

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

September 2, 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 **August 20, 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

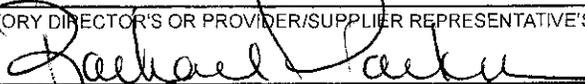
RECEIVED
Division of
PRINTED: 08/21/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475030	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	AUG 27 14 Licensing and Protection	(X3) DATE SURVEY COMPLETED R 08/20/2014
--	--	--	---------------------------------------	---

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	{F 000}	<i>This Plan of Correction is the center's credible allegation of compliance.</i>	
{F 315} SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER 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. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that 2 of 4 applicable residents (Residents #1, 17) received appropriate treatment and services. Findings include: 1. Per record review on 8/20/14 at 9:40 AM, staff failed to record urinary output for Resident # 1. Resident # 1 has an indwelling urinary catheter. An order signed by a physician on 8/7/14 stated "cath care per unit routine - every shift". Review of intake and output records showed that on 8 occasions between 8/2/14 - 8/20/14, there was no documentation that catheter care was done or recording of urinary output. This was confirmed by the Unit Manager (UM) on 8/20/14 at 9:45 AM.	{F 315}	<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> F315 NO CATHETER, PREVENT UTI, RESTORE BLADDER Resident # 1 and Resident # 17 output record was reviewed. Current residents with Foley catheters have the potential to be affected. The DNS, ADNS or designee will review current residents with Foley catheters to ensure that urinary output via catheter is recorded each shift. Licensed nurses will be re-educated to ensure urinary output via catheter is recorded each shift. DNS, ADNS or designee will conduct daily audits of urinary output via catheter x 3 weeks and then monthly x3 month Audit findings will be reported to the QAPI Committee monthly x 3 months <i>F315 POC accepted 9/2/14 RRembiayr/PMC</i>	8/25/2014

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Executive Director	(X6) DATE 8/26/14
--	-----------------------------	----------------------

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: 08/21/2014
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 R 08/20/2014
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 315}	Continued From page 1 2. Per record review on 8/20/14 at 10:05 AM, staff failed to record urinary output for Resident # 17. Resident # 17 has a suprapubic catheter. Per review of the intake and output record, there are 10 occasions between 8/2/14 - 8/20/14 that there is no documentation of urinary output. The care plan for history of kidney stones status post right percutaneous nephrolithotomy has an intervention to monitor output from suprapubic catheter every shift. This was confirmed by the UM on 8/20/14 at 10:15 AM.	{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> <hr/> <p>F325 MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE</p>	