

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

February 1, 2019

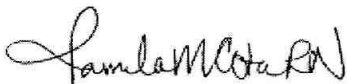
Mr. Bradley Heller, Administrator
Elderwood at Burlington /Starr Farm Nursing Center
98 Starr Farm Rd
Burlington, VT 05408-1396

Dear Mr. Heller:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **January 3, 2019**. 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

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

PRINTED: 01/15/2019
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 01/03/2019
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).

F 000 INITIAL COMMENTS

The Division of Licensing and Protection conducted an unannounced onsite investigation of 1 facility reported incident and 1 anonymous complaint from 1/2/19 - 1/3/19. The following regulatory finding was identified.

F 657 Care Plan Timing and Revision
SS=D CFR(s): 483.21(b)(2)(i)-(iii)

§483.21(b) Comprehensive Care Plans
§483.21(b)(2) A comprehensive care plan must be-

- (i) Developed within 7 days after completion of the comprehensive assessment.
- (ii) Prepared by an interdisciplinary team, that includes but is not limited to--
 - (A) The attending physician.
 - (B) A registered nurse with responsibility for the resident.
 - (C) A nurse aide with responsibility for the resident.
 - (D) A member of food and nutrition services staff.
 - (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.
 - (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.
- (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.

This REQUIREMENT is not met as evidenced by:

F 000

This Plan of Correction is the Facility's allegation of compliance

F 657

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Bradley Keller *Administrator* 01-24-19

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.

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 01/03/2019
--	--	--	---

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 657 Continued From page 1
Based on record review, staff interviews and direct observation the facility failed to revise a care plan for 1 applicable resident (#1) to accurately reflect how oxygen therapy is being used. Findings include:

Per record review, resident #1 has a diagnosis of Obstructive Sleep Apnea and Asthma and the care plan indicates to use oxygen at 2 liters via nasal cannula at night/bedtime only. However, during 2 days of observation the resident was observed wearing oxygen continuously. During an interview with the Director of Nursing (DNS) on 1/3/18 at 1:30 s/he confirmed the care plan does not reflect the oxygen usage accurately.

F 657
F: 657 Care Plan Timing and Revision:

Resident #1 has a physician's order to wear continuous O2. Resident #1's care plan was updated to reflect the Physician's order. A facility wide audit of all O2 orders and O2 care plans was completed on January 4th to ensure the care plans reflected the physician orders.

We have modified our morning clinical meeting process to incorporate a review of the all new orders and corresponding care plans to ensure accuracy and continuity of care.

5 care plans will be reviewed weekly, compared to diagnosis list and orders. Audit findings will be reported on during our weekly Risk management meeting.

Responsible Party: Director of Nursing Services

2/1/19

F657 POC accepted 1/31/19 Lloverna/PMC