VERMONT

AGENCY OF HUMAN SERVICES

DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING
Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

November 30, 2018

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

Dear Ms. Biondolillo:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **November 1, 2018**. 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

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 11/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STARR FARM NURSING CENTER	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
E 000	Initial Comments An emergency preparedness review was conducted by the Division of Licensing and Protection on 10/31/18. The facility was found to be in substantial compliance with the emergency preparedness regulations.	E 000		
F 000	INITIAL COMMENTS The Division of Licensing and Protection conducted an unannounced, onsite annual recertification survey 10/29/18 - 11/1/18. Three complaints and two facility self-reports were also investigated. Regulatory violations were cited as a result of the survey and one complaint investigation.	F 000		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons	F 757		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Susan B Brandolillo Executive Director 11-20-2018

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 757	Continued From page 1 stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, record review and confirmed by staff interview, homeopathic remedies were discovered at the bedside, for 1 of 31 applicable residents sampled, without adequate monitoring and without adequate indications for use (Resident #58). The findings include the following: Per initial tour on 10/29/18 and the three (3) following days, the surveyor discovered over the counter homeopathic medications (a system of alternative medicine) stored on the bedside table, in Resident #58's bedroom. The remedies found were a Neutra Biotic throat spray (herbal resistance) with echinacea goldenseal & yin chiao (immune support) with echinacea, chiao immune support drops, and Traumeel anti-inflammatory homeopathic liquid analgesic. Per physician orders dated 10/27/18, identifies Saline Nasal Spray to be taken as needed by the resident and may be kept at the bedside. Per tour of Resident #58's bedside, in the presence of the Unit Manager (UM), on 10/31/18 at 2:38 PM, confirmation was made that s/he was unaware of the homeopathic remedies at the bedside. The UM confirmed that the saline nasal spray was prescribed by the physician and was permitted to be at the bedside for self-administration. Per discussion with the physician on 11/1/18 at 9:45 AM, s/he acknowledged that s/he was not aware of the homeopathic medications being	F 757	*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.* Enter Plan Of Correction Here. F:757 1. Resident #58 – All homeopathic medications were removed from the resident's room with resident's consent. .Physician was notified and order for a throat spray was obtained. 2.All residents have the potential to be affected by this alleged deficient practice 3. A full house room audit was conducted to identify any visual / medications from home or homeopathic medications in a resident's room. • A notice to family / designated representatives about medications brought from home and homeopathic medications was mailed and placed in the Welcome Binder • The Unit Manager/ Designee will conduct weekly room rounds to monitor for visible homeopathic/medications from home. Medications from home/homeopathic medications will be secured by the nurse and the	11/27/2018

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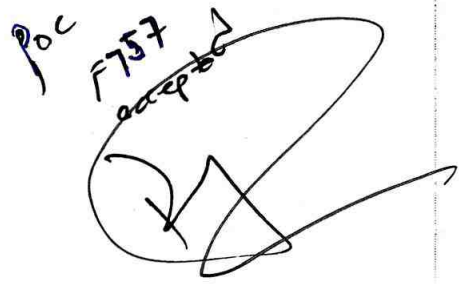
F 757	Continued From page 2 taken by the resident, nor was there any knowledge that they were stored at the bedside. The physician discussed with the resident that there is no documented evidence proving the risks vs. the benefits of taking these remedies. The physician did approve the administration of the Neutra Biotic throat spray only and acknowledged without conducting research s/he could not identify the outcomes of taking those remedies along with prescribed medications.	F 757	MD will be notified for orders 4, A random weekly audit of Residents Rooms for visible medications from home / homeopathic medications will be conducted by The Unit Manager/Designee. • Audit results will be reported to the monthly QAPI Committee until 100% completion is obtained then as directed by the QAPI Committee	
F 802 SS=F	Sufficient Dietary Support Personnel CFR(s): 483.60(a)(3)(b) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.60(a)(3) Support staff. The facility must provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. §483.60(b) A member of the Food and Nutrition Services staff must participate on the interdisciplinary team as required in § 483.21(b)(2)(ii). This REQUIREMENT is not met as evidenced by: Based on resident/family complaints and confirmed by the Food Service Supervisor (FSS) and the Administrator, the facility failed to ensure that sufficient support personnel were provided to	F 802	5. DNS/Designee 11/29/18 POC F757 accepted 	

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F 802	Continued From page 3	F 802	Enter Plan Of Correction Here.	11/27/2018

safely and effectively carry out the functions of the food and nutrition service. The findings include the following:

Per interview during the four-day survey (10/29 through 11/1/18), both residents and families voiced the concern that residents have been served food that is cold and served on disposable dishes/flatware due to a broken dishwasher.

During interviews on 10/31/18 with both the FSS and the Administrator, it was confirmed that disposable dishes and flatware were used on 10/20/18, 10/22/18 and 10/23/18 for all three meals and snacks, due to staff shortages. During those identified days, dietary aides and cooks called out of work for various reasons of both the day and evening shifts. Replacements were attempted, but a full complement of staff was not possible. The FSS confirmed that s/he had restrictions on his/her abilities but did assist with dietary aide duties where possible. The FSS also confirmed the temperature logs for those identified days, evidenced that the food was served at the proper temperatures at the time delivered to the units. However, the FSS also confirmed that the disposable cardboard containers do not hold hot temperatures for an extended period.

Per interview with Resident #46, s/he stated that it is not possible to attend evening activities because dinner is served so late. The Resident states that it has been as late as 7:45 PM when dinner was completed. According to the resident's daughter, on at least 3 occasions her parent stated during phone conversations that dinner was late (after 7 PM). In one conversation the resident stated that s/he had requested cereal for

F:802

1. No individual resident was affected by this alleged deficient practice.

2.All residents have the potential to be affected by this alleged deficient practice

3. Members of the Leadership Team will be trained on select kitchen processes so that they may assist as needed.

- Maintenance and activity staff will be cross trained to perform select kitchen functions to dishwashing and tray service
- The dishwasher tile work is completed and residents are served on proper dishware.
- A new pellet warming system was delivered during survey and has been installed and is operating
- Continue staff recruitment efforts

4. A random weekly audit of Test trays will be completed by the ED/designated rep
    - The Food Service Manager

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F 802	Continued From page 4 dinner because it was taking too long for dinner and the resident was hungry. Per review of the resident council meeting minutes for the months of August through October 2018, residents continually complain of cold food, untimely meal service and food requests not being provided. The FSS confirmed that the staff shortage was brought to the attention to the entire administrative team at the daily morning meeting. The team agreed with the decision to use disposable products during the shortage. Confirmation can not be made that the residents were alerted to the use of the disposable product during those dates. Per discussion with the Nursing Home Administrator on 10/31/18 at 8:17 AM, confirmation was made that the facility has had staffing issues back to mid July 2018. Initiatives have been put in place to compensate staff for cross training that will provide the facility alternatives should the need reoccur.	F 802	will audit daily cart times to ensure timeliness of the meal • All audit results will be reported to the monthly QAPI Committee until 100% compliance is obtained then as directed by the QAPI Committee 5. ED/Designee 11/2-18 POC F802 acc epad	
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent	F 812		

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F 812	Continued From page 5 facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and confirmed by staff interview the facility failed to follow proper sanitation and food handling practices to prevent the outbreak of foodborne illness in accordance with professional standards for food safety. The findings include the following: 1. During the initial tour of the dietary kitchen on 10/29/18 at 9:15 AM, in the presence of the Food Service Supervisor (FSS) and the Registered Dietician (RD), it was discovered that the test strips used to check the efficacy of the sanitizer for the Low Temperature Dish Machine, had an expiration date of 2017. The three-bay sink that is used to wash pots and large kitchen items, have logged sanitization records conducted three times a day. The results identify the concentration of the sanitizer and ensures that the pots and kitchen items are clean and sanitized. The test strip roll used, does not identify the expiration date. Therefore, the facility is unable to ensure the test results are accurate. The FSS and the RD both confirm at this time that the strips are outdated, and the roll does not have any expiration dated, therefore; the facility	F 812	Enter Plan Of Correction Here. 11/27/2018 F:812 1. No individual resident was affected by this alleged deficient practice. 2.All residents have the potential to be affected by this alleged deficient practice 3. All sanitizer test strips were checked for expiration dates and replaced as needed • Ecolab was consulted. New test strip vials are not individually dated but come in an exterior package that is dated. • The Food Service Manager will date each individual bottle to reflect the exterior packaging expiration date. • A copy of the exterior packaging will be kept by the Food Service Manager for reference. • The wall behind the stove will be cleaned nightly by the cook to ensure no food is built up on wall. • Kitchen walls will be included on the biannual full kitchen deep cleaning preventative maintenance schedule.	

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F 812 Continued From page 6

was unable to ensure the accuracy of the results.

2. During the tour of the dietary kitchen on 10/29/18 at 9:15 AM, in the presence of the Food Service Supervisor (FSS) and the Registered Dietician (RD), it was discovered that the entire wall directly behind the main cooking stove has visible accumulated dust and grime that could easily dislodge while food is being prepared. The FSS confirmed at this time that the wall needs cleaning.

3. Per observation on 11/1/18 at approximately 8-8:30 AM, the Mansfield and the Chittenden Units, were found to have heavily soiled microwave ovens containing dry sticky liquids and food. The refrigerator on the Mansfield Unit was also found to have multiple dried spills. The findings were confirmed by the FSS on the Mansfield Unit and the Unit Manger on Chittenden.

F 842 SS=D Resident Records - Identifiable Information
CFR(s): 483.20(f)(5), 483.70(i)(1)-(5)

§483.20(f)(5) Resident-identifiable information.
(i) A facility may not release information that is resident-identifiable to the public.
(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

§483.70(i) Medical records.
§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident

F 812

- The kitchenettes on each unit will be cleaned twice daily by housekeeping staff to include the interior of microwaves and refrigerators.

4. A random weekly audit of Environmental Rounds to include kitchenettes/microwaves and refrigerators will be conducted by the Director of Maintenance and Environmental Services.

- Food Service Manager will audit all sanitizer strips and chemicals weekly for expiration dates
  - All audit results will be reported to the monthly QAPI Committee until 100% compliance is obtained then as directed by the QAPI Committee

5. ED/Designee

F 842

poc F812 accepted 11/29/18

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F 842	Continued From page 7 that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain-	F 842	Enter Plan Of Correction Here. F:842 1. Resident #31 The wound nurse changed the dressing and documented the dressing on the TAR. 2.All residents have the potential to be affected by this alleged deficient practice 3. Licensed nurses will be educated on the Policy and Procedure for treatment documentation. • Nurses will document only on treatments they have physically performed themselves. 4. A random weekly audit of the Treatment Administration Records will be completed to ensure appropriate documentation of treatments • All audit results will be reported to the monthly QAPI Committee until 100% compliance is obtained then as directed by the QAPI Committee 5. DNS/Designee	11/27/2018

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(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and
(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and record review, the facility failed to maintain medical records on 1 of 31 residents in the sample (Resident # 31) that are accurately documented. Findings include:

Per record review, the clinical record for Resident # 31 contained inaccurate documentation. Per interview with the Unit Manager and the facility wound nurse, the wound nurse stated that h/she does the dressing change for this resident. The Unit Manager (UM) stated that the wound nurse does the dressing change at least weekly. Review of the Treatment Administration Record (TAR) for September and October 2018 shows that the wound nurse signed off on the dressing change on only 1 occasion (9/6/18). The TAR shows that nurses other than the wound nurse are signing off as having done the dressing change. When questioned by the Surveyor, the wound nurse stated that h/she should have signed off on the dressing changes if h/she did them. A unit nurse that had signed off on a dressing change for Resident # 31 stated that a check mark and signature code on the TAR means that signing nurse did the procedure and confirmed that h/she had done dressing changes for the resident.

poc F 842 accepted 11/29/18

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F 842	Continued From page 9	F 842		

On 11/01/18 at 8:55 AM, the Director Of Nurses (DNS), stated it is his/her expectation that nurses that perform a procedure sign off as having done the procedure. The DNS Confirmed that the wound nurse had not signed off as doing dressing changes for Resident # 31 and that other nurses had signed off as performing the procedures.