

Division of Licensing and Protection
103 South Main Street
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

November 5, 2014

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 **October 7, 2014**. 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:kc

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

PRINTED: 10/20/2014
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 10/07/2014
--	--	--	---

NAME OF PROVIDER OR SUPPLIER STARR FARM NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 88 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	F 000	<i>This Plan of Correction is the center's credible allegation of compliance.</i>	
F 281 SS=E	<p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interviews, record review and review of facility investigative reports, the facility failed to ensure that nursing services met professional standards of practice for 2 of 3 residents in the sample regarding: 1. Failure to monitor a resident with a potential head injury following an unwitnessed fall (Resident #1) and 2. Failure to assure that medications were administered in a safe and secure manner, failure to respond to a resident report of pain and failure to document the administration of a medication accurately (Resident #2). Findings include:</p> <p>1. Per 10/7/14 medical record review, Resident #1 reentered the facility on 8/21/14 following hospitalization for a supratherapeutic INR (an elevated lab value indicating an increased bleeding risk). The resident had diagnoses that included abnormal coagulation, a history of falls, post hemorrhagic anemia along with other chronic medical conditions. S/he was taking Coumadin 2 mg daily (an anticoagulant that increases bleeding risk) along with other chronic</p>	F 281	<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>F281 SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>Resident #1 no longer resides at the facility. Resident #2 pain is being managed per plan of care and within facility medication administration/storage policy.</p> <p>Residents requiring monitoring of neurological assessment were reviewed to ensure compliance with the Fall Response and Management policy and procedure. Systematic change included review of neurologic vital sign follow up post fall by unit manager daily (Monday-Friday) with report to the Interdisciplinary Team at clinical rounds. Residents on a pain management program were reviewed to ensure no other patients were affected by not following current plan of care and medication administration/storage policy. The nurse caring for resident #2 was terminated from her position.</p>	11/07/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Rachael Faerber Executive Director</i>	TITLE Executive Director	(X6) DATE 10/30/14
--	-----------------------------	-----------------------

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.

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

PRINTED: 10/20/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PRDVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475030	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/07/2014
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	PRDVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE
F 281	<p>Continued From page 1 medications.</p> <p>Per review of the nursing progress note dated 9/7/14, "staff responded to mat alarms sounding at 0500 this am to find resident laying on the floor, alert and oriented...Neurovital signs initiated per facility policy at this time..." Per review of the facility Fall Response and Management Policy, under the section Unwitnessed Fall/Patient Injury, subsection 7. States, "Monitor neurologic assessments every 15 minutes for 1 hour, then every 30 minutes for 1 hour, then every hour for 2 hours or until the condition stabilizes." Per medical record review, the only documentation of nursing staff monitoring neurovital signs (NVS) occurred at the time of the fall at 0500.</p> <p>On 10/7/14 at 4:57 PM, the Director of Nursing (DNS) confirmed that s/he was unable to provide evidence that nursing staff reassessed Resident #1's neurovital signs following the fall as per facility policy. S/he confirmed that Resident #1 died later that morning with the reported manner of death a cardiac arrhythmia.</p> <p>2. Per 10/7/14 medical record review, Resident #2 was admitted to the facility on 3/21/14 with diagnoses that included generalized osteoarthritis, chronic pain, back pain, debility and other chronic medical conditions. Her medications included the application of Lidocaine 5% patches (topical anesthetic patches used in the treatment of pain), 2 patches to be applied daily at 8 AM, one over his/her cervical spine and one over his/her lumbar spine.</p> <p>Resident #2's care plan for acute and chronic pain related to chronic back pain lists the following nursing interventions: Administer</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>Staff Development Coordinator or designee provided education to licensed nurses on the Fall Response and Management Policy. In addition education was provided about medication administration, documentation/storage and response to resident's complaint of pain.</p> <p>DNS or designee will do random audits of neurologic vital signs after an unwitnessed fall weekly x4weeks, then monthly x3 months. The results of the audits will be reviewed monthly by the PI committee.</p> <p>DNS or designee will conduct random audits on residents on pain management program to ensure compliance with medication administration/documentation/storage weekly x4weeks, then monthly x3 months. The results of the audits will be reviewed monthly by the PI committee.</p> <p><i>10/14/14</i></p>

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

PRINTED: 10/20/2014
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 10/07/2014
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 281	<p>Continued From page 2</p> <p>medications as ordered. See medication record. Monitor for effectiveness and side effects. Anticipate need for pain relief and respond immediately to any complaint of pain...Evaluate [Resident #2's] pain level each shift. Record results and interventions taken.</p> <p>During an interview on 10/7/14 at 1:46 PM, a staff LNA (Licensed Nursing Assistant) reported that on 9/7/14 s/he answered a call light for Resident #2 at approximately 2-2:30 PM; the resident reported that s/he was in pain and would like pain medicine. About 20 minutes later, the resident used her call bell and reported pain a second time to the LNA. In both instances, the LNA stated that she reported Resident #2's pain to the resident's nurse who responded both times that the resident had as much pain medication as s/he could get and did not go to the resident's room to evaluate his/her pain after either report. After returning to the resident's room to provide care, the LNA reported finding 2 unused Lidocaine patches dated 9/7/14 on the resident's table. The LNA reported bringing them to a social services staff member to bring to the staff nurse. On 10/7/14 at 2:09 PM, the social services staff member confirmed that the LNA gave him/her 2 Lidocaine patches from Resident #2's room to bring to the resident's nurse. In his/her 9/7/14 progress note, the social services staff member wrote that when s/he gave the patches to the staff nurse, the nurse stated, "I must have forgotten to put them on." Per review of the MAR (Medication Administration Record) for 9/7/14, Resident #2's nurse documented placing the patches on Resident #2 at 8 AM and did not correct the entry after the patches were found unused.</p> <p>On 10/7/14 at 4:57 PM, the facility DNS (Director</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>	

PRINTED: 10/20/2014
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: 475030	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/07/2014	
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 281	Continued From page 3 of Nursing) confirmed the above information and confirmed that the nursing staff member did not ensure that the lidocaine patches were administered in a safe and secure manner, did not respond to the Resident's reports of pain and inaccurately documented administration of the lidocaine patch in the MAR. The nurse was discharged from the facility following the incident.	F 281	<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 282 SS=D	(See F282 and F431) 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to assure that services were provided according to the written plan of care for one of three residents (Resident #2). Findings include: Per 10/7/14 medical record review, Resident #2 was admitted to the facility on 3/21/14 with diagnoses that included generalized osteoarthritis, chronic pain, back pain, debility and other chronic medical conditions. Her medications included the application of Lidocaine 5% patches (topical anesthetic patches used in the treatment of pain), 2 patches to be applied daily at 8 AM, one over his/her cervical spine and one over his/her lumbar spine. The resident's care plan for acute and chronic	F 282	F282 SERVICES BY QUALIFIED PERSONS/PER CARE PLAN Resident #2 pain is being managed per plan of care and within facility medication administration/storage policy. Residents on a pain management program were reviewed to ensure no other patients were affected by not following current plan of care and medication administration /storage policy. The nurse caring for resident #2 was terminated from her position. Staff Development Coordinator or designee provided education to licensed nurses on medication administration, documentation, storage and response to resident's complaint of pain. DNS or designee will conduct random audits of residents on pain management to ensure compliance with medication administration /documentation/storage weekly x4weeks,	11/7/14

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

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 10/07/2014
--	--	--	---

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 282 Continued From page 4
pain related to chronic back pain lists the following nursing interventions: Administer medications as ordered. See medication record. Monitor for effectiveness and side effects. Anticipate need for pain relief and respond immediately to any complaint of pain...Evaluate [Resident #2's] pain level each shift. Record results and interventions taken.
During an interview on 10/7/14 at 1:46 PM, a staff LNA (Licensed Nursing Assistant) reported that on 9/7/14 s/he answered a call light for Resident #2 between 2-2:30 PM; the resident reported that s/he was in pain and would like some pain medicine. About 20 minutes later, the resident used her call bell and reported pain a second time to the LNA. In both instances, the LNA stated that she reported Resident #2's pain to the resident's nurse who responded both times that the resident had as much pain medication as s/he could for now and did not go to the room to evaluate the resident's pain. After returning to the resident's room to provide care, the LNA reported finding 2 unused Lidocaine patches dated 9/7/14 on the resident's table. The LNA reported bringing them to a social services staff member. On 10/7/14 at 2:09 PM, the social services staff member confirmed that the LNA gave him/her 2 Lidocaine patches from Resident #2's room to bring to the resident's nurse. In his/her 9/7/14 progress note, the social services staff member wrote that when s/he gave the patches to the staff nurse, the nurse stated, "I must have forgotten to put them on." Per review of the MAR (Medication Administration Record) for 9/7/14, the resident's nurse documented placing the patches on Resident #2 at 8 AM and did not correct the entry. On 10/7/14 at 4:57 PM, the facility DNS (Director of Nursing) confirmed the above information and confirmed that the nursing staff member did not

F 282
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.

then monthly x3 months. The results of the audits will be reviewed monthly by the PI committee.

F 282: A.C. [unclear] 10/10/14

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

PRINTED: 11/05/2014
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 10/07/2014	
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 431	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on staff interviews and review of the facility internal investigation, the facility failed to assure that all drugs are stored in locked compartments and only authorized personnel have access to drugs for 1 of 3 residents (Resident #2). Per 10/7/14 medical record review, Resident #2 was admitted to the facility on 3/21/14 with diagnoses that included generalized osteoarthritis, chronic pain, back pain, debility and other chronic medical conditions. Her medications included the application of Lidocaine 5% patches (a topical anesthetic patch used in the treatment of pain), 2 patches to be applied daily at 8 AM, one over his/hercervical spine and one over his/her lumbar spine. During an interview on 10/7/14 at 1:46 PM, a staff LNA (Licensed Nursing Assistant) reported that on 9/7/14 s/he answered a call light for Resident #2 between 2-2:30 PM; the resident reported that s/he was in pain and would like some pain medicine. About 20 minutes later, the resident used her call bell and reported pain a second time to the LNA. In both instances, the LNA stated that she reported Resident #2's pain to the resident's nurse who responded both times that the resident had as much pain medication as s/he could for now and did not go to the room to evaluate the resident's pain. After returning to the resident's room to provide care, the LNA reported finding 2 unused Lidocaine patches dated 9/7/14 on the resident's table. The LNA reported bringing them to a social services staff member. On 10/7/14 at 2:09 PM, the social services staff member confirmed that the LNA gave him/her 2	F 431		

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

PRINTED: 11/05/2014
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 10/07/2014
--	--	--	---

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 431 Continued From page 7
Lidocaine patches from Resident #2's room to bring to the resident's nurse. In his/her 9/7/14 progress note, the social services staff member wrote that when s/he gave the patches to the staff nurse, the nurse stated, "I must have forgotten to put them on." Per review of the MAR (Medication Administration Record) for 9/7/14, the resident's nurse documented placing the patches on Resident #2 at 8 AM and did not correct the entry. Per review of the facility policy 5.3 Storage and Expiration of Medications, Biologicals, Syringes and Needles, under section 3. General Storage Procedures, subsection 3.3 states that the "Facility should ensure that all medications and biologicals, including treatment items, are securely stored in a locked cabinet/cart or locked medication room that is inaccessible by residents or visitors."
On 10/7/14 at 4:57 PM, the facility DNS (Director of Nursing) confirmed the above information and confirmed that the Lidocaine patches were left unattended and not stored in a secure manner. (see F281 and F282)

F 431