

Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury VT 05671-2306
<http://www.dail.vermont.gov>
Voice/TTY (802) 241-2345
To Report Adult Abuse: (800) 564-1612
Fax (802) 241-2358

January 25, 2011

Rachael Parker, Administrator
Starr Farm Nursing Center
98 Starr Farm Rd
Burlington, VT 05401

Provider ID #:475030

Dear Ms. Parker:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **November 17, 2010**.

Follow-up may occur to verify that substantial compliance has been achieved and maintained.

Sincerely,



Pamela M. Cota, RN
Licensing Chief

PC:jl

Enclosure



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

RECEIVED
Division of

JAN 21 11

PRINTED: 12/29/2010
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 11/17/2010
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NAME OF PROVIDER OR SUPPLIER STARR FARM NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 98 STARR FARM RD BURLINGTON, VT 05401
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(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
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F 000 INITIAL COMMENTS

An unannounced, on-site complaint investigation was conducted by the Division of Licensing and Protection on November 16-17, 2010. The following regulatory issues were identified.

F 281 483.20(k)(3)(i) SERVICES PROVIDED MEET SS=D PROFESSIONAL STANDARDS

The services provided or arranged by the facility must meet professional standards of quality.

This REQUIREMENT is not met as evidenced by:

Based on record review and staff interview, the facility failed to meet professional standards for quality by not carrying out physician orders for 2 applicable residents in the targeted sample. (Residents #1 and #2). Findings include:

1. Per record review on 11/16/2010 at noon, Resident #1 had an order for Xanax 1 mg (milligram) PO (by mouth) 1 hour prior to a surgical procedure scheduled on 09/15/2010 at 9:15 AM, and for the dose to be repeated in 1 hour if sedation was not achieved. The medication administration record (MAR) and the narcotic count book indicate that Resident #1 received Xanax 2 mg 1.5 hours prior to the procedure. This was confirmed during interview with the DNS (Director of Nursing Services) on 11/16/2010 at 2:41 PM.

2. Resident #2 had an order for Glargine insulin 50 units SC (subcutaneous) every morning and was given 2 doses on the morning of 09/15/2010, totaling 100 units. This was confirmed during interview with staff nurses and the DNS on 11/16/2010 @ 2:41 PM.

F 000 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.

F 281

F 281

1. The nurse that actually was involved in this medication administration for resident #1 was suspended from duty pending investigation. She was then terminated from employment at the facility. DNS did make a formal written complaint to the VT board of nursing due to the medication orders not being followed. Resident #1 is no longer a resident at the facility.

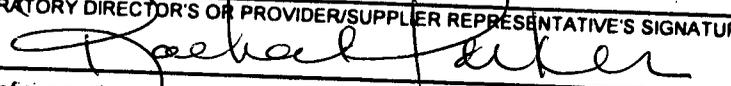
Nurses will be in-serviced on the process of carrying out MD orders according to the policy & procedure of MD orders by 1/17/2011

2. The nurse that was caring for resident #2 was suspended and then was terminated from employment due to her nursing practices, and was reported to the Board of Nursing of VT. This is the same nurse that was caring for both resident #1 & #2.

Nurses will be in-serviced on the proper way to pass medications and document according to the policy & procedure of the facility. The in-service will be completed by 1/17/2011.

Random weekly audits by DNS or designee times 8 weeks.

3. Licensed nurses will be in-serviced on the

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE EI	(X8) DATE 1/18/11
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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 program participation.

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F 281 Continued From page 1

3. Per record review, Resident #1 had a physician's order for oxygen to be increased to 4 liters/minute (l/min) on 10/07/2010 at 3:30 AM. Per nurses' note of 10/07/2010 at 10:20 AM, Resident #1 had an O2 sat (oxygen saturation) of 83% on 3.5 l/min of O2. The oxygen flow rate was not changed to the ordered 4 l/min until 7 hours after the order was received. This was confirmed by the DNS during interview on 11/16/2010 at 2:41 PM.

Refer also to F329.

Reference: Nettina, S.M., (2006), Lippincott Manual of Nursing Practice, 8th Edition, p 18, Lippincott, Williams & Wilkins, Philadelphia
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 meet the requirement to implement the care plan for 1 resident (Resident #1) in the applicable sample. The findings include:

Per medical record review on 11/16/2010 at noon, the care plan for Resident #1 stated that redirection for aberrant behaviors be attempted by the staff prior to the use of an anti-anxiety medication. Per review of staff documentation,

F 281

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proper administration of oxygen and the monitoring of the residents with needs for oxygen. The in-service will be completed for all licensed nurses by 1/17/2011.

The DNS or designee will audit oxygen orders & residents using oxygen, randomly weekly times 8 weeks.

F 282

This will be reviewed at PI monthly meeting. F281 POC Accepted 1/12/11 G Coleman RN / P M Cota RN

F 282 This resident is no longer at the facility.

Care plans of residents on PRN anti-anxiety medications will be reviewed on initial audit. Revisions to care plans as deemed appropriate by the multidisciplinary team.

The nurses will be in-serviced on the policy & procedure of the administration of anti-anxiety medication and the documentation that supports the decision to administer the medication. The in-service will be completed by 1/17/2011.

This will be audited by the DNS or designee with the multidisciplinary team weekly times eight weeks.

This will be reviewed at monthly PI meeting.

F282 POC Accepted 1/12/11 G Coleman RN / P M Cota RN

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F 282 : Continued From page 2
on 08/31/2010 at 23:30 hours and on 09/01/2010 at 03:45 hours, Resident #1 received Ativan without evidence that redirection was attempted prior to the medication being given. On 09/09/2010, the Nurses' Notes reflect that the resident is compliant after redirection and there was no medication needed to be given at that time. This discrepancy in care plan implementation was confirmed by the DNS (Director of Nursing Services) during interview on 11/16/2010 at 2:41 PM.

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.

F 329 : 483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS
SS=D
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.

F 329 : F329
Nurses will be in-serviced on the policy & procedure of medication pass and documentation of administering any medication. This will be completed by 1/17/2011.
The DNS or designee will monitor weekly times 8 weeks.

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 record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.

Resident # 1 is no longer at the facility.
Resident #2 had no adverse reaction.

Nurses will be in-serviced on the policy & procedure on medication pass and documentation of administering any medication. This will be completed by 1/17/2011.
It will be reviewed at the monthly PI meeting.

The DNS or designee will audit weekly times eight weeks.

F329 POC Accepted 11/21/11
Coleman RN / PMcAURN

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F 329 Continued From page 3

F 329

This REQUIREMENT is not met as evidenced by:
Based on medical record review and staff interview, the facility failed to ensure that 2 residents (Residents #1 and 2) received the proper doses of medications that were ordered. The findings include:

1. Per record review on 11/16/2010 at noon, Resident #1 had an order for Xanax 1 mg (milligram) PO (by mouth) 1 hour prior to a surgical procedure scheduled on 09/15/2010 at 9:15 AM, and to be repeated in 1 hour if sedation was not achieved. The medication administration record (MAR) and the narcotic count book indicate that Resident #1 received Xanax 2 mg 1.5 hours prior to the procedure.

2. Per record review on 11/16/2010 at noon, Resident # 2 had an order for Glargine insulin 50 units SC (subcutaneous) every morning and was given 2 doses on the morning of 09/15/2010, totaling 100 units.

Both of these occurrences are confirmed during interview with staff nurses and the DNS (Director of Nursing Services) on 11/16/2010 @ 2:41 PM.

Refer also to F281.