

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

October 21, 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 **September 16, 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: 09/27/2013
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 09/16/2013
NAME OF PROVIDER OR SUPPLIER STARR FARM NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 98 STARR FARM RD BURLINGTON, VT 05408	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced on-site complaint investigation was conducted by the Division of Licensing and Protection from 9/10/13 to 9/16/13. There were regulatory deficiencies identified. A determination of Immediate Jeopardy to the health and safety of residents was made on 9/11/13, which also constituted Substandard Quality of Care. Prior to the end of the survey, on 9/16/13, the facility successfully removed the Immediate Jeopardy, however deficient practice remains.	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 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must	F 225	F225 Investigate/report allegations/individuals Resident #2 No longer resides at the facility Resident #6 No longer resides at the facility Resident #7 A formal event report and the facility investigation was completed post survey. This event was investigated by the state survey during survey. Current resident events reviewed to ensure investigations were completed per policy and reported appropriately. SDC/designee will complete education of staff on policy for completing investigations and reporting to State agencies. Executive Director will ensure education is completed. Events will be reported to the management team as they occur. The management team will complete a thorough investigation and a report will be made to the state survey agency per policy.	10/16/2013

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Richard Parker* TITLE *Executive Director* (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 225	<p>Continued From page 1</p> <p>prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure that the facility is able to provide evidence that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source are reported immediately to the State Survey agency and thoroughly investigated, for 3 of 7 residents identified (Residents #2, #6 and #7) The findings include;</p> <p>1. Per record review on 9/12/13 for Resident #2, on 8/31/13 an incident note indicates that Resident #2 "had a bruise of unknown origin discovered on Resident #2's right outer eye, purple in color measuring 7 cm (centimeters) long and 2 cm wide. Per review of the facility internal investigations, there was no evidence that this documented incident on 8/31/13 of a bruise of unknown origin was reported to the State Survey agency or investigated, and a cause of the bruising of the right eye was not determined.</p> <p>Per review of the facility policy/procedure dated 8/31/12 and titled: "Abuse", "injuries of unknown</p>	F 225	<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>Event reports will be reviewed at morning management meeting for thoroughness of investigation and compliance with reporting policy. Process will be reviewed at Performance Improvement committee x3 months and changes made as needed.</p> <p>F225 POC accepted 10/21/13 McCulhan RN/pmc</p>	

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F 225	Continued From page 2 source are reported and investigated in accordance with this policy and its supporting procedures." Per review of the facility policy titled Accidents and Supervision to Prevent Accidents dated 4/28/11, the policy indicates that the facility will "investigate and report accidents and develop a plan of action to prevent the accident from recurring." Per interview with the facility Administrator and Director of Nursing, they confirmed that no internal investigation had been completed to determine that cause of the bruise of unknown origin identified on Resident #2 on 8/31/13 and the 8/31/13 had not been reported to the appropriate state agencies in accordance with state law. 2. Per review of the medical record on 9/10/13, Resident #6 was admitted to Starr Farm Nursing Center on 2/19/13 with diagnoses that include; status post Coronary Artery Bypass Graft Surgery, Congestive Heart Failure, Cerebral Vascular Accident, Dysphagia, Depression, and weakness and frailty. Per review of a Nurses Note dated 7/19/13 at 12:57 PM the note indicates a Licensed Nursing Assistant (LNA) reported that he/she saw Resident #7 place a pillow over the face of his/her spouse, Resident #6. The nurse asked the LNA what he/she said to	F 225	<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 225	Continued From page 3 Resident #7 and the LNA indicated that Resident #7 did not respond. The LNA indicated that he/she thought that Resident#7 was trying to place the pillow under Resident #6's head. Per review of Social Service Director (SSD) note dated 7/19/13 at 12:57 PM, the note indicates that the SSD received a call from an LNA and indicated to the SSD that Resident #7 was found holding a pillow over the face of Resident #6. Per review of the facility's internal investigations there was no evidence that the facility had investigated the incident. Per interview with SSD on 9/12/13 at 5:07 PM, he/she confirmed that he/she the facility had not conducted an investigation into the incident with Resident #6 and Resident #7 on 7/19/13. Per review of the facility policy/procedure dated 8/31/12 and titled: "Abuse" for all abuse allegations begin an internal investigation and report alleged abuse to the appropriate state agencies in accordance with state law.	F 225	<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 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written 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 on record review and staff interview the facility failed to ensure that written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of	F 226	F 226 Develop/Implement abuse/neglect, etc policies. Resident #2 Resident no longer resides at the facility. Resident #6 Resident longer resides at the facility	

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F 226	<p>Continued From page 4</p> <p>resident property are implemented for 3 of 7 residents identified (Residents #2, #6 and #7) The findings include.</p> <p>1. Per record review on 9/12/13, Resident #2 on 8/31/13 the incident note indicates that Resident #2 "had a bruise of unknown origin discovered on Resident #2's right outer eye, purple in color measuring 7 cm long and 2 cm wide. Per review of the facility internal investigations, there was no evidence that this documented incident on 8/31/13 of a bruise of unknown origin was reported to the State Survey agency or investigated, and a cause of the bruising of the right eye was not determined.</p> <p>Per review of the facility policy/procedure dated 8/31/12 and titled: "Abuse", "injuries of unknown source are reported and investigated in accordance with this policy and its supporting procedures." Per review of the facility policy titled Accidents and Supervision to Prevent Accidents dated 4/28/11, the policy indicates that the facility will "investigate accidents and develop a plan of action to prevent the accident from recurring."</p> <p>Per interview with the facility Administrator and Director of Nursing, they confirmed that no internal investigation had been completed to determine that cause of the bruise of unknown origin identified on Resident #2 on 8/31/13 and the 8/31/13 had not been reported to the appropriate state agencies in accordance with state law.</p>	F 226	<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>Resident #7 A formal event report and the facility investigation was completed post survey. This event was investigated by the state survey during survey.</p> <p>Current resident events reviewed to ensure investigations were completed per policy and reported appropriately.</p> <p>SDC/designee will complete education of staff on policy for completing investigations and reporting to State agencies. Executive Director will ensure education is completed.</p> <p>Events will be reported to the management team as they occur. The management team will complete a thorough investigation and a report will be made to the state survey agency per policy.</p> <p>Event reports will be reviewed at morning management meeting for thoroughness of investigation and compliance with reporting policy. Process will be reviewed at Performance Improvement committee x3 months and changes made as needed.</p>	

F226 POC accepted 10/21/13
Maulhan RN/PMC

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F 226	<p>Continued From page 5</p> <p>2. Per review of the medical record on 9/10/13, Resident #6 was admitted to Starr Farm Nursing Center on 2/19/13 with diagnoses that include; status post Coronary Artery Bypass Graft Surgery, Congestive Heart Failure, Cerebral Vascular Accident, Dysphagia, Depression, and weakness and frailty. Per review of a Nurses Note dated 7/19/13 at 12:57 PM, the note indicates a Licensed Nurse Aide (LNA) reported that he/she saw Resident #7 place a pillow over the face of his/her spouse Resident #6. The nurse asked the LNA what he/she said to Resident #7 and the LNA indicated that Resident #7 did not respond. The LNA indicated that he/she thought that Resident #7 was trying to place the pillow under Resident #6's head.</p> <p>Per review of Social Service Director (SSD) note dated 7/19/13 at 12:57 PM, the note indicate that the SSD received a call from an LNA and indicated to the SSD that Resident #7 was found holding a pillow over the face of Resident #6. Per review of the facilities internal investigations there was no evidence that the facility had reported the incident to the appropriate State authorities.</p> <p>Per review of the facility policy/procedure dated 8/31/12 and titled: "Abuse" for all abuse. allegations begin an internal investigation and report alleged abuse to the appropriate state agencies in accordance with state law. Per interview with SSD on 9/12/13 @ 5:07 PM, he/she confirmed that he/she the facility had not notified the appropriate State authorities as per the regulatory requirements and the facility policy and procedure.</p>	F 226	<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 280 SS=D	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>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.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to review and revise the comprehensive care plan for 2 of 7 residents reviewed. (Resident #1, #5) The findings include:</p> <p>1. Per review of the medical record for Resident #1, the record indicates that Resident #1 was readmitted to the facility on 8/2/13 and had diagnoses that include; morbid obesity, chronic pain, muscle weakness and mechanical limb problems. Per review of the medical record for Resident #1 on 9/11/13, the record indicated that on 8/25/13, Resident #1 was being mechanically</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>F280 Right to Participate Planning Care – Revise Care Plan</p> <p>Resident #1 Care Plan updated Resident #5 Care Plan updated</p> <p>Care plans will be reviewed following events to ensure the care plan is updated to reflect appropriate interventions.</p> <p>DNS/designee will provide education to nursing staff related to revising care plans. Nurse management team will review care plans of residents with events to ensure care plan revisions were completed.</p> <p>DNS/designee will randomly audit Care Plan for residents that have reported status changes to ensure CP revisions were completed. Results will be reported to Performance Improvement committee x3months.</p> <p>F280 POC accepted 10/21/13 McLellan RN/AME</p>	

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F 280	<p>Continued From page 7</p> <p>lifted into the wheelchair, and while being lowered into the chair, the top of the Hoyer (name of the mechanical lift) bar swung and connected with the resident's forehead.</p> <p>Per review of the Physician's Progress note dated 8/29/13, Resident #1 wanted to be seen because Resident #1 had been hit by a hoyer in his/her right eye two days prior and Resident #1 was indicating he/she had blurry vision and since he/she was hit with the hoyer it has been worse. The physician progress notes indicates a need to be seen by an Ophthalmologist. Per consultant report dated 8/30/13, Resident #1 was seen by Ophthalmology and diagnosed with trauma to the brow.</p> <p>Per review of the comprehensive care plan there was no evidence that the care plan had been reviewed and/or revised after the 8/25/13 incident with interventions to prevent reoccurrence. Per interview with the Unit Manager on 9/12/13, he/she reviewed the medical record and the comprehensive care plan and was unable to identify any interventions put into place to ensure that Resident #1 would not be injured again after the 8/25/13 incident of being hit in the eye by the hoyer.</p> <p>2. Per review of the medical record on 9/12/13, Resident #5 has diagnoses that include; history of falls, unspecified disabilities and mechanical problems with limbs. Per review of the medical record, Resident #5 had numerous falls. Per record review, on 6/16/13 Resident #5 was found on the floor after sliding out of a wheelchair. On 6/21/13, Resident #5 was again found on the floor and again on 7/28/13 Resident #5 was found on the floor.</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>		

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F 280	Continued From page 8 Per review of the comprehensive care plan titled "High Risk for Falls" and "Actual Falls" there was no evidence that after the 6/16/13 fall, the care plans had been reviewed and/or revised to reflect interventions used to prevent reoccurrence. There was no evidence that the care plan had been reviewed or revised after the 7/28/13 fall with interventions to prevent reoccurrence. Per review with the Unit Manager on 9/13/13, he/she reviewed the medical record and comprehensive care plans titled "High Risk for Falls" and "Actual Falls", and confirmed that there was no evidence that after the 6/16/13 fall the care plans had been reviewed and/or revised to reflect interventions used to prevent reoccurrence, and there was no evidence that the care plan had been reviewed or revised after the 7/28/13 fall with interventions to prevent reoccurrence.	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>	
F 281 SS=J	483.20(k)(3)(i) SERVICES PROVIDED MEET 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 record review and staff interview, the facility failed to ensure that services provided or arranged by the facility meet professional standards of quality regarding actions and precautions taken when a resident with a head injury from a fall was attended to by staff, for 1 of 7 resident reviewed. (Resident #1) The findings include:	F 281	F281 Services Provided Meet Professional Standards Resident #1 was transported to the hospital for evaluation and was readmitted to the facility on 9/11/2013. LNA #1, LNA #2 and LPN received disciplinary action related to failure to maintain resident #1's safety.	

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F 281	<p>Continued From page 9</p> <p>1. Per review of the medical record for Resident #1, the record indicates that Resident #1 was readmitted to the facility on 8/2/13 and had diagnoses that include; morbid obesity, chronic pain, muscle weakness and mechanical limb problems. Per the facility internal investigation dated 9/2/13, the investigation indicates that Resident #1 was in his/her room and was being transferred from his/her bed to a shower chair, utilizing the assistance of two Licensed Nursing Assistants (LNA's) and a mechanical lift (Hoyer). The investigation indicates that the LNA's used the Hoyer lift (mechanical lift) and had "completed a successful transfer to the shower chair" and "without warning and to their complete surprise, [Resident #1] fell backwards in the shower chair hitting the floor."</p> <p>The investigation also indicates that Resident #1 was bleeding from the head while laying on the floor and verbally indicated to the LNA's and LPN that his/her "head hurt". The internal investigation indicates that the Licensed Practical Nurse (LPN) instructed the LNA's to move Resident #1 from the floor utilizing a Hoyer lift and place Resident #1 back to bed so the LPN could take vital signs and check to resident. There was no evidence that a qualified professional properly assessed the resident prior to the resident being moved, and there was no evidence that staff took measures to stabilize the resident's neck/spine during the transfer.</p> <p>The internal investigation indicated that Resident #1 was hospitalized on 9/2/13 for a subdural hematoma (bleeding in the brain) and a T 11 fracture (spinal fracture). The hospital documentation indicated that the subdural</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> <p>LNA #1 has resigned. LNA#2 has an assigned mentor and weekly reports will be reviewed by DNS or SDC to review performance. After one month this will be completed monthly x3months.</p> <p>LPN is supervised by unit manager. Weekly meetings will review performance. After one month performance will reviewed monthly x3 months.</p> <p>Licensed nurses and LNA's were educated regarding facility policy 618 "Accidents and Supervision to Prevent Accidents" and facility procedure 64001 "Care of Patient with Possible Injury". Staff have been instructed to seek out another nurse (one should be an RN), to ensure adherence to procedure 64001. If there is not an RN present and it is not a 911 emergency, the nurse should call the on-call RN to consult.</p> <p>DNS/designee will review falls that occur with a possible head injury to ensure compliance with facility policy 618 "Accidents and Supervision to Prevent Accidents" and facility procedure 64001 "Care of Patient with Possible Injury". Findings will be reviewed at the Performance Improvement Committee x3months.</p>	

F281 POC accepted 10/11/13
McWhorter/AME

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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 09/16/2013
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F 281	<p>Continued From page 10</p> <p>hematoma and T11 fracture were a result of the fall.</p> <p>Per interview with the LPN on 9/12/13, he/she confirmed that Resident #1 had fallen backward in the shower chair after being Hoyer lifted from the bed to the shower chair. The LPN confirmed that he/she observed Resident #1 on the floor on his/her back with head on floor. The LPN stated that the LNA had part of the residents head in his/her hand and the other part of the head was on the floor. The LPN confirmed that the resident was bleeding from a laceration on the back of the head and was verbalizing that his/her head hurt. The LPN confirmed that he/she instructed the aides to hoyer the resident from the floor and place back in bed and that once in bed, the LPN assessed the resident for injuries. The LPN stated that after Resident #1 was placed back to bed, when the head of the bed was raised the resident verbalized pain in his/her back and the LPN lowered the residents head back down. The LPN indicated that he/she did not know that if a person who has fallen and is complaining of head pain and bleeding from the head that the standard of practice is to not move the resident to avoid further injury and pain to the resident.</p> <p>Per review of the facility policy/procedure titled "Head Injury" and dated 4/28/09, the policy indicates that the nurse is to "look for obvious signs of injury, such as lacerations, bleeding, ecchymosis and depressed areas of head and do not move the resident." Review of the facility policy and procedure titled Care of a Patient with Possible Injury, it indicates to "call for assistance and do not move patient." "Do an initial assessment to check for life threatening injuries, e.g., bleeding, fractures and neck injuries, if there</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 282	Continued From page 12 Per review of the physical therapy notes and the physical mobility sheet/care plan, Resident #4 was to have assist of 1 person with utilization of a slideboard to make transfers from one surface to another. Per review with the LNA on 9/11/13, the LNA confirmed that he/she had not utilized the slideboard as the care plan indicates but instead the LNA lifted the resident by placing on hand under the residents knees and the other arm around the residents upper body and lifting Resident #4 from the bed to the wheelchair. The LNA confirmed that that the resident was care planned to have transfers be done with a slide board and confirmed that he/she should have followed care plan.	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>	
F 323 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES. The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review the facility failed to ensure that the environment for 5 of 7 residents identified (#1, #2, #3, #5 and #8) was as free of accident hazards as is possible and that each resident receives adequate supervision and assistance devices to prevent accidents. The findings include:	F 323	F323 Free of Accident Hazards/Supervision/Devices Resident #2 No longer resides at the facility Resident # 3 No longer resides at the facility Resident #8 The two LNA's involved in the transfer cited were educated upon discovery. Resident #5 Falls were investigated and Care Plan updated to reflect any new interventions	

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F 323	Continued From page 13 1. Per review of the medical record for Resident #1, the record indicates that Resident #1 was readmitted to the facility on 8/2/13 and had diagnoses that include; morbid obesity, chronic pain, muscle weakness and mechanical limb problems. Per review of the facility internal investigation dated 9/2/13, the investigation indicates that Resident #1 was in his/her room and was being transferred from his/her bed to a shower chair, utilizing the assistance of two Licensed Nursing Assistants (LNA's) and a mechanical lift (Hoyer). The investigation indicates that the LNA's used the hoier lift and had "completed a successful transfer to the shower chair" and "without warning and to their complete surprise, [Resident #1] fell backwards hitting the floor." The internal investigation indicated that Resident #1 was hospitalized on 9/2/13 for a subdural hematoma (bleeding in the brain) and a T 11 fracture (spinal fracture). The hospital documentation indicated that the subdural hematoma and T11 fracture were a result of the fall. Review of the Nursing Admission Assessment completed on 8/2/13 indicates that Resident #1 "has bilateral impairment to both lower extremities." Review of the Comprehensive Assessment (MOS) dated on 8/5/13 and 8/16/13 indicates that Resident #1 was a total assist with transfers. The assessment dated 8/2/13 indicates that Resident #1 has "very limited mobility"(makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently.) The assessment also indicates the Resident #1 is "chairfast" (ability to walk severely limited or nonexistent. Cannot bear weight and/or must be assisted into chair or wheelchair.) Per review of	F 323	<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> Resident #1 was re-admitted to Starr Farm Nursing Center on 9/11/13 and has been re-assessed for safety. Her assessments include: level of pain and care plan interventions to address, skin inspection, risk of pressure ulcer development, bed safety, fall prevention strategies, transfer requirements, and other pertinent health factors. Medical orders have been reviewed and noted and care plan interventions updated. Adhoc Performance Improvement meeting including maintenance director, staff educator, DNS and ED was conducted on 9/3/2013 to investigate event that occurred on 9/2/2013 with Resident #1. Reviewed the procedure mechanical lift with nursing staff. Investigation began on 9/2/2013 with staff interviews, equipment removed from service immediately. Findings indicated that there was no equipment failure. The only logical conclusion is human error. LNA #1 has resigned. LNA#2 has an assigned mentor and weekly reports will be reviewed by DNS or SDC to review performance. After one month this will be completed monthly x3months.		

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F 323	<p>Continued From page 14</p> <p>the physical therapy documentation starting on 8/2/13, it indicates that Resident #1 was receiving therapy services related to decreased functional ability.</p> <p>Per interview and demonstration of incident with 2 facility LNA's on 9/11/13, LNA #1 indicated that he/she was behind the shower chair, Resident #1 was hoiered into the shower chair and was sitting comfortably in the chair, the LNA #1 indicated that the hoier was away from the chair and all of a sudden the chair with Resident #1 in it flipped backwards onto the LNA, and Resident #1 and the LNA landed on the floor with Resident #1 hitting his/her head on the floor and complaining of head pain. LNA #1 indicated that she was facing the resident but did not see how Resident #1's shower chair flipped over. LNA #1 demonstrated how the incident occurred. Per interview and demonstration on 9/11/13 with LNA #2, he/she indicated that Resident #1 was hoiered from the bed to the shower chair successfully, and that Resident #1 was sitting in the shower chair comfortably, not moving when suddenly Resident #1 flipped backwards in the chair hitting the floor and his/her head and was complaining of head pain. LNA #2 indicated in interview that he/she was looking at Resident #1 when the chair flipped backward and LNA #2 never saw any movement from Resident #1 in the chair. LNA #2 indicated also in interview that the Hoyer lift was moved completely away from the shower chair and did not cause the chair to flip.</p> <p>Per direct observation by the state surveyor on 9/10/13, the shower chair utilized for Resident #1 was observed along with several other bariatric shower chairs in the shower room on the unit. The state surveyor sat in the shower chairs and</p>	F 323	<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>LPN is supervised by unit manager. Weekly meetings will review performance. After one month performance will reviewed monthly x3 months.</p> <p>Maintenance inspected all mechanical lift devices and found them to be in good working order.</p> <p>Residents at or above 300lbs were reassessed for appropriate shower chairs use.</p> <p>The center Performance Improvement Team met on 9/11/2013 to address this adverse event as well as measures to prevent any re occurrence. Root cause analysis was completed and the center focused on retraining licensed nursing staff, licensed nursing assistants and therapy staff, including return demonstration techniques on the following:</p> <ul style="list-style-type: none"> o Transfers of patients – Pivot competency with return demonstration o Transfers of patients— Slide Board competency with return demonstration o Gail Belt competency with return demonstration 		

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F 323	<p>Continued From page 15</p> <p>attempted to flip the wheelchair backwards by pushing feet against the wall and the floor. The state surveyor was unable to make the shower chair tip backwards, despite having full mobility and strength. All four wheels remained on the floor at all times.</p> <p>Per observation on 9/10/13, at 2:45 PM, 2 facility LNA's were observed transferring another resident, Resident #8, from his/her bed to the resident's wheelchair utilizing a hooyer lift. LNA#1 identified his/her self as and LNA Coordinator and that his/her responsibilities included training new LNA staff. Residen #8t was observed being lifted in the hooyer lift over the bed with one LNA controlling the mechanical lift and the other LNA standing behind the wheelchair at the foot of the bed. At no time while the resident was suspended in the hooyer over the bed and moved to over the wheelchair was the resident observed to be being physically secured by the LNA. It was observed that once Residen #8t was suspended over the wheelchair, the LNA Coordinator tipped the standard wheelchair backwards holding the left handle with one hand and the LNA Coordinator grabbed the back of the sling that held the resident and pulled the sling backward and guided the resident as the hooyer lowered that resident into the chair that was tipped backward by the LNA. The LNA Coordinator was observed tipping the wheelchair backwards with one hand the entire time the resident was being lowered into the chair. The LNA Coordinator did not place the wheelchair on all four wheels and the wheelchair remained tipped and held by one hand by the LNA Coordjnator until the resident was in the wheelchair and the hooyer pad disconnected from the hooyer and the hooyer moved away from the resident wheelchair by LNA #2. The LNA</p>	F 323	<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> <ul style="list-style-type: none"> o Transfer –Sit to Stand Lift competency with return demonstration o Mechanical Lift (Sling Lift) competency with return demonstration o Patient Transfers/Mobility includes Bariatric Algorithm o POL 618 "Accidents and Supervision to Prevent Accidents", and PRO 64001 "Care of a Paticat with Possible Injury" has also been in-serviced to nursing staff. <p>The education was provided by the facility DNS, ADNS, the SDC or the clinical consultant on September 11, 12, and 13 and includes the licensed nurses, licensed nurses aides and the Rehab staff.</p> <p>Newly hired staff will be provided the same in-service training in new employee orientation. This training will be provided by the Director of Nursing, the SDC or another designated nursing administrative team member.</p>	

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F 323	<p>Continued From page 16</p> <p>Coordinator indicated that he/she utilizes this practice "all the time" to ensure that the resident is properly positioned in the wheelchair. The LNA Coordinator indicated that he/she instructs the new LNA's to perform hoyer transfers in this manner, by tipping chairs back during transfers.</p> <p>Per interview with a facility employee on 9/12/13, he/she indicated that on 9/2/13 he/she had observed LNA #1 and LNA #2 doing the transfer of Resident #1 with the hoyer. The facility employee indicated that he/she observed the LNA's to have the shower chair tipped backwards during the transfer that resulted in injury and the LNA that was behind Resident #1 in the shower chair had the chair tipped and leaning against his/her body and the LNA did not have his/her hands placed on the shower chair at all. The facility employee indicated that just after the employee left the room he/she heard thru the open door a crash and yells for help. The facility employee indicated when he/she returned to the room, Resident #1 was on the floor in the shower chair on top of the LNA and indicating that his/her head hurt.</p> <p>Per review of the facility policy and procedure titled Mechanical Lift, dated 3/16/12 indicates that during the mechanical transfer of a resident "one staff member is to guide the patient and one staff member is to maneuver the lift."</p> <p>Per interview with the facility Administrator on 9/13/13, he/she confirmed that in his/her investigation of the 9/2/13 incident with Resident #1, the Administrator asked LNA #1 and #2 specifically if "they had tipped the wheelchair back for better positioning". The Administrator confirmed that question was asked specifically</p>	F 323	<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>In addition yearly competencies will include transfer training as well as education regarding these two policies in specific.</p> <p>A Performance Improvement Team, (PIP) group has been appointed and will conduct a monthly safety meeting to identify and resolve safety concerns. This review will consist of a review of preventative maintenance logs for compliance, any identified safety concerns identified by staff members through interview and/or observation or by residents and families through the grievance system. Review of resident and staff event reports, observation of employees in providing transfers with residents, review of new hires to ensure that orientation for safety has occurred</p> <p>The Director of Nursing, Assistant Director of Nursing and the Staff Development Director or designee will be assigned to each unit to conduct random, unannounced observations of all types of resident transfers 5 times per week x 4 weeks, then weekly x 3 months. Department Managers will report findings during Morning Meetings. The Executive Director and the Director of Nursing will ensure timely follow-up to any identified concerns.</p>		

F323 POC accepted 10/21/13
MculinaurRN/PMC

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F 323	<p>Continued From page 17</p> <p>because the Administrator was a licensed therapist and has seen staff utilize this during transfers in her career.</p> <p>The facility investigation was deemed inconclusive and there was no evidence the facility discovered the unsafe practice of tipping back chairs described above, from the period of 9/2/13 to when the facility was alerted by the state surveyors on 9/11/13. There was no evidence that facility staff included observations of actual transfers using the hoier lift during their investigation of the 9/2/13 incident. Due to the inability of the facility to identify the potential root cause of the 9/2/13 incident, no corrective action was taken until at least 9/11/13, when the facility was informed of the Immediate Jeopardy determination.</p> <p>2. Per review of the medical record for Resident #1 on 9/11/13, the record indicated that on 8/25/13, Resident #1 was being hoiered into a wheelchair. While being lowered into the chair, the top of the hoier bar swung and connected with residents forehead. Per review of the Physicians Progress note dated 8/29/13, Resident #1 wanted to be seen because Resident #1 had been hit by a hoier in his/her right eye two days prior and Resident #1 was indicating he/she had blurry vision and since he/she was hit with the hoier it has been worse. The physician progress notes indicate need to be seen by an Ophthalmologist. Per consultant report dated 8/30/13, Resident #1 was seen by Ophthalmology and diagnosed with trauma to the brow.</p> <p>Per review of the facility policy titled Accidents and Supervision to Prevent Accidents dated 4/28/11, the policy indicates that the facility will</p>	F 323	<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 323	<p>Continued From page 18</p> <p>"investigate accidents and develop a plan of action to prevent the accident from recurring." Per interview with the facility Administrator, he/she confirmed that no investigation had been done to identify the cause of incident and potential interventions to help prevent reoccurrence.</p> <p>Per interview with the Unit Manager on 9/12/13, he/she reviewed the medical record and the comprehensive care plan and was unable to identify any interventions put into place to ensure that Resident #1 would not be injured again after the 8/25/13 incident of being hit in the eye by the hoyer.</p> <p>3. Per record review on 9/12/13, Resident #2 on 8/31/13 the incident note indicates that Resident #2 "had a bruise of unknown origin discovered on Resident #2's right outer eye, purple in color measuring 7 cm [centimeters] long and 2 cm wide." Per review of the facility internal investigations there was no evidence that this documented incident on 8/31/13 of a bruise of unknown origin was investigated and a cause of the bruising of the right eye was determined.</p> <p>Per review of the medical record, Resident #2 had diagnosis that include obesity, mechanical problems with limbs, legally blind, and chronic pain. Per review of the medical record it indicates that Resident #2 is a 2 person assist with activities of daily living and uses 2 persons for transfers. Per review of the facility policy titled Accidents and Supervision to Prevent Accidents dated 4/28/11, the policy indicates that the facility will "investigate accidents and develop a plan of action to prevent the accident from recurring."</p>	F 323	<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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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 09/16/2013
NAME OF PROVIDER OR SUPPLIER STARR FARM NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 98 STARR FARM RD BURLINGTON, VT 05408		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	<p>Continued From page 19</p> <p>Per interview with the facility Administrator and Director of Nursing, they confirmed that no internal investigation had been completed to determine that cause of the bruise of unknown origin identified on Resident #2 on 8/31/13 and development of interventions to prevent reoccurrence.</p> <p>4. Per review of the medical record on 9/12/13, Resident #5 has diagnosis that include; history of falls, unspecified disabilities and mechanical problems with limbs.</p> <p>Per review of the medical record, Resident #5 had numerous falls. Review of the Comprehensive Assessment it indicates that Resident #5 has had falls and the comprehensive care plan identifies Resident #5 at "high risk for falls". Per review on 6/16/13 Resident #5 was found on the floor after sliding out of wheelchair. On 6/21/13, Resident #5 again was found on the floor and again on 7/28/13 Resident #5 was found on the floor.</p> <p>Review of the records indicate that on 6/16/13 the facility asked therapy to evaluate the resident for positioning needs. The documentation indicates that resident refused any interventions by the facility to prevent reoccurrence. Per interview with the Unit Manager, he/she reviewed the progress notes, therapy notes and comprehensive care plan and was unable to provide evidence that the falls on 6/21 and 7/28 were reviewed and interventions placed to prevent reoccurrence of falls.</p> <p>5. Per review of the medical record for Resident #3, on 6/21/13 at 1430, Resident #3 was found in his/her room, laying on the floor on his/her back</p>	F 323	<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 323	Continued From page 20 in the doorway. Resident #3 was unresponsive, no response to sternal rub, extremities were flaccid, blood pressure was 150/111, pulse was 69, respirations were 18, resident was sent to ER. Per review of the Emergency room record on 6/21/13, Resident #3 was pronounced dead upon arrival. Per review of the facility's internal investigations there was no evidence that the facility investigated the possible cause for the fall. Per review of the facilities policy and procedure titled "Falls Management" it indicates that falls are to be investigated for the cause of the event immediately after emergency care has been given and the patient's condition stabilized. Per review of the facility policy and procedure titled "Accidents and Supervision to Prevent Accidents, the facility is to investigate all accidents and develop a plan of action to prevent the accident from reoccurring." Per interview with the Director of Nursing he/she was unable to provide an internal investigation regarding the fall on 6/21/13 of Resident #3, where resident expired after being transported status post fall to the emergency room. Per interview with the Intake Department for the Division of Licensing and Protection there is no record that and investigation was conducted concerning possible cause of the 6/21/13 fall that proceeded Resident's #3 death on 6/21/13.	F 323	<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 490 SS=J	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest	F 490	F490 Effective Administration/Resident well-being Licensed nurses and LNA's were educated regarding facility policy 618 "Accidents and Supervision to Prevent Accidents" and facility procedure 64001 "Care of Patient with Possible Injury" Adhoc Performance Improvement meeting including maintenace director, staff educator, DNS and ED was conducted on 9/3/2013 to investigate event that occurred on 9/2/2013 with Resident #1. Reviewed the procedure mechanical lift with nursing staff. Investigation began on 9/2/2013 with staff	

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F 490	Continued From page 21 practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based regulatory violations found at the Immediate Jeopardy level at F281 and F323, the facility is not Administered in a manner that enables it to use its resources effectively to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. Findings include: 1. The Administrator failed to assure that services provided or arranged by the facility meet professional standards of quality regarding actions and precautions taken when a resident with a head injury as a result of a fall was attended to by staff. Refer to F281. 2. The Administrator failed to assure that the environment was as free of accident hazards as is possible regarding the use of mechanical lifts and transfer techniques used by staff, and that each resident receives adequate supervision and assistance devices to prevent accidents. Refer to F323.	F 490	<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> interviews, equipment removed from service immediately. Findings indicated that was no equipment failure. The only logical conclusion is human error. The center Performance Improvement Team met on 9/11/2013 to address this adverse event as well as measures to prevent any re occurrence. Root cause analysis was completed and the center focused on retraining licensed nursing staff, licensed nursing assistants and therapy staff, including return demonstration techniques on the following: <ul style="list-style-type: none">o Transfers of patients - Pivot competency with return demonstrationo Transfers of patients— Slide Board competency with return demonstrationo Gait Belt competency with return demonstrationo Transfer -Sit to Stand Lift competency with return demonstrationo Mechanical Lift (Sling Lift) competency with return demonstrationo Patient Transfers/Mobility includes Bariatric Algorithm		
F 517 SS=C	483.75(m)(1) WRITTEN PLANS TO MEET EMERGENCIES/DISASTERS The facility must have detailed written plans and procedures to meet all potential emergencies and disasters, such as fire, severe weather, and missing residents. This REQUIREMENT is not met as evidenced	F 517			

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F 517	Continued From page 22 by: Based on record review and staff interview the facility failed to ensure that their written disaster manual had current up to date information. The findings include: 1. Per review of the facility's disaster manual, the manual's call tree, of who should be notified in the event of a disaster, the contact information was inaccurate. The call list listed the wrong contact information for 2 Nurse Managers and the Assistant Director of Nursing. Per interview with the Director of Nursing on 9/16/13, s/he confirmed that the information on the call list in the disaster manual was not accurate and did not reflect the current nurse managers for 2 units and did not list the current Assistant Director of Nursing.	F 517	<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> o POL 618 "Accidents and Supervision to Prevent Accidents", and PRO 64001 "Care of a Patient with Possible Injury" has also been in-serviced to nursing staff.
F 518 SS=C	483.75(m)(2) TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure that facility staff periodically reviewed the procedures with existing staff and carry out unannounced staff drills using those procedures for missing persons and evacuations. The findings include;	F 518	The education was provided by the facility DNS, ADNS, the SDC or the clinical consultant on September 11, 12, and 13 and includes the licensed nurses, licensed nurses aides and the Rehab staff. Newly hired staff will be provided the same in-service training in new employee orientation. This training will be provided by the SDC or designee. In addition yearly competencies will include transfer training as well as education regarding these two policies in specific. A Performance Improvement Team, (PIP) group has been appointed and will conduct a monthly safety meeting to identify and resolve safety concerns. This review will consist of a review of preventative maintenance logs for compliance, any identified safety concerns identified by staff members through interview and/or observation or by residents and families

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through the grievance system. Review of resident and staff event reports, observation of employees in providing transfers with residents, review of new hires to ensure that orientation for safety has occurred

The Director of Nursing, Assistant Director of Nursing and the Staff Development Director or designee will be assigned to each unit to conduct random, unannounced observations of all types of resident transfers 5 times per week x 4 weeks, then weekly x 3 months. Department Managers will report findings during Morning Meetings. The Executive Director and the Director of Nursing will ensure timely follow-up to any identified concerns.

F490 POC accepted 10/21/13
McGuinnan RN/PMU

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F 518	<p>Continued From page 23</p> <p>Per review of the facility's disaster drill log, there was no evidence of missing person drills and evacuation drills being conducted periodically with staff.</p> <p>Per interview with the facility Administrator, he/she confirmed on 9/13/13 that the facility did not have any evidence of missing persons drills and evacuation drills being conducted with staff on a periodic basis.</p>	F 518	<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>F517 Written Plans to Meet Emergencies/Disasters</p> <p>Facility Disaster Manual call tree was updated immediately</p> <p>Education provided on procedure for updating call tree.</p> <p>Maintenancce/designee will review the Disaster Manual at Safety Committee quarterly to ensure the call tree is up to date. Finding reported to Performance Improvement Committee x1 year</p> <p>F517 POC accepted 10/21/13 McLellan RWT/PM</p> <p>F518 Train All Staff-emergency procedure drills</p> <p>Documentation of Emergency procedures for missing persons and evacuation added to list of covered topics in Orientation.</p> <p>Education calendar for the year developed to schedule periodic unannounced review/drills of missing persons and evacuation.</p> <p>SDC/designee will provide education to staff about missing person and evacuation procedures.</p>	

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Audit of the drills will be reviewed quarterly at the Performance Improvement Committee. Any further education or revision of procedures will be identified and completed per Performance Improvement Committee recommendations.

F518 POC accepted 10/21/13
McWhinon RA/PML