VERMONT

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

May 11, 2011

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

Provider ID #:475030

Dear Ms. Parker:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **April 6, 2011**.

Follow-up may occur to verify that substantial compliance has been achieved and maintained.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

PC:jl

Enclosure

PRINTED: 04/19/2011
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475030	A. BUILDING _____ B. WING _____	C 04/06/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STARR FARM NURSING CENTER	98 STARR FARM RD BURLINGTON, VT 05401

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F 000	INITIAL COMMENTS An unannounced complaint investigation was conducted by the Division of Licensing and Protection on 4/6/11. There were Federal regulatory violations related to the complaint allegations.	F 000	*This Plan of Correction is the center's credible allegation of compliance.* *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.*	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. 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. 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). This REQUIREMENT is not met as evidenced by: Based upon interview and record review, the facility failed to develop a nutritional care plan that included measures to promote wound healing for 1 applicable resident (Resident #1), who was admitted with a pressure ulcer. Findings include:	F 279	Paste Plan Of Correction Here. F 279 Resident #1 is no longer at our facility. DNS or designee and the IDC team will audit residents with pressure ulcers to ensure that a nutritional care plan is in place. SDC will re-educate the dietician and licensed nursing on the need for a nutritional plan of care for residents will pressure ulcer areas. Residents with a Stage II or greater pressure area will be monitored monthly by the dietician to ensure the nutritional care plan is in place. Monthly audits (x3months) will be conducted along the quarterly MDS schedule. Residents with pressure ulcer will be ensured to have a nutritional care plan included. Results of the audit will be discussed at the center monthly PI meeting.	Enter Date Here. May 6th

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Rachael [signature] ED TITLE 4/29/11 (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 record review and interviews, the staff failed to develop a care plan that addresses specialized nutritional needs related to the presence of a pressure ulcer. Per record review on 4/6/11, the MDS 3.0 dated 12/21/10 idenifies Resident #1 as having a stage 2 pressure ulcer. Per review of the MDS 3.0 dated 12/21/10, and confirmed during interview with the Registered Dietician at 3:55 PM, the Review of Indicators for Nutritional Status for Resident #1 states, "Resident's diet provides adequate energy and protein, however resident's diet is poor". Documentation in this section does not include that Resident #1 had a Stage 2 pressure ulcer present upon admission. Per record review on 4/6/11, and confirmed by the Unit Manager at 3:21 PM, the Alteration in Nutritional Status care plan does not include a nutritional assessment to promote wound healing for Resident #1, who was admitted with a Stage 2 pressure ulcer (partial thickness skin loss involving the epidermis, dermis or both) on 12/14/10. The pressure ulcer progressed to a Stage 4 pressure ulcer (full thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures) on 12/28/10.	F 279	*This Plan of Correction is the center's credible allegation of compliance.* *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.* POC assmt 5.11.11 T Cummis /8[illegible]	
F 314 SS=G	Also see F314 and F325 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and	F 314	F314 Resident #1 is no longer at the facility.	

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F 314	Continued From page 2 services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based upon closed record review and interview, the facility failed to provide necessary treatment and services to promote healing, prevent infection and prevent a Stage 2 pressure ulcer (partial thickness skin loss involving the epidermis, dermis or both) from progressing to a Stage 4 pressure ulcer (full thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures) for Resident #1. Findings include: Per record review on 4/6/11, and confirmed during interview at 1:27 PM with the DNS (Director of Nursing Services), the Weekly Skin Assessment for Resident #1 documents that on 12/14/10, Resident #1 had a Stage 2 pressure ulcer present upon admission on the sacrum and coccyx which measured 5 cm (centimeters) x 2.7 cm. On 12/22/10, the Stage 2 pressure ulcer measured 5 cm x 3 cm. On 12/28/10, the pressure ulcer measured 10 cm by 4 cm and was documented as a Stage 4. Per record review on 4/6/11, the Discharge Planning Notes dated 12/15/10 documents that Resident #1 was admitted to Starr Farm on 12/14/10 from FAHC. Prior to hospitalization, Resident #1 was living at home with his/her spouse. The resident was ambulating and needed help with Activities of Daily Living and was no longer able to complete household chores or errands. Resident #1's goals were to return home when physically able. Per staff interview on	F 314	*This Plan of Correction is the center's credible allegation of compliance.* *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.* Residents with pressure areas will have their weekly condition report reviewed to determine if the individual wound is making progress. If not the IDC team will review the individuals plan of care and update interventions. The center will use the BWAT score that is obtained weekly to assist in identifying when the wound is deteriorating. Wound champion identified at the center will monitor wound progress weekly and adjust treatment orders as needed. Education provided to staff completing the sections of the CAAs and care plans Audit monthly for 3 months and review at PI meeting. Review Pressure Ulcer Risk Tool scores of the residents, who have pressure ulcers upon admission, weekly at the weight and skin meeting. Report findings at monthly PI meeting for 3 months. Weekly weight and skin meeting to take place as scheduled. Monitored by the DNS or designee.	

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F 314	Continued From page 3 4/6/11 10:38 AM, the Social Worker confirmed the admission plan for Resident #1 was for rehabilitative Physical Therapy and Occupational Therapy and the plan was for Resident #1 to return home. Per record review on 4/6/11, and confirmed during interview with the Registered Dietician at 4:05 PM, the admission "Medical Nutritional Therapy Assessment" dated 12/14/10 did not include a nutritional assessment that included the presence of the Stage 2 pressure ulcer which was present upon admission. Per record review on 4/6/11, and confirmed during interview with the Registered Dietician at 3:55 PM, the MDS 3.0, Review of Indicators for Nutritional Status dated 12/21/10 for Resident #1 states, the "Resident's diet provides adequate energy and protein, however resident's diet is poor" and does not include documentation that Resident #1 had a stage 2 pressure ulcer present upon admission. Per record review on 4/6/11, and confirmed during an interview with the Unit Manager at 3:21 PM, the Alteration in Nutritional Status care plan does not include a nutritional assessment related to promoting wound healing for Resident #1 who was admitted with a Stage 2 pressure ulcer present upon admission 12/14/10 and progressed to a Stage 4 pressure ulcer on 12/28/10. Per staff interview on 4/6/11 1:18 PM, the Director of Nursing (DNS) stated the facility does not have a specific policy for residents admitted with a pressure ulcer and that nursing conducts an assessment per the facility's Initial Resident Assessment Policy and uses the Pressure Ulcer Risk Assessment Tool. Per record review on 4/6/11, the Pressure Ulcer Risk Assessment	F 314	*This Plan of Correction is the center's credible allegation of compliance.* *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.* POC auth 5-11-11 T Cumms RN	

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F 314	Continued From page 4 Tool dated 12/14/10 scores Resident #1 as a "14" (not high risk). Per notation on the the scoring sheet, a total score of 12 or less represents high risk for developing pressure ulcers. The assessment tool dated 12/21/10 scores the resident as a "17" (not high risk) and the 12/28/10 assessment tool (completed the same day the resident's pressure ulcer was documented as progressing to a Stage 4) also scores the resident as a "17". Per interview with the DNS on 4/6/11 at 1:27 PM, the DNS confirmed that the Pressure Ulcer Risk Assessment Tool scores are incongruent with the Weekly Pressure Ulcer Condition Report. Per staff interview on 4/6/11 at 4:05 PM, the Registered Dietician stated the facility typically conducts a "Weight and Skin meeting" weekly on all residents with a Stage 2 or greater pressure ulcer. The Registered Dietician stated the "Weight and Skin" meeting includes all the unit managers, registered dietician and Director of Nursing Services, and they call in rehab staff as needed. Per staff interview on 4/6/11 at 4:14 PM, the Unit Manager confirmed that a weekly weight and skin meeting did not occur for Resident #1. On 4/6/11 at 4:05 PM, the Registered Dietician verified there is no documentation in Resident #1's record that the weekly "Weight and Skin" meeting occurred. Per record review on 4/6/11, the Physician's Progress Notes for Resident #1 dated 12/31/10, labeled "Acute Visit", documents a large sacral ulcer with necrotic tissue at center and erythema [redness] at edges, and states Resident #1 is very ill with a history of COPD [congestive obstructive pulmonary disease], now with worsening respiratory status, large infected sacral ulcer, pneumonia, hypoxia, and delirium. Per	F 314	*This Plan of Correction is the center's credible allegation of compliance.* *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.*	

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F 314	Continued From page 5 record review on 4/6/11, a Physician Order dated 1/1/11 states "Send to FAHC ED (Fletcher Allen Health Care Emergency Department) for assessment of coccyx wound and positive blood culture reported to ED today". The facility Resident Transfer Form states: "reason for transfer: positive blood culture and increased temp". Per record review on 4/6/11, the Resident Progress Note dated 1/1/11 states " Family came in to discuss next steps. Transferred at 1515 (3:15 PM) to FAHC with family to meet him at ED. The RN viewed decubitus ulcer today when dressing change was done. Extremely foul odor. Wound large, necrotic, with yellow and red borders. Has an active blood infection". Per staff interview on 4/6/11 at 5:00 PM, the Administrator stated s/he was aware that Resident #1 died after being transferred to FAHC from Starr Farm. Also see F325 and F279.	F 314	*This Plan of Correction is the center's credible allegation of compliance.* *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.* POC accepted 5-11-11 T [illegible]	
F 325 SS=G	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced	F 325	F 325 Review of residents with open areas to ensure that nutritional status is being maintained for the specific open area. These residents will be reviewed at the weekly weight and skin meeting. Education to be provided to staff completing the CAAs and the care plans. Audit monthly and review at the PI meeting monthly. Oversight by the DNS or designee.	

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F 325	Continued From page 6 by: Based upon interview and record review, the facility failed to ensure acceptable parameters of nutritional status and protein levels to promote wound healing for Resident #1 who was admitted with a pressure ulcer. Findings include: Per record review on 4/6/11, and confirmed during interview with the DNS at 1:27 PM, the Weekly Skin Assessment for Resident #1 documents that on 12/14/10, Resident #1 had a Stage 2 pressure ulcer (partial thickness skin loss involving the epidermis, dermis or both) present upon admission on the sacrum and coccyx which measured 5 cm x 2.7 cm. On 12/22/10 the Stage 2 pressure ulcer measured 5 cm x 3 cm. On 12/28/10 the pressure ulcer measured 10 cm by 4 cm and was documented as a Stage 4 (full thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures). Per record review on 4/6/11, and confirmed during interview with the Registered Dietician at 4:05 PM, the admission "Medical Nutritional Therapy Assessment" dated 12/14/10 did not include a nutritional assessment that included the presence of a Stage 2 pressure ulcer, which was present upon admission. Per record review, Nutritional interventions to promote wound healing (increased protein, vitamin C, and zinc) were not ordered until 12/29/10, after the pressure ulcer had progressed to a Stage 4. Per record review on 4/6/11, and confirmed during interview with the Unit Manager at 3:21 PM, the Alteration in Nutritional Status care plan does not include a nutritional assessment related to promoting wound healing for Resident #1 who	F 325	*This Plan of Correction is the center's credible allegation of compliance.* *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.* POC accepted 5.11.11 T Cimmo RN	

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F 325	Continued From page 7 was admitted with a Stage 2 pressure ulcer present upon admission 12/14/10 and progressed to a Stage 4 pressure ulcer on 12/28/10. Per record review on 4/6/11, and confirmed during an interview with the Registered Dietician at 3:55 PM, the MDS 3.0, Review of Indicators for Nutritional Status dated 12/21/10 for Resident #1 states, the "Resident's diet provides adequate energy and protein, however resident's diet is poor", and does not include documentation that Resident #1 had a Stage 2 pressure ulcer present upon admission. Per staff interview on 4/6/11 at 4:05 PM, the Registered Dietician stated the facility typically conducts a "Weight and Skin meeting" weekly on all residents with a Stage 2 or greater pressure ulcer. The Registered Dietician stated the "Weight and Skin" meeting includes all the unit managers, registered dietician and Director of Nursing Services, and they call in rehab staff as needed. Per staff interview on 4/6/11 at 4:14 PM, the Unit Manager confirmed that a weekly weight and skin meeting did not occur for Resident #1. On 4/6/11 at 4:05 PM, the Registered Dietician verified there is no documentation in Resident #1's record that the weekly "Weight and Skin" meeting occurred. Per record review on 4/6/11, the Physician's Progress Notes for Resident #1 dated 12/31/10, labeled "Acute Visit", documents a large sacral ulcer with necrotic tissue at center and erythema [redness] at edges, and states Resident #1 is very ill with a history of COPD [congestive obstructive pulmonary disease], now with worsening respiratory status, large infected sacral ulcer, pneumonia, hypoxia, and delirium. Per record review on 4/6/11, a Physician Order dated	F 325	*This Plan of Correction is the center's credible allegation of compliance.* *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.* DOC [illegible] 5-11-11 T. [illegible] 15[illegible]	

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F 325	Continued From page 8 1/1/11 states "Send to FAHC ED (Fletcher Allen Health Care Emergency Department) for assessment of coccyx wound and positive blood culture reported to ED today". The facility Resident Transfer Form states: "reason for transfer: positive blood culture and increased temp". Per record review on 4/6/11, the Resident Progress Note dated 1/1/11 states " Family came in to discuss next steps. Transferred at 1515 (3:15 PM) to FAHC with family to meet him at ED. The RN viewed decubitus ulcer today when dressing change was done. Extremely foul odor. Wound large, necrotic, with yellow and red borders. Has an active blood infection". Per staff interview on 4/6/11 at 5:00 PM, the Administrator stated s/he was aware that Resident #1 died after being transferred to FAHC from Starr Farm. Also see F279 and F314	F 325		