

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

May 27, 2015

Ms. Susan Biondolillo, Administrator
Starr Farm Nursing Center
98 Starr Farm Rd
Burlington, VT 05408-1396

Dear Ms. Biondolillo:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **May 6, 2015**. Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,



Pamela M. Cota, RN
Licensing Chief



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

MAY 26 2015 PRINTED: 05/14/2015
FORM APPROVED
OME NO. C938-C934

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 05/06/2015
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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 05408
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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

F 000

An unannounced onsite investigation was conducted by the Division of Licensing and Protection on 5/6/15 regarding four entity self reports and one complaint regarding care and services. The following regulatory deficiencies were identified as a result of the survey:

F 281 483 20(k)(3)(i) SERVICES PROVIDED MEET SS=0 PROFESSIONAL STANDARDS

F 281

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 interview, the facility failed to provide services that meet professional standards for 2 of 6 residents by failing to follow physician orders for a medication dose change (Resident #1) and for failing to act on the medical recommendation made by the Emergency Department for a resident with altered mental status and for continuing to administer a prn (as needed) medication without indicating a reason (Resident #3). Finding include:

1. Per 5/6/15 medical record review, Resident #1 had a diagnosis of hypothyroidism, a condition where the thyroid gland does not make sufficient thyroid hormone, and was receiving medication to correct the deficiency. On 3/11/15, labs that monitored thyroid function were reported as abnormal and on 3/13/15, Resident #1's physician ordered an increase in the dose of levothyroxine (thyroid replacement medication) from 200 mcg to 225 mcg per day. Per review of the MAR (Medication Administration Record),

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

TITLE

(X6) DATE

Susan B. Beaudouille Executive Director 5-21-15

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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Ftag 281

F 281: Continued From page 1
from 3/14/15- 3/31/15 Resident #1 received 225 mcg of levothyroxine. However, when nursing staff reconciled Resident #1's medical orders for April and May 2015, they incorrectly entered the previous dose of 200 mcg into the orders and MAR. As a consequence, Resident #1 received 200 mcg of Levothyroxine instead of the ordered 225 mcg from 4/1/15 until the day of the survey when the error was identified. On 5/6/15 at 1:35 PM, a facility Unit Manager (UM) confirmed the above information and that physician orders were not followed.

2. Per 5/6/15 medical record review, Resident #3 was diagnosed with multiple chronic medical conditions, which included polypharmacy (the use of multiple medications with increased risk for drug to drug interactions and side effects). Per review of the nursing progress notes, on 3/23/15, Resident #3 was sent to the ER (Emergency Room) after awakening at 1:30 AM angry, confused and tearful. A covering physician was notified, and the resident was sent to the ER for evaluation and treatment for altered mental status. Per review of the ER After visit Summary, the Discharge Instructions included, "1. Regular medicine, but would not take Benadryl again," (a medication that had been administered to the resident on 3/22/15 at 8 PM for reported pruritus (itching)). Per review, there was no evidence in the medical record that Resident #3's primary care provider had been notified by staff of the ER recommendation to stop Benadryl. The resident was also administered Benadryl on 3/25, 3/26, 3/27, and 3/30. Though the medication was listed as a prn medication, there was no documentation in the MAR or in the nursing progress notes to indicate the reason it was administered to the resident.

- F 281
- Resident #1 Levothyroxine medication is being administered per physicians' orders. Resident # 3 no longer resides at the facility. June 3, 2015
 - House audit completed during monthly editing of residents Medication administration records-to- Physician orders to ensure no other residents affected by this deficient practice. All residents have the potential to be affected by this practice.
 - The SDC/ designee Re-Educated nursing staff on the best practices for monthly editing procedure, Medication guidelines for administering and documenting PRN utilization. Also re-education on best practices of reading and reviewing the discharge summary with physician upon return from emergency room or other sites of services to ensure follow up on recommendations.
 - The DNS/designee will complete random monthly audits of residents medication record edits as well as discharge summaries recommendations to ensure compliance. The results of these audits will be reviewed monthly with the QAPI committee x 90 days to ensure substantial compliance.

F281 POC accepted 5/14/15 Amstar-RN

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

PRINTED: 05/14/2015
FORM APPROVED
OMB NO. 0938-035

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 05/06/2015
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 201 Continued From page 2

F 281

On 5/6/15 at 10:20 AM, the Staff Development Nurse confirmed the above information. Additionally, s/he reported that when residents return from the ER, the nurse who receives the resident back in the facility reviews the transition of care summary and is responsible for notifying the resident's physician of ER recommendations. s/he confirmed that there was no evidence that this occurred after Resident #3 returned to the facility (including in a physician communication book). Also, she confirmed that although it is an expectation for nursing staff to document a reason for prn medication use, there was no documentation as to the reason Resident #3 was administered Benadryl on the dates following the ER visit.

Reference: Lippincott Manual of Nursing Practice (9th ed) Wolters Kluwer Health/Lippincott Williams & Wilkins.

F 428 483.60(c) DRUG REGIMEN REVIEW, REPORT
SSFD IRREGULAR, ACT ON

F 428

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

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

PRINTED: 05/14/2015
FORM APPROVED:
OMB NO. 0938-0097

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F 428 Continued From page 3

Based on staff interview and record review, The facility failed to ensure that the consultant Pharmacist reported any medication irregularities to the facility and attending physician for 2 of 6 applicable residents in the survey sample (Resident #1 and Resident #3). Findings include 1. Per 5/6/15 medical record review, Resident #1 had a diagnosis of hypothyroidism, a condition where the thyroid gland does not make sufficient thyroid hormone, and was receiving medication to correct the deficiency. On 3/11/15, labs that monitored thyroid function were reported as abnormal and on 3/13/15, Resident #1's physician ordered an increase in the dose of levothyroxine (thyroid replacement medication) from 200 mcg to 225 mcg per day. Per review of the MAR (Medication Administration Record), from 3/14/15- 3/31/15 Resident #1 received 225 mcg of levothyroxine. However, when nursing staff reconciled Resident #1's medical orders for April and May 2015, they incorrectly entered the previous dose of 200 mcg into the orders and MAR. As a consequence, Resident #1 received 200 mcg of Levothyroxine instead of the ordered 225 mcg from 4/1/15 until the day of the survey when the error was identified. On 5/6/15 at 1:35 PM, a facility Unit Manager (UM) confirmed the above information and that the pharmacist consultant did not identify or report the irregularity during his/her monthly medication review.

2. Per 5/6/15 medical record review, Resident #3 was diagnosed with multiple chronic medical conditions, which included polypharmacy (the use of multiple medications with increased risk for drug to drug interactions and side effects). Per review of the nursing progress notes, on 3/23/15, Resident #3 was sent to the ER (Emergency Room) after awakening at 1:30 AM angry, confused and tearful. A covering physician was

F 428 Ftag 428

- Resident #1 Levothyroxine medication is being administered per physicians' orders. Resident # 3 no longer resides at the facility.
- All residents have the potential to be affected by this deficient practice.
- The SDC/designee re-educated the consultant pharmacist on the requirement of the monthly drug regimen review.
- The DNS/ designee will complete random audits on monthly drug regimen reviews and report the results to the QAPI committee monthly x 90 days to ensure compliance.

June 3, 2015

F428 POC accepted 5/26/15 pmoctaw

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

PRINTED: 05/14/2015
FORM APPROVED
OMB NO. 0938-0397

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475030	(X3) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X5) DATE SURVEY COMPLETED C 05/06/2015
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F 428 Continued From page 4

F 428

notified and the resident was sent to the ER for evaluation and treatment for altered mental status. Per review of the ER After Visit Summary, the Discharge instructions included, "1. Regular medicine, but would not take Benadryl again," (a medication that had been administered to the resident on 3/22/15 at 8 PM for reported pruritus (itching)). Per review, there was no evidence in the medical record that Resident #3's primary care provider had been notified by staff of the ER recommendation to stop Benadryl. The resident was also administered Benadryl on 3/25, 3/26, 3/27, and 3/30. Though the medication was listed as a prn medication, there was no documentation in the MAR or in the nursing progress notes to indicate the reason.

On 5/6/15 at 10:20 AM, the Staff Development Nurse confirmed the above information. Additionally, s/he reported that when residents return from the ER, the nurse who receives the resident back in the facility reviews the transition of care summary and is responsible for notifying the resident's physician of ER recommendations. s/he confirmed that there was no evidence that this occurred after Resident #3 returned to the facility. On 5/6/15 at 10:50 AM, the Staff Development nurse also confirmed that the pharmacist consultant did not identify or report the failure to act on the ER recommendation to discontinue use of Benadryl to the facility or physician during his/her monthly medication review.