

Division of Licensing and Protection  
103 South Main Street, Ladd Hall  
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

December 9, 2013

Ms. Rachael Parker, Administrator  
Starr Farm Nursing Center  
98 Starr Farm Rd  
Burlington, VT 05408-1396

Dear Ms. Parker:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **November 6, 2013**. 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

PC:jl

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

PRINTED: 11/21/2013  
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 11/06/2013
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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)	(X5) COMPLETION DATE
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F 000	INITIAL COMMENTS  An unannounced on-site complaint investigation and investigation of facility self-reported incidents were conducted by the Division of Licensing and Protection on 11/04/13 - 11/06/13. The following are regulatory findings.	F 000	<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 223 SS=D	483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION  The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.  The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.  This REQUIREMENT is not met as evidenced by: Based upon record review, observation and staff interview the facility failed to ensure that 2 of 17 residents in the survey sample were free from verbal abuse, sexual abuse and mistreatment (Residents #4 and #7). The findings include:  1. Per review of the medical record, Resident #4 was admitted to the facility on 5/13/08. He/she had diagnoses that included myasthenia gravis (a condition characterized by weakness and rapid fatigue of any muscles under voluntary control), cerebral vascular disease, hemiplegia (paralysis on one side of the body) and depression along with other chronic medical conditions, and was listed as having poor cognition and safety awareness. According to his/her 8/23/13 annual Minimum Data Set (MDS) review, he/she was listed as frequently incontinent of urine and	F 223	F223 12/12/2013 Resident #7 has been interviewed on a regular basis by Social Services to assure no further incidents have occurred and that she/he feels safe. The resident has also been visited by an outside advocate that provides support.  Resident #4 is interviewed by the Social Services/designee on a regular basis to assure that there is no mistreatment of this resident.  The facility will be monitored by administrative staff to ensure that proper communication and treatment between staff and residents exists. Additionally rounds will be conducted paying particular attention to the dialogue and treatment between the staff and residents. Included in these rounds will be observation of the responsiveness to call bells. Grievances / Concerns are reviewed daily at the Administrative meeting and are assigned to the appropriate discipline for follow-up. Resident interviews will be conducted by the Social Workers to ensure compliance with proper dialogue, treatment and responsiveness to call bells. Additionally at the monthly Resident Council meeting the	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* TITLE *Executive Director* DATE *12/4/13*

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 223	<p>Continued From page 1</p> <p>occasionally incontinent of bowels and required extensive assistance of 1 for transfers, bed mobility, dressing, personal hygiene and toileting. Per 11/6/13 observation of morning care at 7:20 AM, an LNA, using a gait belt, assisted Resident #4 to standing position and then pivoted him/her to a wheelchair to bring him/her to the bathroom. The resident was observed to wear incontinence briefs; he/she assisted with care as able with his/her non-paralyzed side.</p> <p>Per review of the facility's internal investigation dated 10/17/13, it was reported to Administration on 10/17/12 that a staff nurse over heard an interaction between a facility Licensed Nursing Assistant (LNA) and Resident #4. According to the nurse's statement, he/she was walking past Resident #4 's room and heard the LNA telling Resident #4, "Why didn't you get up and go earlier?" and "Do you think I have time for this?" The LNA was cleaning up Resident #4 from a bowel incontinence episode. A written statement dated 10/17/13 from an LNA who was in an adjacent room, stated that when Resident #4 asked the LNA to get up to go to the bathroom, the LNA said that he/she "wasn't in there for (him/her)." The LNA then asked Resident #4 "Who washed you up" then said, "Why didn't you get up with them...Why didn't you go to the bathroom with them." The statement indicated "He was very loud."</p> <p>Per 11/5/13 review of the facility policy for abuse, "Patients have the right to be free of verbal, sexual, physical, and mental abuse, corporal punishment, involuntary seclusion, and neglect of the patient as well as mistreatment, neglect, and misappropriation of patient property. " (POL:504-01)</p> <p>Per review of the facility's final investigation for this incident, dated 10/18/13, the LNA's</p>	F 223	<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> <hr/> <p>residents will be polled regarding staff treatment of residents and call bell responsiveness.</p> <p>The Administrator, Director of Nursing and /or Social Workers or their designees will inservice the staff on the facility Abuse prohibition including emphasis on verbal abuse, sexual abuse and mistreatment. In addition there will be training on call bell responsiveness with an emphasis on all staff responding timely to call bells.</p> <p>The Staff Development Coordinator or designee will continue to include the Abuse prohibition procedures in the orientation of new facility personnel. Call bell responsiveness will be included in orientation for new employees.</p> <p>The Administrator, Director of Nursing or Designee will continue to investigate reports of suspected abuse according to the facility policy and procedure.</p> <p>The Administrator or designee will monitor</p>	

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F 223	Continued From page 2 employment was terminated on 10/18/13 and per interview on 11/6/13 at 2:45, the facility DNS stated that a report of the incident was sent to the Board of Nursing.  2. Per record review on 11/04/13 of Resident #7's care plan, who has a diagnosis of Huntington's, requires staff assistance for all personal needs. The care plan also notes no caregivers of the opposite sex. On 09/09/13 during the evening hours at approximately 8:00 PM a resident of the opposite sex [Resident #6] entered the room and proceeded to kiss and touch Resident #7. Per interviews on the evening of 11/05/13 and during the morning of 11/06/13 with the four staff who worked the evening of 09/09/13, stated that Resident #6 has had inappropriate sexual behaviors with staff and other residents but was not care planned for those behaviors, "we just heard it from other staff to keep an eye on [Resident #6]".  Per record review Resident #6 had inappropriate sexual behavior since April 2013. A Nursing note dated 04/25/13 states "continues to engage inappropriate sexual behavior with nursing staff." Per interview on 11/05/13 at 5:36 PM the DNS stated "we were not aware of the [recent] incident with [another resident], staff didn't let us know but since [Resident #7's] incident we had a big educational training regarding when, why, who, to report". S/he confirmed that Resident #7 was not free from sexual/intimate contact by another resident.	F 223	<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>  through record review of resident interviews weekly for the next month and monthly there after to assure prevention of mistreatment of residents. Grievance / Concerns are reviewed daily at the Administrative meeting and are assigned to the appropriate discipline for follow-up. Call bell response times will be audited weekly for one month and monthly there after to assure timeliness.  This will be reviewed at the Quality Assurance meeting with subsequent plan of correction developed and implemented as necessary. The Administrator is responsible for the overall compliance.  <i>F223 PDC accepted 12/11/13 SEMONSON/Pme</i>		
F 224 SS=G	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN  The facility must develop and implement written	F 224			

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F 224	Continued From page 3 policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.  This REQUIREMENT is not met as evidenced by: Based upon record review and staff interview the facility failed to ensure that 3 of 17 residents in the survey sample were free from neglect or mistreatment (Residents #1, #3, #5). The findings include:  1. Per review of the facility medical record, Resident #1 was admitted to the facility on 9/9/13. He/she had diagnoses that included depression, diabetes, history of falls, debility, mechanical problems with limbs, congestive heart failure, kidney disease, peripheral vascular disease, chronic obstructive pulmonary disease, tremor, and other chronic medical conditions. Per review of the facility's internal investigation written statement by a staff physical therapist, on 10/18/13 Resident #1 reported to the therapist that the LNA that provided his morning care that day, "was upset that an LNA called out." The LNA "slammed" the rolling walker and chair. The resident reported that he/she "had the call light on so long [he/she] was incontinent in bed." The therapist reported that when he/she went to adjust the resident's stockings, he/she noted that Resident #1 had "dried feces all over pants/back and covering w/c [wheelchair]. Patient stated [he/she] thought [he/she] smelled something." The therapist reported that he/she went directly to the unit manager (UM) and the social services	F 224	<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>  F224 12/12/2013 Resident #1 no longer resides at the facility An investigation was completed for Resident #3. Education was completed with nursing staff Resident #5 no longer resides at the facility  The Social Services Director, or her designee, will conduct individual resident interviews to determine other possible neglect or mistreatment issues. The Administrator will investigate identified concerns and assure individualized follow through.  The Staff Development Coordinator/designee will in-service the staff on neglect and mistreatment. The Staff Development Coordinator will include information on neglect and mistreatment in the orientation of new personnel.  The Social Services Director will monitor through direct observation of resident care, individual resident interview, and review of grievances and resident interview forms, monthly for three months, then at least quarterly, to assure resident needs are not neglected. This will be reviewed at the quality		

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F 224	Continued From page 4 director [to report the incident]. Per review of the social services director's statement dated 10/18/13, he/she interviewed Resident #1 with the UM. Resident #1 reported "putting his call light on and waiting about 20 minutes on the edge of [his/her] bed." When the LNA arrived, [the resident] told her you are too late "I shit myself." He/she said the LNA "got upset" stating "its not my fault I am filling in for someone else, there's not enough staff." The resident said the LNA seemed "really upset to have to clean him up." He/she said the LNA "threw his dirty clothes around the room" and said that the LNA was "rough but that it didn't necessarily hurt." The resident said that he/she could smell something and realized that he/she still had BM (bowel movement) all over his/her back. The resident reported that he/she "prefers to not have [him/her] as his LNA". The resident was upset that [the LNA] also "left clothes with BM on the floor." Per review, the resident's 9/16/13 admission Minimum Data Set (MDS) assessment documented that Resident #1 is cognitively aware and able to understand and be understood; required extensive assistance of one for bed mobility, dressing, personal hygiene and toileting and extensive assistance for transfers. His/her 9/2013 activities of daily living (ADL) log and his/her 10/16/13 Resident Profile listed toileting as requiring extensive assistance. His/her 9/10/13 Physical sheet lists the resident as "wheel chair mobility dependent." Per review of the facility policy for abuse, "Patients have the right to be free of verbal, sexual, physical, and mental abuse, corporal punishment, involuntary seclusion, and neglect of the patient as well as mistreatment, neglect, and misappropriation of patient property."	F 224	<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>  assurance meeting with subsequent plan of correction developed and implemented as necessary.  <i>F224 PDC accepted 12/1/13 SEMmona PML/PM</i>		

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F 224	<p>Continued From page 5 (POL:504-01) Per 11/6/13 interview with the facility DNS at 2:45 PM, the involved LNA was suspended immediately and his/her employment was terminated and a copy of the investigation was sent to the Board of Nursing.</p> <p>2. Per 11/4/13 medical record review, Resident #3 was admitted to the facility on 9/11/12 with diagnoses that included depression, diabetes, a history of falls, chronic kidney disease, debility, mechanical problems with limbs, chronic pain, peripheral neuropathy and other chronic medical conditions.</p> <p>Per review of the resident's 8/12/13 Minimum Data Set (MDS) annual assessment, Resident #3 had cognitive and memory impairments; required extensive assistance for bed mobility, dressing, personal hygiene and toileting; was totally dependent and required the extensive assistance of 2 persons for transfers. Balance was assessed as not steady for moving on and off the toilet, only able to stabilize with human assistance; He/she was assessed as at risk for the development of pressure ulcers. Resident #3's 10/14/13 "Resident Profile," the LNA plan of care, specified that the resident be transferred to the toilet with the assistance of two persons and a transfer disc. Per review of the facility investigation dated 10/22/13, two facility LNA's (LNA #1 and LNA #2) transferred Resident #3 to the toilet using a gait belt at 1:15 PM. LNA #1 went on a break right after the transfer leaving his/her gait belt on the resident and stated the call bell was near the resident. LNA #1 could not recall if he/she told anyone she/he was going on a break. When he/she returned to the floor, he/she finished his/her rounds, documented and then went home. LNA #2 stated that after transferring Resident #3 to the toilet, he/she went on to care for other</p>	F 224	<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 224	Continued From page 6 residents leaving LNA #1 by the bathroom door, and then went on a break, returned for rounds, documented and went home. LNA #2 reported that LNA #1 typically had Resident #3 on his/her assignment and assumed LNA #1 would know how to transfer the resident, so did not look up the resident's transfer status. In LNA #2's written statement dated 10/23/13, he/she reported that he/she assumed that Resident #3 had been transferred back [from the toilet] but was not around to witness and was unaware that he/she was still on the toilet when he/she left to go home. Per review of the facility's internal investigation written statement by a facility physical therapist, on 10/22/13 at 4:00 PM the therapist reported trying to find Resident #3 for therapy. He/she spotted his/her leg rests outside a common area bathroom door. The therapist wrote, upon opening the bathroom door... Resident #3 "was close to falling off the toilet, left unsupervised without the use of transfer disc (gait belt still on pt [patient], so [he/she] hadn't transferred himself)." "Quickly asked for assist, pt was so tired it took 3 people to help him stand pivot to chair. Pt diaphoretic and fatigued. Asked pt how long [he/she] felt he had been in the bathroom 'I'm not sure, probably about an hour.' This pt should never be left unsupervised!" The therapist added an addendum to his/her statement, "This [resident] was drenched in sweat and so tired! [He/she] is unable to keep [his/her] eyes open (unable to do therapy at this time!) ([His/her] transfer disc was still in [his/her] room)." Per 11/5/13 at 10:10 AM interview with the facility physical therapist, he/she reported finding the resident on the toilet in the bathroom on 10/22/13 with his wheelchair in front of him; he/she reported that the resident's transfer status states for toileting is 2 person assist and the use of a	F 224	<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>		

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F 224	<p>Continued From page 7</p> <p>transfer disc; "they are supposed to be with him and not leave." Per 11/6/13 interview at 11:21 AM with the ADNS, he/she reported that he/she was on duty the day of the incident. He/she reported that Resident #3 does not consistently use his call light, "that is why the LNA should have stayed with [him/her]." Per 11/6/13 interview with the facility Director of Nursing at 2:45 PM, LNA #1's employment was terminated and a copy of the facility investigation was sent to the Board of Nursing.</p> <p>3. Per record review, Resident #5 had a history of CHF and weakness, and needed assistance from staff to safely transfer or ambulate. The resident utilized a wheelchair for mobility. On the morning of 10/23/13, Resident #5 was sitting in their room in a wheelchair. At approximately 10:40 AM, a housekeeper entered the room of the resident to clean. The housekeeper stated that the resident was not very responsive when greeted, and appeared to be trying to stand up from the wheelchair. The housekeeper left the room and found a nurse nearby to relay the concern that the resident was trying to get up. Per interview with the housekeeper, s/he stated that the nurse told them to ring the call light so the LNAs would respond. The housekeeper then told the other nurse on the unit about Resident #5 attempting to stand. This nurse also told the housekeeper to put on the call light to alert the LNAs. When the housekeeper returned to the room to mop the floor, Resident #5 was more alert, and agreed to stay in the wheelchair while the floor was drying.</p> <p>A second housekeeper was delivering clean laundry to the rooms at approximately 10:50 AM, and went to the door of Resident #5's room. S/he observed the resident was standing in front of their wheelchair. The housekeeper then looked</p>	F 224	<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 224	Continued From page 8 out in the hall to find a staff person, and saw no one was around. When the housekeeper looked back in the room, s/he witnessed Resident #5 fall forward to the floor. The resident sustained a laceration to the head, and was transported to the hospital. After diagnostic tests showed no apparent internal head injury, the resident was sent back to the facility, however did pass away the following morning at the facility.  On 11/6/13, the LNAs working on the day of the fall were each interviewed. There were four LNAs working on that unit on 10/23/13. At the time Resident #5 fell, two of the LNAs were out on a break, and the remaining two LNAs were together assisting a resident who required a two person transfer. The nurses on the unit passing medications did not respond to the concerns of the first housekeeper, both telling him/her to activate the call light for the LNAs, although there was no LNAs available at that time. Per interview on 11/6/13 at 3:55 PM, the Administrator confirmed that the usual staffing for that unit was 5 LNAs on the day shift, and that there were only 4 scheduled the day of 10/23/13, and that only one of the LNAs at a time should have been out on a lunch break to assure adequate monitoring of residents. The Administrator also stated that the housekeeping staff needs to be supported by the nursing staff when they express a concern about a resident, and that prompt response from the staff who were alerted of the situation may have avoided the resident's fall.	F 224	<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	F 280	F280 Resident #1 no longer resides in the facility.  Care Plans of other residents with a	12/12/2013	

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F 280	Continued From page 9 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.  This REQUIREMENT is not met as evidenced by: Based upon medical record review and interview, the facility failed to revise the care plan of 1 of 17 residents following a significant change in medical condition (Resident # 1). Findings include: Per record review on 11/5/13, Resident #1 re-entered the facility on 10/30/13 with a new diagnosis of CVA (CVA=cerebral vascular accident or stroke) and orders for comfort care. Per interview on 11/5/13 at 3:44 PM, the facility Director of Nursing Services (DNS) confirmed that the care plan had not been revised to include comfort care and the full complement of care and services needed for this significant change in medical condition.	F 280	<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>  significant change in medical condition will be reviewed to ensure the CP reflects changes.  Staff Development Coordinator/designee will in-service the Interdisciplinary Care Planning Team on care plan revisions needed with significant change in medical condition.  The Director of Nursing, or her designee, will monitor through resident record review, at least monthly for three months, then at least quarterly, to assure Care Plans reflect significant changes in medical condition. This will be reviewed at the Quality Assurance meeting with subsequent plan of correction developed and implemented as necessary.  <i>F280 POC accepted 12/9/13 Semmons Rdl/pme</i>		
F 282	483.20(k)(3)(ii) SERVICES BY QUALIFIED	F 282			

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F 282 SS=D	<p>Continued From page 10 PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to assure that the plan of care was implemented for 2 of 17 residents reviewed. (Residents #3, #5). Findings include:</p> <p>1. Per record review on 11/5/13, Resident #5 had generalized weakness and required staff assistance to transfer and ambulate safely due to poor safety awareness, and high risk of falls with actual falls documented. The MD ordered a pad rise alarm to be placed in the resident's bed and wheelchair to alert staff when Resident #5 was attempting to get up on their own. The signed order read "1. Bed/Chair alarm in place. 2. Assess alarm for placement and functionality q shift. 3. Change batteries to alarm q 7th and 21st on 11-7 shift." The plan of care for Resident #5 related to Risk of Falls also indicated the use of the alarms, and to assure that they were in place under the resident. Resident #5 fell on 10/23/13, witnessed by housekeeping staff. The resident sustained a laceration to the head, and was transported to the hospital. After diagnostic tests showed no apparent head injury, the resident was sent back to the facility, however did pass away the following morning at the facility. Per review of the staff statements and internal investigation regarding the resident's fall on 10/23/13, the staff witnesses stated that the chair</p>	F 282	<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>F282 12/12/2013 Resident #3's care plan was reviewed with staff immediately to ensure proper implementation of the interventions in the care plan. Resident #5 no longer resides at the facility</p> <p>Review of current resident's alarms and transfers were reviewed to ensure knowledge of interventions and proper implementation.</p> <p>New process in place to have an alarm on each surface needed instead of needing to move an alarm when resident changed surfaces.</p> <p>Staff Development Coordinator/designee to provide education on new system. In addition education to be provided on utilizing profile to ensure care plan interventions are implemented.</p> <p>Director of Nursing/designee will monitor through record review new care plan interventions and audit weekly implementation for one month and then monthly thereafter. This will be reviewed at the Quality Assurance meeting with subsequent plan of correction developed and implemented as necessary.</p>	

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F 282	<p>Continued From page 11</p> <p>pad alarm was not sounding when the resident stood up. Although placement of the chair pad was verified during the morning rounds, the LNA admitted to not checking the alarm to see if it was functioning correctly. On 11/6/13 at 4:00 PM, the Administrator confirmed that the plan of care was not implemented for the use of the alarms.</p> <p>2. Per 11/4/13 medical record review, Resident #3 was admitted to the facility on 9/11/12 with diagnoses that included depression, diabetes, a history of falls, chronic kidney disease, debility, mechanical problems with limbs, chronic pain, peripheral neuropathy and other chronic medical conditions.</p> <p>Per review of the facility investigation dated 10/22/13, two facility LNA's (LNA #1 and LNA #2) transferred Resident #3 to the toilet using a gait belt at 1:15 PM. LNA #1 went on a break right after the transfer leaving his/her gait belt on the resident and stated the call bell was near the resident. LNA #1 could not recall if he/she told anyone she/he was going on a break. When he/she returned to the floor, he/she finished his/her rounds, documented and then went home. LNA #2 stated that after transferring Resident #3 to the toilet, he/she left LNA #1 outside the bathroom door, went on to care for other residents and then went on a break, returned for rounds, documented and then went home. LNA #2 reported that LNA #1 typically had Resident #3 on his/her assignment and assumed LNA #1 would know how to transfer the resident, so did not look up the resident's transfer status. In LNA #2's written statement dated 10/23/13, he/she reported that he/she assumed that Resident #3 had been transferred back [from the toilet] but was not around to witness and was unaware that he/she was still on the toilet when he/she left to</p>	F 282	<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> <hr/> <p>This will be reviewed at the Quality Assurance meeting with subsequent plan of correction developed and implemented as necessary.</p> <p><i>FABA POC accepted 12/9/13 Semmons RN/AMC</i></p>	

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F 282	Continued From page 12 go home. Per review of the facility's internal investigation written statement by a facility physical therapist, on 10/22/13 at 4:00 PM the therapist reported trying to find the resident for therapy. She/he spotted his leg rests outside a common area bathroom door. The therapist wrote, upon opening the bathroom door... Resident #3 "was close to falling off the toilet, left unsupervised without the use of transfer disc (gait belt still on pt [patient], so [he/she] hadn't transferred himself)." "Quickly asked for assist, pt was so tired it took 3 people to help him stand pivot to chair. Pt diaphoretic and fatigued. Asked pt how long [he/she] felt he had been in the bathroom 'I'm not sure, probably about an hour.' This pt should never be left unsupervised!" The therapist added an addendum to his/her statement, "This [resident] was drenched in sweat and so tired! [He/she] is unable to keep [his/her] eyes open (unable to do therapy at this time!) ([His/her] transfer disc was still in [his/her] room)." Per review of the resident's 8/12/13 Minimum Data Set (MDS) annual assessment, Resident #3 had cognitive impairments; required extensive assistance for bed mobility, dressing, personal hygiene and toileting; was totally dependent and required the extensive assistance of 2 persons for transfers. Balance was assessed as not steady for moving on and off the toilet, only able to stabilize with human assistance; He/she was assessed as at risk for the development of pressure ulcers. Resident #3's 10/14/13 "Resident Profile," LNA care plan, specified that the resident be transferred to the toilet with the assistance of two persons and a transfer djsc. Per 11/5/13 at 10:10 AM interview with the facility physical therapist, he/she reported finding the resident on the toilet in the bathroom on 10/22/13	F 282	<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>		

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F 282	Continued From page 13 with his wheelchair in front of him; he/she confirmed that the resident's transfer status states for toileting; the resident requires a 2 person assist and the use of a transfer disc; "they are supposed to be with him and not leave."	F 282	<i>This Plan of Correction is the center's credible allegation of compliance.</i>		
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING  Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.  This REQUIREMENT is not met as evidenced by: Based on record review and interviews facility failed to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care for 3 of 17 residents in the sample.( Residents # 5, 7) Findings include:  1. Per record review, Resident #5 had a history of CHF and weakness, and needed assistance from staff to safely transfer or ambulate. The resident utilized a wheelchair for mobility. On the morning of 10/23/13, Resident #5 was sitting in their room in a wheelchair. At approximately 10:40 AM, a housekeeper entered the room of the resident to clean. The housekeeper stated that the resident was not very responsive when greeted, and appeared to be trying to stand up from the	F 309	<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>		
			F309 Resident #5 no longer resides at the facility  Resident #7 has been interviewed on a regular basis by Social Services to assure no further incidents have occurred and that she/he feels safe. The resident has also been visited by an outside advocate that provides support.  The Director of Nursing/designee and Director of Social Services/designee, through record review, interview and observation will ensure other residents are being provided with the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being. The Administrator will investigate any identified concerns and assure individualized follow through.  Staff Development Coordinator/designee to	12/12/2013	

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F 309	<p>Continued From page 14</p> <p>wheelchair. The housekeeper left the room and found a nurse nearby to relay the concern that the resident was trying to get up. Per interview with the housekeeper, s/he stated that the nurse told them to ring the call light so the LNAs would respond. The housekeeper then told the other nurse on the unit about Resident #5 attempting to stand. This nurse also told the housekeeper to put on the call light to alert the LNAs. When the housekeeper returned to the room to mop the floor, Resident #5 was more alert, and agreed to stay in the wheelchair while the floor was drying.</p> <p>A second housekeeper was delivering clean laundry to the rooms at approximately 10:50 AM, and went to the door of Resident #5's room. S/he observed the resident was standing in front of their wheelchair. The housekeeper then looked out in the hall to find a staff person, and saw no one was around. When the housekeeper looked back in the room, s/he witnessed Resident #5 fall forward to the floor. The resident sustained a laceration to the head, and was transported to the hospital. After diagnostic tests showed no apparent internal head injury, the resident was sent back to the facility, however did pass away the following morning at the facility.</p> <p>On 11/6/13, the LNAs working on the day of the fall were each interviewed. There were four LNAs working on that unit on 10/23/13. At the time Resident #5 fell, two of the LNAs were out on a break, and the remaining two LNAs were together assisting a resident who required a two person transfer. The nurses on the unit passing medications did not respond to the concerns of the first housekeeper, both telling him/her to activate the call light for the LNAs, although there was no LNAs available at that time. Per interview</p>	F 309	<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>provide education on care plan interventions, and responsiveness to call bells to ensure we provide the necessary care and services.</p> <p>Director of Nursing/designee will monitor through record review new care plan interventions and audit weekly implementation for one month and then monthly there after. Additionally at the monthly Resident Council meeting the residents will be polled regarding call bell responsiveness. This will be reviewed at the Quality Assurance meeting with subsequent plan of correction developed and implemented as necessary.</p> <p><i>F309 PDC accepted 12/4/13 STAMMONS RN/AME</i></p>		

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F 309	<p>Continued From page 15</p> <p>on 11/6/13 at 3:55 PM, the Administrator confirmed that the usual staffing for that unit was 5 LNAs on the day shift, and that there were only 4 scheduled the day of 10/23/13, and that only one of the LNAs at a time should have been out on a lunch break to assure adequate monitoring of residents. The Administrator also stated that the housekeeping staff needs to be supported by the nursing staff when they express a concern about a resident, and that prompt response from the staff who were alerted of the situation may have avoided the resident's fall.</p> <p>2. Per record review on 11/04/13 of Resident #7's care plan, who has a diagnosis of Huntington's, requires staff assistance for all personal needs. The care plan also notes no caregivers of the opposite sex. On 09/09/13 during the evening shift at approximately 8:00 PM a resident of the opposite sex [resident #6] enter the room and proceeded to kiss and touch Resident #7. Per interviews on the evening of 11/05/13 and on the morning of 11/06/13 with the four staff who worked the evening of 09/09/13, two staff stated that they were either on supper break or a short break, one stated that s/he was administering medications on the other hall and one staff member stated that s/he was answering call lights and/or providing care. It took staff approximately "10 -15 minutes to answer the call light", although all four staff were not sure how long [ resident #6] had been in Resident #7's room prior to the call light being turned on. Staff further stated that Resident #7 is unable to call out for help or use a regular button type call light, so a 'touch pad' type is placed on the resident". Staff further acknowledged that they were not sure if Resident</p>	F 309	<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 309	Continued From page 16 #7 used the call light or if it got accidentally turned on by the other resident and stated that the resident was upset by this incident. The Unit Manager on 11/05/13 at 1:15 PM confirmed that Resident #7's the highest practicable physical, mental, and psychosocial well-being was not maintained.	F 309	<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 353 SS=G	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS  The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.  The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:  Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.  Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.  This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to assure sufficient staff to provide nursing and supervision to maintain the highest	F 353	F353 12/12/2013 Resident #7 has been interviewed on a regular basis by Social Services to assure no further incidents have occurred and that she/he feels safe. The resident has also been visited by an outside advocate that provides support. Resident #5 no longer resides at the facility.  The Director of Nursing, or her designee, will identify through direct observation those residents affected by insufficient staffing. Adequate staff will be provided to meet the needs of the resident identified through this process.  The facility has been aggressively recruiting for licensed nurses and LNA's since August 2013. Utilizing local and online recruiting services. The facility contracted with three temporary staffing agencies to provide direct care staff for the facility. Exit interviews utilized to identify improvements needed for staff retention. Changes made to orientation based on those findings.  The Director of Nursing or designee will	

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F 353	<p>Continued From page 17</p> <p>practicable well-being of each resident according to residents' assessments and individual plans of care. (Resident #7 and #5) Findings include:</p> <p>1. Per record review on 11/04/13 of Resident #7's care plan, who has a diagnosis of Huntington's disease, requires staff assistance for all personal needs. The care plan also notes no caregivers of the opposite sex. On 09/09/13 during the evening hours at approximately 8:00 PM a resident of the opposite sex [Resident #6] entered the room and proceeded to kiss and touch Resident #7. Per interviews on the evening of 11/05/13 and in the morning of 11/06/13 with the four staff who worked the evening shift on 09/09/13, two staff stated that they were either on supper break or a short break, one stated that s/he was administering medications on the other hall and one staff member stated that s/he was answering call lights and/or providing care. It took staff approximately "10 -15 minutes to answer [Resident #7's] the call light", although all four staff were not sure how long Resident #6 had been in Resident #7's room.</p> <p>Per review of the census, Eighteen out of twenty-three residents on this unit need at least one person assist and several residents need 2 person Hoyer lift assistance. Per interview on 11/05/13 at 11:55 AM the District Clinical Director stated "we're working on it...trying to hire and to get the aides we need...maybe we need to do something different during those periods during the highest needs".</p> <p>2. Per record review, Resident #5 had a history of CHF and weakness, and needed assistance from staff to safely transfer or ambulate. The resident utilized a wheelchair for mobility. On the morning</p>	F 353	<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>monitor staffing and scheduling of nursing personnel on a daily basis to assure that staffing levels are sufficient to meet the residents' needs.</p> <p>Review of nursing staffing hours, recruitment and retention plans will be reviewed at the Quality Assurance meeting. As necessary new plans of corrections will be developed and implemented.</p> <p>F353 POC accepted 12/9/13 SEMMONS RN/AME</p>		

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NAME OF PROVIDER OR SUPPLIER  <b>STARR FARM NURSING CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>98 STARR FARM RD BURLINGTON, VT 05408</b>		
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F 353	<p>Continued From page 18 of 10/23/13, Resident #5 was sitting in their room in a wheelchair. At approximately 10:40 AM, a housekeeper entered the room of the resident to clean. The housekeeper stated that the resident was not very responsive when greeted, and appeared to be trying to stand up from the wheelchair. The housekeeper left the room and found a nurse nearby to relay the concern that the resident was trying to get up. Per interview with the housekeeper, s/he stated that the nurse told them to ring the call light so the LNAs would respond. The housekeeper then told the other nurse on the unit about Resident #5 attempting to stand. This nurse also told the housekeeper to put on the call light to alert the LNAs. When the housekeeper returned to the room to mop the floor, Resident #5 was more alert, and agreed to stay in the wheelchair while the floor was drying.</p> <p>A second housekeeper was delivering clean laundry to the rooms at approximately 10:50 AM, and went to the door of Resident #5's room. S/he observed the resident was standing in front of their wheelchair. The housekeeper then looked out in the hall to find a staff person, and saw no one was around. When the housekeeper looked back in the room, s/he witnessed Resident #5 fall forward to the floor. The resident sustained a laceration to the head, and was transported to the hospital. After diagnostic tests showed no apparent head injury, the resident was sent back to the facility, however did pass away the following morning at the facility.</p> <p>On 11/6/13, the LNAs working on the day of the fall were each interviewed. There were four LNAs working on that unit on 10/23/13. At the time Resident #5 fell, two of the LNAs were out on a</p>	F 353	<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 353	Continued From page 19 break, and the remaining two LNAs were together assisting a resident who required a two person transfer. The nurses on the unit passing medications did not respond to the concerns of the first housekeeper, both telling him/her to activate the call light for the LNAs, although there was no LNAs available at that time. Per interview on 11/6/13 at 3:55 PM, the Administrator confirmed that the usual staffing for that unit was 5 LNAs on the day shift, and that there were only 4 scheduled the day of 10/23/13, and that only one of the LNAs at a time should have been out on a lunch break to assure adequate monitoring of residents. The Administrator also stated that the housekeeping staff needs to be supported by the nursing staff when they express a concern about a resident, and that prompt response from the staff who were alerted of the situation may have avoided the resident's fall.	F 353	<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 356 SS=B	483.30(e) POSTED NURSE STAFFING INFORMATION  The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census.  The facility must post the nurse staffing data specified above on a daily basis at the beginning	F 356	F356 No residents were identified for this citation.  The Director of Nursing/designee will provide education to staff filling out the staffing sheets to ensure they are completed correctly.  New system in place to have the sheets reviewed by an assigned, trained staff member prior to the shift to ensure its accuracy.  Director of Nursing/designee will review staffing postings to insure compliance. This will be reviewed at the Quality Assurance meeting.  <i>F356 POC accepted 12/1/13 SEMMONS, RW/PMC</i>	12/12/2013	

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F 356	<p>Continued From page 20 of each shift. Data must be posted as follows:</p> <ul style="list-style-type: none"> <li>o Clear and readable format.</li> <li>o In a prominent place readily accessible to residents and visitors.</li> </ul> <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>This REQUIREMENT is not met as evidenced by: Based on review and interview, the facility failed to ensure that daily census and staffing information was posted as required. This potentially affects all Residents in the facility. Findings include:</p> <p>During review of the facility's Posting of Licensed and Unlicensed Direct Care Staff on 11/01/13 for the evening shift notes 3 RNs (Registered Nurses) and 6 LPNs (Licensed Practical Nurses). Upon review of the corresponding Daily Staffing sheet, one LPN was actually working as an aide and not as the listed LPN. Per the Posting on 11/02/13 for the day shift notes 4 RN's, however per review of the Daily staffing shows only 3 RN providing direct care. Per the Posting on 11/04/13 for the night shift shows 9 total LNAs (Licensed Nursing Assistants), however the Daily staffing sheet has only 8 LNAs.</p> <p>Per interview at that time, the personnel staff stated that usually the posting is done first thing in</p>	F 356	<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 514	<p>Continued From page 22</p> <p>diagnosis of dementia and anxiety. Per a self report dated 08/27/13 Resident #9's family reported to the Social worker that [resident's] call light was not being answered timely and felt staff were ignoring the resident. There are no nursing progress notes, grievance reports for the month of August nor social service notes about the reported incident of the resident's call light not being answered nor the resident being tangled in the phone cord.</p> <p>Per interview the Social Service on 11/05/13 at 4:30 PM stated that "when there is something we think we have to report we make a red folder, which had two typed unsigned and undated papers about staff being educated about answering call lights, receiving a telephone call from the family, unable to verify how long the call light was on, as well as an APS report. The Social Service also stated there was a meeting with the family member regarding the concerns and "would've expected that we would write this down". S/he confirmed that the chart was not complete and accurate.</p> <p>2. Per review of the Grievances Log dated 08/21/13 Resident #8 reported a concern for call light timeliness and wet bed sheets. Although a social service note on 08/23/13 reports that "it took a long time" for staff to answer the call light, that the sheets were wet after a bed bath, and "spoke to staff", there was no further information if there was follow up with the resident. Per interview with the Administrator and Social Services on 11/05/13 at 2:35 PM stated "it does look as if the resident was not responded back to about the concerns". They confirmed that the Grievance Log would contain a resolution with the resident, which is not documented.</p>	F 514	<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>medical records of residents with concerns to ensure documentation includes appropriate elements. Administrator will review grievance log for appropriate resolutions documented. This will be reviewed at the Quality Assurance meeting.</p> <p><i>F514 POC accepted 12/19/13 Semmons R/P/AMC</i></p>		

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F 514	Continued From page 23  3. Per record review Resident #10 was admitted on 08/05/13 for a short term respite stay. The Independent Living Activities (ILA) assessment dated 07/13/13 notes frequent incontinence of bowel and bladder and the resident "is on strict toileting schedule [every] q2 hours during the day". Per interview on 11/04/13 at 2:44 PM the Unit Manager stated that when a resident is admitted staff will monitor the voiding pattern for three full days to formulate a plan. Per review of the monitoring sheet dated 08/06/13 through 08/09/13 there was no documentation on 08/08/13 on the evening shift and on 08/09/13 no documentation for the day and evening shift. Additionally, per the LNAADL self performance/support record shows no documentation for 08/06 & 08/07/13. The DNS confirmed on 11/05/13 at 3:36 PM that the records were not consistent and accurate.  4. Per 11/4/13 medical record review, Resident #3 was admitted to the facility on 9/11/12 with diagnoses that included depression, diabetes, a history of falls, chronic kidney disease, debility, mechanical problems with limbs, chronic pain, peripheral neuropathy and other chronic medical conditions. Per review of a facility self report, on 10/22/13 the facility investigated an alleged incident of staff to resident abuse that resulted in a facility LNA initially being suspended and then his/her employment was terminated.  Per 11/4/13 review of the facility policy labeled, "Identification of An Event that May Constitute Abuse," the documentation guidelines state: Step 1. Record the investigation and outcomes on the Resident event worksheet and in the resident's medical record, if appropriate. Step 6 states:	F 514	<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>		

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F 514	Continued From page 24 Record notification of physician and family member/responsible party in the resident's medical record. On 11/4/13 at 3:00 PM, the Director of Nursing (DNS) confirmed there is no documentation in the 10/22/13 nursing progress notes regarding the 10/22/13 incident or that the resident's physician or family were notified. (Refer to F224)	F 514	<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>		
F9999	FINAL OBSERVATIONS  Per Vermont Licensing and Operating Rules for Nursing Homes:  Regulation 7.13(d)(1)(i):  (d) Staffing Levels. The facility shall maintain staffing levels adequate to meet resident needs. (1) At a minimum, nursing facilities must provide: (i) no fewer than 3 hours of direct care per resident per day, on a weekly average, including nursing care, personal care and restorative nursing care, but not including administration or supervision of staff; and of the three hours of direct care, no fewer than 2 hours per resident per day must be assigned to provide standard LNA care (such as personal care, assistance with ambulation, feeding, etc.) performed by LNAs or equivalent staff and not including meal preparation, physical therapy or the activities program.  This REQUIREMENT is NOT MET as evidenced by:  Based on record review and staff interview, the facility failed to assure that no fewer than 2 hours per resident per day are assigned to provide standard LNA (Licensed Nursing Assistant) care.	F9999	  F9999 12/12/2013 No residents were identified under this tag.  The Director of Nursing, or her designee, will identify through direct observation those residents affected by insufficient staffing. Adequate staff will be provided to meet the needs of the resident identified through this process.  The facility has been aggressively recruiting for licensed nurses and LNA's since August 2013. Utilizing local and online recruiting services. The facility contracted with three temporary staffing agencies to provide direct care staff for the facility. Exit interviews utilized to identify improvements needed for staff retention. Changes made to orientation based on those findings.  The Director of Nursing or designee will monitor staffing and scheduling of nursing personnel on a daily basis to assure that staffing levels are sufficient to meet the residents' needs and that no fewer than 2 hours per resident per day are assigned to provide standard LNA care.  Review of nursing staffing hours, recruitment and retention plans will be reviewed at the Quality Assurance meeting. As necessary new plans of corrections will be developed and implemented.		

F9999 POC accepted 12/11/13 Semmons RN | PML

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F9999	Continued From page 25 Findings include:  Per record review, the facility provided less than two (2) hours per resident per day of assigned LNA staffing on the following days this year:  August - 02, 04, 09, 10, 11, 16, 18, 24, 25, and 28th September - 01, 03, 05, 07, 08, and 30th October - 05, 10, , 19, 23, 24, and 31st November - 3rd  Per interview on 11/05/13 at 2:48 p.m., the Scheduler confirmed that the State required 2 hours of Direct care hours per resident per day were not met on the above days and stated that although the facility was aware, "we were just short".	F9999	<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>		