



AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury VT 05671-2306
<http://www.dail.vermont.gov>
Voice/TTY (802) 241-2345
To Report Adult Abuse: (800) 564-1612
Fax (802) 241-2358

July 8, 2011

Ms. Rachael Parker, Administrator
Starr Farm Nursing Center
98 Starr Farm Rd
Burlington, VT 05401

Dear Ms. Parker:

Enclosed is a copy of your acceptable plans of correction for the on-site annual recertification survey conducted on **June 8, 2011**. 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,

A handwritten signature in black ink that reads "Pamela M. Cota RN". The signature is written in a cursive style.

Pamela M. Cota, RN
Licensing Chief

PC:jl



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

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Division of
JUL - 1 11

PRINTED: 06/21/2011
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 _____	Licensing and Protection	(X3) DATE SURVEY COMPLETED 06/08/2011
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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 05401
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<p>F 000 INITIAL COMMENTS</p> <p>F 279 SS=D</p>	<p>The Division of Licensing and Protection conducted an unannounced on-site annual recertification survey from 6/6/11 to 6/8/11. The following regulatory violations were found.</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, staff interview and resident observation, the facility failed to develop a comprehensive plan of care for 1 resident of 16 in the applicable sample in Stage 2 (Resident #158). The findings include:</p>	<p>F 000</p> <p>F 279</p>	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>Enter Plan Of Correction Here. F279D Development comprehensive Care Plan</p> <p>1) Resident # 158 now has a current up to date care plan reflecting current interventions to assist in managing resident's falls/risk.</p> <p>2) An audit has been conducted for the current residents.</p> <p>3) Other current resident have fall risk care plans in place.</p> <p>4) Education for licensed staff; the procedure of an interim care plan to be in place.</p> <p>5) The DNS or designees will complete audits weekly x 4 weeks and then monthly x 8 weeks. Results will be reviewed at PI monthly, monitor & revise as necessary.</p> <p>F279 POC Accepted 7/8/11 G. Coleman RN / Pincot RN</p>	<p>Enter Date Here. 7/8/2011</p>
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 279	Continued From page 1 Per staff interview during Stage 1 of the survey on 06/06/2011, Resident #158 was reported to have fallen on 05/11/2011 at 3:00 AM. Per record review on 06/08/2011, the Fall Risk Assessment dated 05/03/2011 codes resident #158 a 14 (high risk for falls). The care plan for falls for Resident #158 is dated 05/11/2011, after the fall had occurred. The nurses' notes dated 05/11/2011 describe the fall. Staff confirm during interview on 06/08/2011 at 11:22 AM that the plan of care for managing fall risks was not developed until after a fall and that preventative action was not in place on 05/11/2011.	F 279	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280	F280 D~ Comprehensive Care Plan 1) Care Plan for resident # 2 is current and has been updated. 2) Audit current residents weekly skin checks to ensure any identified areas are on the care plan. 3) Education for nurses on the wound management protocol, which includes process for wounds that are found on weekly skin checks and the process to get the information to the care plan. via the Unit Manager / Charge nurse or designee. 4) The DNS or designee will monitor and audit weekly to ensure accuracy of wound management documentation. The results of the audits will be presented at PI meeting for 3 months for review and recommendation. F280~ Comprehensive Care Plan 1) ADL profile for resident # 117 has been reviewed and updated to resident's current status.		

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F 280	<p>Continued From page 2</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on staff interview and record review, the facility failed to revise the care plan to reflect each resident's current assessed needs for 2 of 16 applicable residents in the stage 2 sample. (Residents #2 & #117) Findings include:</p> <p>1. Per record review on 6/7/11, Resident #117 requires extensive assistance from staff for completion of Activities of Daily Living (ADLs) including transfers, dressing, toileting and personal hygiene. The Minimum Data Set Assessment (MDS) dated 6/3/11 noted extensive assist (#3 for self performance for these ADLs). The resident was coded as non-ambulatory in the room and in the hallway and uses a wheelchair for locomotion. The resident's current care plan/profile for mobility, dated 10/1/10, stated the goal is to 'maintain walking and restorative bike' and includes 'min A [assist] to contact guard with RW [rolling walker] x 50 feet'. Per review, the LNA Flow Sheets for 5/2011 and 6/2011 regarding ambulation were coded as "8" (except 3 shifts in May which charge nurse believed are errors) which means activity did not occur. During interview on 6/7/11 at 5 PM, an LNA who provides care for this resident stated that s/he no longer walks due to pain and weakness and is unable to stand. This failure of the care plan to address the resident's current status/needs was confirmed with the charge nurse on 6/8/11 at 10:35 AM.</p> <p>2. Per record review on 6/6/11, Resident #2's care plan was not revised after nurses noted new open areas to the buttock area on 6/2/11. A nursing progress note dated 6/2/11 at 0900</p>	F 280	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>2) ADL profiles will be reviewed over the next 30 days to ensure accuracy for any significant changes in status noted over the last quarter.</p> <p>3) SDC or designee will provide education to the staff that document or participate in developing the plan of care regarding changes being completed timely. Resident's ADL profile will be reviewed at their next scheduled care conference and updated to reflect the resident's current status.</p> <p>4) The DNS or designee will oversee this process. An audit of one ADL profile from each unit (total 3) per week will be conducted to ensure the accuracy of the resident's ADL Profile. The results of this audit will be presented at the PI meeting for the next 3 months for review and recommendations.</p> <p>F280 POC Accepted 7/8/11 G. Coleman RN / Pincot RN</p>	<p>7/8/11 Per PC to facility on 7/8/11.</p>
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F 280 Continued From page 3 stated "noted open areas to buttocks" and describes 3 open areas. The current care plan for "actual alteration in skin integrity" in the medical record stated "resolved - 3/11/11". (The resident has a previous history of recurrent open areas.) During interview at 3 PM the same day, the Unit Manager confirmed the care plan was not revised to reflect the new problem.

Additionally, further record review of the Resident Weekly Skin Check Sheet for May, 2011, revealed that nurses documented open areas on 5/13/11, 5/20/11 and 5/27/11 and failed to completely describe the open areas and failed to update the care plan at that time. This was confirmed during interview and review of the documentation with the charge nurse on 6/8/11 at 10:45 AM.

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 staff interview and record review, the facility failed to meet professional standards of practice for the delivery of medications and/or assessment of skin conditions for 2 of 16 residents in the applicable sample (Residents #267 and #127). Findings include:

1. Per medical record review on 06/08/2011 at 1:37 PM, 7 medications ordered for Resident #267 contain no route of administration on the physician order forms. The Medication

F 280 *This Plan of Correction is the center's credible allegation of compliance.*

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F 281
F281 D ~ Services provided meet professional standards.
1) Orders for resident # 267 were clarified and updated with a route of administration.
2) Medication orders have been audited and updated.
3) Education to licensed staff on the required information contained in a medication order by SDC / DNS or designee.
4) Random weekly audits x 4 weeks then monthly for 8 weeks. Review at PI.

F281 POC Accepted 7/8/11
G. Coleman RN / P. Mott RN

7/8/11
Per PC to facility on 7/8/11

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F 281	<p>Continued From page 4</p> <p>Administration Record (MAR) and the medication cards contain routes of administration. This is confirmed during staff interview at 2:30 PM on 06/08/2011 and by the pharmacy during a phone interview on 06/08/2011 at 3:06 PM. Medications have been administered by mouth since the resident was admitted on 05/26/2011.</p> <p>2. Per record review on 6/8/11 at 1:20 PM, Resident #127 had a bruise to his/her left forearm from a fall, documented on a weekly skin check sheet dated 4/13/11. Weekly skin checks dated 4/20, 4/27, 5/4, 5/11, 5/18, 5/25, 6/1, 6/8/11 list skin as CDI (Clean Dry and Intact) with no mention of bruises. On 6/8/11 at 1:35 PM, the Surveyor, accompanied by the Unit manager (UM) and the Licensed Practical Nurse (LPN) who made the 4/13/11 observation and note, observed Resident #127's skin. There is an approximately 5 x 5 cm (centimeter) bruise on the outer aspect of the left forearm and an approximately 3 x 3 cm bruise on the inner aspect of the right wrist. The LPN confirmed that the bruise was the same noted in the 4/13/11 note. Per the UM, skin checks are done weekly by nurses and documented on Resident Weekly Skin Check Sheet. On 6/8/11 at 3:05 PM, the Unit Manager confirmed that the bruise observed with the surveyor at 1:35 PM on 6/8/11 on Resident #127 was the same bruise documented by a unit LPN 4/13/11 and that nursing staff did not document any bruising for an 8 week period 4/13/11 - 6/8/11.</p> <p>References: 1. Lippincott, Williams & Wilkins. Nursing 2010 Drug Handbook, pg 13-18. 2. Lippincott Manual of Nursing Practice (9th ed.).</p>	F 281	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p>		

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F 281 Continued From page 5
Wolters Kluwer Health/Lippincott Williams & Wilkins, pg 17.

F 371 483.35(i) FOOD PROCURE,
SS=E STORE/PREPARE/SERVE - SANITARY

The facility must -
(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and
(2) Store, prepare, distribute and serve food under sanitary conditions

This REQUIREMENT is not met as evidenced by:
Based on observations and staff interview, the facility failed to serve foods in accordance with accepted safe food handling practices during 2 observations of meal service and failed to maintain a sanitary environment in all kitchen areas. Findings include:

1. During 2 observations of meal service on 6/6/11, the following unsanitary practices were noted:

a. Per observation of the noon meal on 6/6/11 at 12:40 PM, a dietary aide was observed placing dishes on trays and also touching personal clothing with gloved hands and then returning to placing dishes and meal tickets on trays for service to residents. The dietary aid failed to remove gloves and sanitize hands and re-glove after touching personal clothing. The observation was confirmed with the aide at 12:50 PM.

F 281 *This Plan of Correction is the center's credible allegation of compliance.*

F 371 *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*

Feb

F371 E ~ Food procure, store, prepare/serve-sanitary

- 1) Debris was cleaned immediately from the storage area
- 2) Dietary manager or designee will provide education for dietary personnel for proper use of food handling and glove use.
- 3) Random observations will be done weekly x 4 weeks then monthly x 8 weeks. Results will be reported to PI. Responsible person is the Dietary Manager.

F371 POC Accepted 7/8/11
G. Coleman RN / PMost RN

7/8/11
Per PC to facility on 7/8/11