unit manager (UM) confirmed that Resident #3 had a PT care plan for ROM exercise; however, s/he stated that there is no place to track whether the LNAs are actually providing daily ROM to Resident #3. S/he also reported that the OT did not update Resident #3's profile to include the upper body exercises and there was no evidence that the exercise program was communicated to LNA staff for implementation.
(Refer F311)

F 311 483 25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS

F 311

A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section.

This REQUIREMENT is not met as evidenced by:

Based on resident and staff interview and record review, the facility failed to ensure that 1 of 4 residents received appropriate treatment and services to maintain or improve his/her abilities and quality of life (Resident #3). The findings include:

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F 311 Continued From page 8
On 7/14/15 at 12:30 PM, Resident #3 reported that s/he had an exercise program set up by Physical Therapy (PT) and Occupational Therapy (OT) to have Range of Motion (ROM) exercises done by licensed nursing assistants (LNAs) each morning with his/her care. The resident reported that the exercises are done at most 2 times/week. The resident reported that the exercises are essential to keep him/her functional so s/he can continue to feed him/herself, reach with his/her arms and hands and support his/her body in the wheelchair.

F 311

Per medical record review, Resident #3 had diagnoses of muscle weakness, paraplegia and spasticity related to a diagnosis of cerebral palsy (CP). A nursing maintenance program plan of care for passive ROM was present in the LNA care binder. It stated that Resident #3 "... requires daily ROM of legs due to cerebral palsy ... Interventions: 1. ROM to both legs daily. 2. Resident benefits from slow passive range of both legs in a.m. prior to getting in chair." An OT discharge summary dated 5/11/15 states that "The patient will participate in a BUE [bilateral upper extremity] maintenance ROM program for hands through shoulders with LNAs to prevent contracture, prevent further hypertonicity, and maintain joint health, skin integrity and BUE use during self feeding, w/c [wheelchair] mobility and leisure interests."

On 7/14/15 at 1:21 PM LNA #1 reported that s/he assisted Resident #3 with his/her AM care but was unaware that the resident needed ROM exercises done with his/her care. On 7/15/15 at 2:07 PM LNA #2 reported that ROM exercises were not done this AM as there was no time. S/he also reported that s/he was not aware of the need

Ftag 311
Resident # 3 is receiving range of motion per his current plan of care.

08/18/2015

House audit was completed on residents with a plan of care of range of motion to ensure no other residents were affected by this practice. The SDC/designee re-educated license nurses, licensed nursing assistants and therapy staff on following/communicating the residents' plan of care on range of motion. (Re-education was inclusive of the facility range of motion policy/procedure).

Random audits of residents with a plan of care with range of motion will be completed by the DNS/designee weekly x 30 days then monthly x 60 days. The results of these audits will be presented monthly to the Quality Assurance Performance Improvement Committee for 3 months for further review.

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F 311	Continued From page 9 for upper body exercises as listed by the OT.	F 311		
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On 7/15/15 at 9:33 AM, the facility PT reported that Resident #3 is "at risk for contractures and decline in lower extremity ROM." S/he reported that the resident is on a program to maintain what s/he's got so s/he won't lose ROM.

On 7/15/15 at 10:42 AM, the nurse unit manager (UM) confirmed that Resident #3 had a PT care plan for ROM exercise; however, s/he stated that there is no place to track whether the LNAs are actually providing daily ROM to Resident #3. S/he also reported that the OT did not update Resident #3's profile to include the upper body exercises and there was no evidence that the exercise program was communicated to LNA staff for implementation.
(Refer F282)