

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

July 31, 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 **July 2, 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:jl

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

PRINTED: 07/17/2014
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 07/02/2014
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 000	INITIAL COMMENTS The Division of Licensing and Protection conducted an unannounced onsite annual recertification survey ending 7/2/14. Findings for the survey are as follows. Additionally, a complaint investigation was conducted during the survey. There were no regulatory findings related to the complaint.	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 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on direct observation and staff and resident interview, the facility failed to care for 3 of 21 residents in the survey sample in a manner and in an environment that maintains the resident's dignity and respect. (Residents #264, 84) Findings include: 1. Per observation on 2/18/14 at 9:00 AM, a resident (who requested anonymity) was observed eating breakfast in the main dining room of the long term care unit wearing a johnny (a short gown that is fastened in the back with string ties) with only the string at the neck fastened, exposing bare skin from the neck, with widening exposure down to the lower back. The gown was not pulled down over the lap area sufficiently, so skin from the knee to the upper right thigh was also visible. On 2/18/14 at 9:05	F 241	F241 DIGNITY AND RESPECT OF INDIVIDUALITY Nursing staff responded to dignity needs of Residents # 264, #94 and resident that requested anonymity upon discovery. Rounds completed to observe other residents and ensure each resident's dignity and respect in full cognition of their individuality. Staff will be re-educated regarding need to ensure the following: residents are appropriately dressed and/or covered when in common areas and in their rooms per their preferences, staff will knock and/or call when entering resident rooms and explain procedures/ tasks to resident on entry into resident's room. Nursing Managers, staff nurses and/or Social Services will conduct random weekly unit rounds x 3 months to ensure compliance with promoting resident care in a manner and in an environment that maintains or enhances each resident's dignity and respect. Audit findings will be reported to the QAPI Committee monthly x 3 months.	8-2-2014

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

Michael J. Feltus Executive Director 7/28/14

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.

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F 241	<p>Continued From page 1</p> <p>AM, a facility LNA (Licensed Nursing Assistant) confirmed that the resident's back and upper right thigh were exposed and visible to anyone who entered the dining room. The LNA confirmed that this was a dignity issue for the resident. When interviewed on 2/18/14 at 3:30 PM about the incident, the resident stated, "I think that is indicative of how I am treated here."</p> <p>2. Per interview on 06/30/14 at 9:01 AM, Resident #264 stated that not all staff knock or call when entering the room. When asked for any examples the resident stated 'I was very upset that two nurses came breezing in and wanted to take out my staples... it was so rude of them, they didn't knock, I didn't know they were planning on this and during the night, besides. That night one of the other nurses came in to talk to me and I finally stopped crying and then the next day [another nurse] took them out.' Per interview, the Unit Manager at 2:12 PM on 07/01/14 stated that there was an order to remove staples on the evening shift 'but it got busy so staff went in at 1030-11 [PM] at night and woke the resident up'. S/he confirmed at that time that care was not provided in a manner that enhanced the resident's dignity or individuality.</p> <p>Also see F-166</p> <p>3. Per observations by a surveyor on 6/30/14 at 2:24 PM and again at 3:20 PM, Resident # 94 was lying in bed with the left side of his/her lower body uncovered. A disposable brief that the resident was wearing was visible from the open doorway on both occasions. At 3:24 PM, the resident was again observed by two surveyors, accompanied by the Unit Manager (UM) in the position and state of undress described above.</p>	F 241	<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>F241 POC accepted 7/3/14 RTVenblay RN/PMC</p>	

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F 241	Continued From page 2	F 241	<i>This Plan of Correction is the center's credible allegation of compliance.</i>	
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to develop a comprehensive care plan to meet the needs of 3 of 21 residents in the stage 2 sample (Resident # 274, #47 and # 70). Findings include: 1. Per record review on 7/2/14 at 8:29 AM, there was no plan of care to address Resident #274's	F 279	<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> F279 DEVELOP COMPREHENSIVE CARE PLANS Resident # 274's care plan was reviewed and revised to address needs related to fall risk. Resident #47's care plan was reviewed and revised to address dental issues, oral care and monitoring for pain and infection. Residents # 70's care plan was reviewed and revised to address Foley catheter care needs. The facility must develop a comprehensive care plan for each resident that addresses needs that are identified in the comprehensive assessment. Licensal nurses and interdisciplinary team members will be re-educated regarding need to develop comprehensive care plans based on care needs identified in the comprehensive assessment. Licensal nurses will be re-educated regarding need to document Foley catheter care on the TAR. The DNS, ADNS or designee will audit care plans of newly admitted residents and residents with a significant status change during Clinical Rounds Monday through Friday x 3 months to ensure care needs identified in the comprehensive assessment are addressed in the resident's care plan. The DNS, ADNS or designee will audit	

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F 279	<p>Continued From page 3</p> <p>needs related to fall risk. The Resident was admitted on 6/20/14 after a fall at home resulting in a arm fracture. Per stage 1 staff interview, the Resident fell at the facility on 6/25/14 at 9:30 AM. A Morse fall risk assessment was done at admission on 6/20/14 and was scored at 80 which indicates high risk. There is no evidence in the clinical paper or electronic medical record of a care plan to address needs related to fall risk. On 7/2/14 at 9:24 AM, the Unit Manager (UM) confirmed that there was no care plan in place to address needs related to fall risk and stated that there should be a care plan in place due to high fall risk identified on 6/20/14.</p> <p>2. Per record review on 7/2/14 at 3:00 PM, Resident #47 who is observed to have missing, broken and carious teeth and debris in his/her mouth following 2 meals has no care plan regarding dental issues and oral care including monitoring pain and infection. In an interview on 7/2/14 at 3:45 PM, the nurse present on the unit confirmed that there is no dental care plan developed for this resident.</p> <p>3. Per record review on 7/1/14, Resident # 70 was admitted to the facility on 6/9/14 following hospitalization with a Foley catheter in place for urinary retention. The 6/9/14 nursing admission evaluation identified the indwelling catheter as present on admission. Per interview on 7/1/14 at 11:29 AM, the Nursing Unit Manager (UM) confirmed that a care plan for the catheter should have been established on admission, but</p>	F 279	<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>TARs of residents with Foley catheters weekly x 3 months to ensure Foley catheter care is documented on the TAR.</p> <p>Audit findings will be reported to the QAPI Committee monthly x 3 months.</p> <p>F279 POC accepted 7/31/14 RReventagen/PMC</p>		

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F 279	Continued From page 4 reported "I missed it." A care plan was developed on 7/1/14 at the time of the survey. The UM stated that when residents are admitted with a catheter, procedures identified by the care plan are entered in the treatment administration record (TAR). Per review of the TAR, there was no entry for nursing to monitor Foley catheter care per shift from 6/9/14 - 6/21/14 and there is no documentation in the nursing progress that catheter care was monitored on each shift.	F 279	<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 280 SS=D	(Refer F315) 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 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. 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. This REQUIREMENT is not met as evidenced	F 280	F280 RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP Resident # 135's care plan has been revised to reflect current oral and denture care needs. The DNS, ADNS or designee will review current residents to ensure that current dental care needs are addressed in the care plan. Routine scheduled interdisciplinary care plan reviews will focus on compliance with addressing current dental care needs. Current residents triggering on the MDS with dental issues have the potential to be affected. The DNS, ADNS or designee will review current residents to ensure that current dental care needs are addressed in the care plan. Routine scheduled interdisciplinary care plan reviews will focus on compliance with addressing current dental care needs.	

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F 280	Continued From page 5 by: Based on record review and staff interview, the facility failed to ensure that a comprehensive care plan was reviewed and revised for 1 resident in the sample by a team of qualified persons to address current needs around dental issues. (Resident #135) The findings include: 1. Resident #135 does not have a revised care plan to reflect current dental condition and interventions. Per a social service note dated 04/02/14, states the family stated that resident has some back teeth and staff are not cleaning them. Per a nursing assessment dated 06/02/14 notes the resident has "full upper plate and full lower plate, moist, pink oral". Per the Care Plan dated 07/18/13 notes that the resident wears full dentures and will comply with mouth care at least daily and will be free of infection pain/bleeding in the oral cavity. Intervention notes the family continues to want staff to put dentures in even though resident has questionable abscess on left upper gum, dentures fit poorly related to a questionable abscess [dated 11/12/13]. It also notes the resident is known to refuse to have the dentures cleaned and to remove the dentures cleaned at least once daily and as needed if they are soiled and at family request. Per interview the Unit Manager at 1:17 PM on 07/01/14 stated the care plan should be revised to reflect the resident wears partial dentures, does not currently have an abscess, at times will not use dentures and that the nurse will administer Biotene as ordered. S/he confirmed that the care plan was not revised to reflect the current care and services.	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> Licensed nurses and interdisciplinary team members will be re-educated regarding need to develop comprehensive care plans based on care needs identified in the comprehensive assessment. Licensed nurses will be re-educated regarding need to include dental needs in care plan updates. Nurse Managers will audit care plans weekly x 3 months to ensure current dental care needs are addressed in the care plan. Audit findings will be reported to the QAPI Committee monthly x 3 months FABO POC accepted 7/31/14 RTremblayRN/PMC	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN	F 282		

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F 282	<p>Continued From page 6</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to implement the care plan for 1 of 21 residents in the stage 2 sample (Resident #138). Findings include:</p> <p>Per record review on 7/1/14 at 1:15 PM, staff did not administer medication as ordered by the physician for Resident #138. The Resident's care plan for psychotropic drug use had an approach that stated "Administer medication as prescribed by the physician (see current MAR & physician orders for current dosage)". There was a 3/20/14 physician order to decrease Quetiapine (an anti-psychotic drug) to three times a day. Review of the MAR (Medication Administration Record) shows that staff administered Quetiapine 25 milligrams by mouth QID (4 times a day) through May 28, 2014 when the physician signed an order for Quetiapine 25 mg by mouth four times daily. On 7/1/14 at 2:45 PM, the Director of Nursing Services (DNS) confirmed that the facility had not acted on the 3/20/14 physician order to decrease the Quetiapine dosage and confirmed the resident had been receiving Quetiapine 25 mg QID since 3/20/14. The DNS also confirmed that the care plan had not been implemented as written.</p>	F 282	<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>F282 SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>Resident # 138 physician's orders for psychotropic medication have been clarified.</p> <p>Current residents receiving psychotropic medications have the potential to be affected.</p> <p>The DNS, ADNS or designee will review physician's orders for psychotropic medications on current residents to ensure that care plan reference accurately reflects current physician's orders.</p> <p>Licensed nurses will be re-educated regarding need to ensure that physician's orders are noted and implemented timely.</p> <p>DNS, ADNS or designee will audit psychotropic medication orders to ensure timely implementation and that care plan reference accurately reflects current physician's orders weekly x 3 months.</p> <p>Audit findings will be reported to the QAPI Committee monthly x 3 months</p>	
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER	F 315	F282 POL accepted 7/31/14 RTVembtag RN/pme	

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F 315	<p>Continued From page 7</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, and staff interview, the facility failed to assure that 1 applicable resident in the stage 2 sample with an indwelling catheter received appropriate services and treatment to prevent urinary tract infection (Resident #70). Findings include: Per record review on 7/1/14, Resident # 70 was admitted to the facility on 6/9/14, following hospitalization, with a Foley catheter in place for urinary retention. The 6/9/14 nursing admission evaluation identified the indwelling catheter as present on admission. Per interview on 7/1/14 at 11:29 AM, the Nursing Unit Manager (UM) confirmed that a care plan for the catheter should have been established on admission, but reported "I missed it." A care plan was developed on 7/1/14 at the time of the survey. The UM stated that when residents are admitted with a catheter, procedures identified by the care plan are entered in the treatment administration record (TAR). Per review of the TAR, there was no entry for nursing to monitor Foley catheter care per shift from 6/9/14 - 6/21/14; there was inconsistent</p>	F 315	<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>F315 NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>Resident # 70's care plan and TAR has been reviewed and revised to reflect Foley catheter care needs.</p> <p>Current residents with Foley catheters have the potential to be affected.</p> <p>The DNS, ADNS or designee will review current residents with Foley catheters to ensure that care plans reflect interventions to prevent urinary tract infections, catheter care is documented on the TAR, urinary output via catheter is recorded each shift.</p> <p>Licensed nurses will be re-educated regarding developing care plans to reflect interventions to prevent urinary tract infections, documenting Foley catheter care on the TAR, urinary output via catheter is recorded each shift.</p> <p>DNS, ADNS or designee will conduct weekly audits of care plans, TARs, urinary output via catheter x 3 months.</p> <p>Audit findings will be reported to the QAPI Committee monthly x 3 months</p>	
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F315 Poc accepted 7/31/14 RT/enblay/rn/pml

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F 315	<p>Continued From page 8</p> <p>catheter monitoring documented in the nursing progress notes during this time period.</p> <p>Per review and confirmed by the UM on 7/1/14 at 12:52 AM, the "comprehensive intake-output record" was also incomplete with no documentation of urine output entries for 17 of the 21 days in June that were monitored; the nursing progress notes have few entries documenting urine output (volume). Per the output record, on 6/17/14 there is one entry for the day recording a urine output of 300 ml; on 6/18/14 there was one entry recording a urine output of 600 ml; on 6/19/14 there were 2 urine output entries, 550 ml and 355 ml; on 6/20/14 there was one urine output recording of 360 ml and a progress note entry for "150 ml so far this shift," and on 6/21/14 there was one urine output recording of 250 ml for the day. On 6/20/14, the nursing progress notes documented that the resident's doctor was contacted and orders received to "flush the Foley catheter as needed for blockage/decreased output." Per review of the TAR, the catheter was flushed on 6/20/14. Nursing progress notes document that the catheter was flushed again on 6/21/14.</p> <p>The UM confirmed that if there was no entry made on the urine output record, it is difficult to tell if staff provided catheter care and the resident's fluid status; s/he confirmed the many of the outputs that were recorded were low. According to medlineplus, "the normal range for 24-hour urine volume is 800 to 2000 milliliters per day (with a normal fluid intake of about 2 liters per day) ... Disorders that cause reduced urine volume include dehydration, not enough fluid intake, or some types of chronic kidney disease." Per review, the hydration log had no fluid intake</p>	F 315	<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 315	Continued From page 9 entries on 6/14, 6/15, 6/21, 6/22, 6/28 and 6/29/14, Recorded total fluid intake ranged from 360 ml- 960 ml; the recorded intake and output entries were confirmed by the UM. When asked if nursing had established a fluid intake goal for the resident [related to having a catheter], the UM stated "no." (Refer F279)	F 315	<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 325 SS=D	<p><http://www.nlm.nih.gov/medlineplus/ency/article/003425.htm></p> <p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE</p> <p>Based on a resident's comprehensive assessment, the facility must ensure that a resident -</p> <p>(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and</p> <p>(2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the facility did not serve 1 applicable resident in the sample the correct therapeutic diet that was ordered by the physician. (Resident #167) Findings include:</p> <p>1. Resident #167 who has a diagnosis of Huntington's Disease and Dysphasia was not</p>	F 325	<p>F325 MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE</p> <p>Resident #167 no longer resides at the facility.</p> <p>Residents receiving altered textured diets are at risk.</p> <p>Nutrition Services Manager/designee will provide re-education to serving staff about textured diets and following diet order.</p> <p>Weekly audits of meal service and diet textures will be conducted by NSM/designee x3 months. Audit findings will be reported to the QAPI committee monthly x3 months.</p> <p><i>F325 Pol accepted 7/13/14 RTremblay RN/PML</i></p>	

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F 325	Continued From page 10 served the proper texture meal. The Physician order dated 06/20/14 for diet states puree texture with dysphasia mechanical pleasure foods and nectar thick liquids. Per observation during the noon meal on 06/30/14 the resident was served meat pie in which the food server took off the crust, chopped the meat with the fork, poured some gravy over the meat and mashed potatoes and pureed spinach. Per interview on 06/30/14 at 12:08 PM the food service supervisor stated that per the Therapeutic diet menu "the meat pie should be pureed". Per interview on 07/01/14 at 8:55 AM the Speech Language therapist (SPL) stated "for [the resident's] safety [s/he] can't progress beyond puree meals but the pleasure foods can be ice cream and well-cooked food like macaroni and cheese". The SPL confirmed that the resident was served an incorrect texture.	F 325	<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 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical	F 329	F329 DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Resident # 138 physician's orders for psychotropic medication have been clarified. Current residents receiving psychotropic medications have the potential to be affected. The DNS, ADNS or designee will review physician's orders for psychotropic medications on current residents to ensure that care plan reference accurately reflects current physician's orders. Licensed nurses will be re-educated regarding need to ensure that physician's orders are noted and implemented timely.	

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F 329	Continued From page 11 record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that the drug regimen for 1 of 10 applicable stage 2 residents were free from unnecessary medications (Resident # 138.) Findings include: Per record review on 7/1/14 at 1:15 PM, staff did not administer medication as ordered by the physician for Resident # 138. There was a 3/20/14 physician order to decrease Quetiapine (an anti-psychotic drug) 25 milligrams by mouth to three times a day from the current four times daily. Review of the MAR (Medication Administration Record) shows that staff administered Quetiapine 25 milligrams by mouth QID (4 times a day) through May 28, 2014 when the physician signed an order for Quetiapine 25 mg by mouth four times daily. On 7/1/14 at 2:45 PM, the Director of Nursing Services (DNS) confirmed that the facility had not acted on the 3/20/14 order to decrease the Quetiapine dosage and confirmed the resident had been receiving Quetiapine 25 mg QID since 3/20/14.	F 329	<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> DNS, ADNS or designee will audit psychotropic medication orders to ensure timely implementation and that care plan reference accurately reflects current physician's orders weekly x 3 months. Audit findings will be reported to the QAPI Committee monthly x 3 months F329 POC accepted 7/2/14 RTrenblay RN/MLC	
F 353 SS=F	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS	F 353		

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F 353	<p>Continued From page 12</p> <p>The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.</p> <p>The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:</p> <p>Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.</p> <p>Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interviews and record review the facility failed to provide sufficient staff to assure that care was provided to residents according to their needs and plan of care. Findings include:</p> <p>1). Per resident interview, a resident who wished to remain anonymous stated that there is not enough staff and that weekends are the worst and that it is at various times on all shifts. S/he stated that "sometimes the wait when you turn on your light is 1/2 to 1 hour or longer. Sometimes they just don't come and I have to use my phone to call the desk (by dialing the facility) to ask for help. I have never wet the bed but 2 nights ago I</p>	F 353	<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>F353 SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS</p> <p>The Director of Nursing or designee will monitor staffing and scheduling of nursing personnel on a daily basis to assure that staffing levels are sufficient to meet the residents' needs.</p> <p>The facility has been aggressively recruiting for licensed nurses and INA's. Utilizing local and online recruiting services. The facility contracted with three temporary staffing agencies to provide direct care staff for the facility. Exit interviews utilized to identify improvements needed for staff retention. Changes made to orientation based on those findings.</p> <p>DNS/Social services/designee will interview residents weekly to ensure their care needs have been met timely. In addition family members will be interviewed monthly to ensure they feel their family member's needs are being met.</p> <p>Review of nursing staffing hours, recruitment and retention plans as well as the resident/family interview information will be reviewed at the QAPI meeting monthly x3months.</p>		

F353 POC accepted 7/31/14 RTrendley RM/PMC

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F 353	<p>Continued From page 13</p> <p>had been waiting a long time and they finally came. They got me into the lift and started to move me but I couldn't wait and they had to use the bedpan to catch the urine." S/he also stated that there are days when the LNA's (Licensed Nursing Assistants) are too busy and they don't get around to passing out the water that they usually bring once a day, in the morning. Many times s/he has to ask for water if she wants it.</p> <p>2). During the Stage 1 portion of the survey 7 of the 21 interviewable residents answered the question "Do you feel there is enough staff available to make sure you get the care and assistance you need without having to wait a long time?" with a "No". One of those 7 residents stated "I messed myself once when I had to wait too long," and another stated "I waited a long time for pain medication."</p> <p>3). During the Stage 1 portion of the survey 3 of the 4 family members interviewed answered the question "Is there enough staff available in this facility to make sure that residents get the care and assistance they need without having to wait a long time?" with a "No". One family member stated that weekends are bad and that the most difficult times are on the Day and Evening shifts when staff are really busy. Another family member stated that there have been 2-3 times that his/her relative had to wait 1/2-1 hr so that a staff member could find a second person to help do a mechanical lift transfer to assist his/her relative to bed.</p> <p>4). In a review of of the Resident Council meeting minutes for 2014 there are issues raised which include meals not being served in a timely</p>	F 353	<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 353	Continued From page 14 manner, call lights not being answered in a timely manner, call light being turned off and resident waiting until noon for assistant, and resident feeling rushed during care. Both the January and June minutes state that there has been some improvement in call lights being answered.	F 353	<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 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to store, prepare, distribute and serve food under sanitary conditions. This has the potential to effect one of two resident serving areas. Findings include 1. During the initial tour on 06/30/14 at 9:00 AM the following was noted in the Chittenden serving areas. Both microwaves which are used for the residents were dirty with dried food and the insulated cold food server which contained salad items and condiments was dirty with visible old food crumbs and dirty/sticky surfaces. Per observation on 07/01/14 at 9:15 AM the insulated cold food server continued to have the sticky dirty surface, food debris and utensils stored on the	F 371	F371 FOOD PROCURE STORU/PREPARE/SERVE-SANITARY The microwaves were cleaned by the staff as part of after meal service routine. The insulated cold food server was brought to the kitchen prior to the next meal to be cleaned as part of the kitchen routine. NSM/designee will provide education to dietary staff about following cleaning procedure after each meal. Weekly audits will be conducted by NSM/designee to ensure food service equipment is in sanitary condition. Audit findings will be reported to the QAPI Committee monthly x 3 months <i>F371 POC accepted 7/31/14 RTremblay RN/PML</i>	

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F 371	Continued From page 15 dirty surface. Also noted food particles; i.e. lemon wedges, that were served the day before [at the noon meal] were on the serving table shelf. Per interview and observation on 07/01/14 at 9:24 AM the Food Service Supervisor confirmed the above observations that the insulated cold food server and warm server were not in sanitary condition.	F 371	<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 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to act on the Pharmacy Consultant's report of irregularities and recommendations for 2 of 21 resident's in the stage 2 sample (Resident # 138 and #116). Findings include: 1. Per record review on 7/1/14 at 1:15 PM, staff did not act on the consultant pharmacist's recommendation to consider a Gradual Dose Reduction (GDR) for Resident #138. Resident #138 has been on Quetiapine (an anti-psychotic drug) since admission on 7/5/12. A GDR was recommended in March, April and May of 2014 for Quetiapine Resident has been on Quetiapine	F 428	F428 DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON AIMS assessments have been completed and physician's orders for antipsychotic medications for residents # 116 and # 138 have been reviewed. Current residents receiving antipsychotic medications have the potential to be affected. The DNS, ADNS or designee will review current residents to ensure the following: (1)Pharmacist recommendations for antipsychotic medications have been forwarded to the attending physician, (2) a documented response has been received from the physician (3) physician 's orders for antipsychotic medications are noted timely by licensed nurses (4) AIMS assessments are completed per facility policy. Licensed nurses will be educated regarding revised process for ensuring timely response to Pharmacist's recommendations and facility policy regarding completion of AIMS assessment.		

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F 428	<p>Continued From page 16 dosage since 6/7/13. The 5/19/14 recommendation states "repeated recommendation from 3/20/14". There are physician progress notes on 3/7/14 and 5/28/14, neither note addresses GDR. Per interview with the Director of Nurses (DNS) on 7/1/14 at 2:45 PM, the facility process is the Unit Manager (UM) receives recommendations from the pharmacy consultant and faxes them to the physician. The physician then will react to the pharmacy consultant's recommend and fax a response back to the UM. The DNS confirmed that the facility had not acted on the March or April 2014 pharmacy recommendation.</p> <p>2. Per record review on 7/1/14, Resident #116 was taking Zyprexa, an antipsychotic medication. On 1/17/14, 2/20/14 and 3/20/14 the consultant pharmacist recommended that an AIMS (AIMS = Abnormal Involuntary Movement Scale- used to monitor for antipsychotic medication side effects) be conducted for this resident. Per record review and confirmed though interview with the facility DNS on 7/2/14 at 7:19 AM, staff failed to act on the pharmacist recommendation and an AIMS was not completed until 4/7/14.</p> <p>On 4/30/14 Resident #116's Zyprexa was increased from 2.5 mg per day to 5 mg/day. On 5/9/14, Zyprexa 2.5 mg was added (for a total dose of 7.5 mg/day) until the Zyprexa was reduced back to 5 mg/day on 5/13/14). On 5/19/14 the pharmacist noted that the Zyprexa had been changed. On 7/2/14 at 7:19 AM the DNS confirmed that baseline AIMS were not obtained after the two increases in Zyprexa dosing; an AIMS was subsequently completed during the survey. The DNS confirmed that the unit managers are responsible to see that</p>	F 428	<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>The DNS, ADNS or designee will audit compliance with completion of AIMS assessments per facility policy and physician's response to Pharmacist's recommendations weekly x 3 months Audit findings will be reported to the QAPI Committee monthly x 3 months</p> <p>F428 POC accepted 7/31/14 R Vembalay RN/PMC</p>		

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F 428	Continued From page 17 consultant pharmacist recommendations are acted upon.	F 428	<i>This Plan of Correction is the center's credible allegation of compliance.</i>	
F 431 SS=B	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 431	<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> F431 DRUG RECORDS LABEL /STORE DRUGS AND BIOLOGICALS Licensed nurses have been re-educated regarding facility process for documenting medication room refrigerator temperatures. Unit managers/designee will audit compliance with recording medication room refrigerator temperature weekly. Audit findings will be reported to the QAPI Committee monthly x 3 months F431 POC accepted 7/31/14 RTremblay RN/PMC	

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 07/02/2014
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 18 This REQUIREMENT is not met as evidenced by: Based on interviews and observations the facility failed to store all drugs and biologicals under proper temperature controls. Findings include: During the review of medication storage observation on 07/02/14 all three units did not have consistent and regular refrigerator temperature checks. Each unit had insulins, vaccines and other biologicals needing refrigeration. There were no temperatures noted for two units for the month of July and all three units had numerous missing information for the previous months. Per interview and observation on 07/02/14 at 11:14 AM, the DNS stated that the temperatures should be checked every night by the nurse. S/he confirmed the facility failed to assure all drugs and biologicals were stored under proper temperatures.	F 431	<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 465 SS=D	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview the Facility failed to assure a safe and comfortable environment for residents, staff and the public. Findings include: 1. Per observations on the Chittenden Unit for	F 465	F465 SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRONMENT Items in the hallway were cleared during the survey. SDC/designee will provide education to staff about storage of equipment and maintaining clear hallways. Maintenance Director/designee will audit hallways weekly x3 months to ensure a safe and comfortable environment. Audit findings will be reported to the QAPI Committee monthly x 3 months <i>F465 POC accepted 7/31/14 RTVrenbley RN/PMC</i>		

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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 07/02/2014
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 CORRECTIDN (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 465	Continued From page 19 two days of survey, numerous unused wheelchairs, oxygen equipment and a large meal tray cart was observed on one side of the long hall. During observation on 06/30/14 at 1:15 PM a resident who was self-propelling in a wheelchair attempted to turn but was unable to because of being stuck and entangled in one of the parked wheelchairs. On 07/01/14 two residents bumped into each other and were unable to pass each other's wheelchair from the lack of space in the hallway. Per observation and interview with the Maintenance Director, on 07/01/14 at 12:16 PM, stated that the meal cart is not supposed to be stored in the hallway at all times. S/he confirmed at that time that equipment stored in the hallway impeded resident's ability to maneuver comfortably in the environment.	F 465		

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

AH
"A" FORM

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFS AND NIS	PROVIDER # 475030	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	DATE SURVEY COMPLETE: 7/2/2014
NAME OF PROVIDER OR SUPPLIER STARR FARM NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 98 STARR FARM RD BURLINGTON, VT	

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 166	<p>483.10(1)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES</p> <p>A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to keep one applicable resident appropriately apprised of its progress toward resolution of a grievance. (Resident #264) Findings include:</p> <p>Per interview on 06/30/14 at 9:01 AM Resident #264 stated that not all staff knock or call when entering the room. The resident communicated this concern to staff, which was then documented on their grievance form (Communication Response Form), and there was no evidence the resident was informed of the outcome of the grievance. When asked for any examples regarding this, the resident stated 'I was very upset that two nurses came breezing in and wanted to take out my staples...it was so rude of them, they didn't knock, I didn't know they were planning on this and during the night, besides. That night one of the other nurses came in to talk to me and I finally stopped crying and then the next day [another nurse] took them out.'</p> <p>Per interview the Unit Manager at 2:12 PM on 07/01/14 stated that there was an order to remove staples on the evening shift 'but it got busy so staff went in at 1030-11 [PM] at night and woke the resident up'. Per the Communication Response Form dated 05/29/14, notes [resident] reporting "2 nurses came in and woke me up they did not introduce themselves". This form notes that it was referred to nursing with a response of 'spoke with nurses about treatments being completed during working hours'. However, there was no response/completion to the resident by the executive director or some other department head as to the resolution, date and the action needed.</p> <p>Per interview on 07/01/14 at 3:12 PM the MSW [social services] stated that the other social worker [who is currently on vacation] spoke to the resident when they were aware of the concern as part of their investigation but thought that the nurse spoke to [the resident]'. S/he confirmed that there was no evidence that the resident received a prompt resolution to the grievance.</p> <p>*This is an "A" level citation.</p> <p>Also see F-241</p>

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

The above isolated deficiencies pose no actual harm to the residents