

Division of Licensing and Protection

HC 2 South, 280 State Drive

Waterbury, VT 05671-2060

<http://www.dail.vermont.gov>

Survey and Certification Voice/TTY (802) 241-0480

Survey and Certification Fax (802) 241-0343

Survey and Certification Reporting Line: (888) 700-5330

To Report Adult Abuse: (800) 564-1612

March 4, 2016

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 February 3, 2016. 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

PRINTED: 02/17/2016
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 02/03/2016
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
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F 000 INITIAL COMMENTS

F 000

An unannounced onsite recertification survey was conducted by the Division of Licensing and Protection on 2/1-3/2016. The following regulatory deficiencies were identified as a result of the survey:

F 241 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY
SS=E

F 241

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.

Ftag 241

- Resident # 79 and Resident # 24 are currently receiving meals in a dignified manner. Resident #71 sign above bed has been removed.
- All residents have the potential to be affected by this deficient practice. House audit completed on posted signage to ensure no other patients affected by this practice.
- The SDC has re-educated the staff on the facility policy of maintaining dignity and enhancing residents during dining as well as privacy of care.
- The DNS /designee will complete random weekly audits on dining service as well as posting of privacy issues in patient rooms x 90 days. The results of these audits will be reviewed monthly with the QAPI committee x 3 months to ensure compliance.

03/03/2016

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, the facility failed to ensure residents were cared for in a manner and an environment that maintains or enhances each resident's dignity for at least 3 residents in the total sample of residents observed during dining. (Residents #79, #24 and #71) Findings include:

1. Per observations from 2/1/16 - 2/3/16, Resident #79 was not cared for in a manner that maintained dignity during the dining experience. Per observation of the noon meal, beginning at 11:34 AM on 2/1/16, Resident #79, who is legally blind, was not assisted with his/her meal for at least 20 minutes and was unable to eat independently. Resident #79 asked for help with no response, then yelled for help, expressing frustration that he couldn't feel his food and needed assistance. When staff did come over to assist the resident, they proceeded to squat and/or crouch by the resident to feed him/her

F241 PDC accepted 3/2/16 Mthgqumrn/enc

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Susan B. Brondolillo EXECUTIVE DIRECTOR 2/24/16

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	Continued From page 1 bites instead of sitting with the resident to assist in a dignified manner. Per observation of the noon meal on 2/3/16 at 11:30 AM, an LNA (Licensed Nursing Assistant), without introducing self or speaking to the resident at all, placed a clothing protector around Resident #79's neck in preparation for the meal. The clothing protectors used resembled bibs made of white terrycloth. Also, Resident #79 was not assisted in a timely nor dignified manner with the meal. Resident was observed seated with the meal on the table without assistance, while an LNA was feeding 2 other residents at the same table. An LNA asked another staff member loudly, and in front of other residents "Do we feed him?". An LNA came from another table and remained standing to feed Resident #79 a bite without introducing themselves or engaging with the resident. The LNA then left to assist another resident at another table. When the LNA left, Resident #79 continued to open his/her mouth in anticipation of the next bite, but no one was assisting and resident was not able to feed him/herself. Per review of the comprehensive care plan for Resident #79, the care plan for impaired cognitive function/dementia states to "Use communication techniques that facilitate interaction...identify yourself with each contact PRN" The care plan for risk for nutritional decline states to provide feeding/dining assistance as needed. Per interviews with 2 LNA's present in the dining room on 2/3/16 at 12:34 PM and 3:05 PM, they stated that there is not enough staff in the dining room to assist all residents in a timely and dignified manner that need staff assistance.	F 241			

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F 241 Continued From page 2

2. Per observation on 2/3/16, Resident #24 was brought his/her meal at 11:34 AM and 2 other residents at the same table received assistance from an LNA at that time to eat. Resident #24 was not able to eat independently and per review of the comprehensive care plan, the resident is at risk for nutritional decline and it directs staff to provide feeding/dining assistance as needed. No staff assisted Resident #24 with his/her meal until 11:56 AM, greater than 20 minutes after receiving the meal and watching other residents at the table receive assistance.

3. Per observation on 2/2/16 at 8:30 AM, Resident #71 has a sign posted on the wall near the head of the bed, clearly visible to all visitors that states "Please walk with [Resident #71's name] daily with rolling walker and gait belt." Per interview with the resident at the time of the observation, the resident clearly indicated that s/he does not like the sign there and would prefer if it weren't posed on his/her wall.

4. Per observations on 2/1/16 - 2/3/16, staff in the dining room during the noon meals were not assisting residents in a manner that promoted dignity and respect. In addition to the findings noted in the above dining examples, per observation of meals; staff placed clothing protectors on multiple residents without asking or introducing self and explaining their actions, staff were seen standing to assist residents with bites of food instead of sitting and engaging residents, staff failed to engage and talk to residents during feeding assistance even when sitting, staff talked loudly to each other about residents present in the dining room in front of other residents, and staff were unable to assist residents in a timely manner or in a consistent way, sometimes

F 241

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F 241	Continued From page 3 hopping back and forth between 2 tables to gives bites of food to different residents. On 2/3/16, while waiting for assistance with the noon meal a resident stated "Are they going to feed us?". Per interviews with 2 LNA's present in the dining room on 2/3/16 at 12:34 PM and 3:05 PM, they stated that there is not enough staff in the dining room to assist all residents in a timely and dignified manner that need staff assistance. They stated that the LNA's who are assigned to offer assistance with feeding are also responsible for getting drinks, assisting all residents, cleaning up dishes/tables, and taking residents back to their rooms/units after they are finished, which makes it difficult to focus on each resident that needs assistance without having to rush.	F 241			
F 279 SS=D	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 residents 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 residents 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	F 279			

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F 279	Continued From page 4 under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to develop a care plan to meet all assessed needs of the residents for 2 of 18 residents in the sample. (Residents #184 and #188). Findings include: 1. Per interview on 2/1/16, Resident #184 expressed concerns about loose-fitting dentures that sometimes fall out while s/he is in bed. Per record review, Resident #184's care plan does not identify needs related to dentures, assistance with dentures or monitoring of dentures. The care plan for self-care deficit refers to the "resident profile" and the care plan for dental health states to "provide mouth care as per ADL personal hygiene". Per review of the resident/ADL profile located on the back of the bathroom door in the resident's room, there is no information regarding dentures or mouth care. Per interview with the Unit Manager on 2/3/16 at 8:55 AM, s/he confirmed the lack of care plan or direction to staff regarding use and care for dentures and indicated that the resident would not be able to be independent with denture care, so does need assistance from staff. 2. Per record review, Resident #188 has physician orders for and has received PRN (as needed) doses of an anti-psychotic medication. The PRN anti-psychotic medication is ordered to be given for "agitation". Per review of the comprehensive care plan, it fails to address what non-pharmacological (non-medication) interventions should be attempted prior to giving	F 279	Flag 279 <ul style="list-style-type: none"> Resident # 184 care plan for dental issues has been developed. Resident # 188 care plan for non-pharmacological interventions have been added to current plan of care. House audits have been completed on residents with dental issues and residents on antipsychotics to ensure no other residents were affected by this deficient practice. The SDC/Designee completed re-education on developing care plans for residents with dental issues and to develop non-pharmacological interventions for residents on antipsychotics. The DNS/Designee will complete random care plan audits on residents with dental issues and residents on antipsychotics monthly x 90 days. The results of these audits will be reviewed with the QAPI committee monthly x 3 months to ensure compliance. 	03/03/2016	

F279 POC accepted 3/2/16 MHT/ggr/RS/PMU

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F 279	Continued From page 5 the PRN anti-psychotic medication. Resident #188 received the PRN anti-psychotic several times in August, September and October with no evidence of any non-pharmacological interventions attempted prior to giving, and staff were administering the drug for non-indicated reasons like "restlessness" and "anxiety". Per interview on 2/3/16 at 10:10 AM, the DNS (Director of Nursing Services) was informed of concerns and was not able to produce evidence of a care plan that directed staff regarding use of the PRN anti-psychotic or a care plan that presented resident-specific non-pharmacological interventions to attempt prior to administering the anti-psychotic PRN. See also F329.	F 279			
F 280 SS=D	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.	F 280			

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F 280	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interviews between 02/02 and 02/03/2016,, the facility failed to assure that the plan of care was revised to reflect the addition of hospice services and end of life care for 1 of 18 residents (Resident # 255) findings include: Per record review on 02/03/2016 at 2:33 PM, Resident # 255 was admitted to the facility on 12/11/2015 with failure to thrive, Alzheimer's disease, diabetes and other co-morbidities. His/her original plan of care included functional and nutritional needs as determined by the admission assessment. Per interview with social service staff on 02/03/2016 at 2:30 PM and reflected in the notes, Resident # 255 continued to decline and Hospice services were requested by the family. Hospice services were begun on 01/14/2016. The unit manager confirmed during interview on 02/03/2016 at 2:58 PM that this resident's plan of care had not been revised to reflect the addition of or collaboration with the hospice team with regard to end of life care.	F 280 Flag 280	<ul style="list-style-type: none"> Resident # 255 care plan has been revised to include hospice services and team collaboration for end of life care. House audit for residents receiving hospice services has been completed to ensure no other residents affected. The SDC/designee will re-educate staff on the facility policy/procedure of care plan requirements for hospice /end of life care. The DNS/Designee will complete random care plan audits on residents on hospice monthly x 90 days. The results of these audits will be reviewed monthly with the QAPI x 3 committee auditor signature x 3 months to ensure compliance. 	03/03/2016	
F 329 SS=E	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	F 329	<i>F329 POC accepted 3/2/16 mthgmsr/pmc</i>		

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F 329	Continued From page 7 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 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 interview and record review, the facility failed to assure each resident is free from unnecessary drugs for 2 of 5 residents in the sample. (Residents #188 and #71). Findings include: 1. Per record review, Resident #188 has physician orders for and receives a scheduled anti-psychotic medication and PRN anti-psychotic medication without an appropriate diagnosis, without regular monitoring of behaviors, and without employing non-pharmacological interventions that are resident-specific to attempt to decrease or eliminate use of the PRN anti-psychotic. Resident #188's diagnoses include "unspecified dementia with behavioral disturbance" but no other diagnoses are listed	F 32	Flag 329 <ul style="list-style-type: none"> Resident # 188 PRN antipsychotic has been discontinued and a behavior monitoring has been initiated. Resident # 71 insulin is currently being administered and documented per MD order. House audit completed on all residents on antipsychotics to ensure behavior monitoring and non-pharmacological interventions in place. House audit on all residents receiving insulin to ensure administration and documentation per MD order. The SDC/ designee has Re-Educated nursing staff on policy/procedure for antipsychotic and insulin administration (specific to behavior monitoring and accurate documentation of insulin administration. The DNS/designee will complete random weekly audits of residents on antipsychotics and insulin x 1 month then monthly x 2 months. The results of these audits will be reviewed monthly with the QAPI committee x 90 days to ensure substantial compliance. 	03/03/2016	

F329 POC accepted 3/2/16 mtigginsrd/pme

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F 329	Continued From page 8 that are indicated for use of powerful anti-psychotic medication. Per review of behavior monitoring sheets for the month of January 2016, there were no documented behavioral problems or problems with agitation. Prior to January 2016 there was no method of consistent behavioral monitoring used by staff to be able to track and identify behavioral problems. Per review of a physician progress note dated 10/15/15, it states "referred for the evaluation and management of dementia with behavioral disturbance in context of recent medications changes...continue Zyprexa [anti-psychotic] for now - re-evaluate medical necessity in the near future. No reported psychotic behavior." There was no evidence after 10/15/15 of a comprehensive review of the need for continued used of the medication despite the indication in the note of a lack of psychotic behavior. Per review of the comprehensive care plan, it fails to identify what interventions should be attempted prior to giving the PRN anti-psychotic and fails to include any non-pharmacological interventions for use with the resident in general to decrease alleged problems with agitation and anxiety. The PRN anti-psychotic is ordered for "agitation". Resident #188 received PRN anti-psychotic medication several times in August, September and October 2015 without any indication or documentation of non-pharmacological interventions attempted and sometimes for reasons not listed as an indication to administer the drug, like "restlessness" or "anxiety". Per interview with the Unit Manager on 2/2/16 at 4:25 PM, s/he confirmed the lack of behavior monitoring sheets or other tool used for	F 329			

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F 329	Continued From page 9 consistent monitoring of behaviors while on an anti-psychotic medication. Per interview on 2/3/16 at 10:10 AM, the DNS (Director of Nursing Services) was informed of concerns and was not able to produce evidence of a diagnosis, consistent behavioral monitoring, or care plan that directed staff regarding use of the PRN anti-psychotic or a care plan that presented resident-specific non-pharmacological interventions to attempt prior to administering the anti-psychotic PRN. 2. Based on interview and record review, the facility failed to ensure that Resident #71's drug regimen is free from unnecessary drugs. Physician order states to hold administration of Humalog insulin TID (three times per day) if blood glucose is less than 150 mg/dl. Per review of the MAR (Medication Administration Record) for January 2016, staff failed to clearly indicate when the insulin was not given by failing to follow proper documentation principles for all days in January with the exception of 1/27/16. In addition, there is a complete lack of indication whether the dose was held on 1/1, 1/2, 1/5, 1/6, 1/17, 1/25, 1/28. On 2/2/16 at 3:10 PM, the Unit Manager confirmed the lack of clear documentation for the month of January regarding the insulin administration and stated the expectation would be for staff to circle their initials on the MAR when a dose was held	F 329	• Ftag 371 <ul style="list-style-type: none"> All residents have the potential to be affected by this deficient practice. The Culinary Manager/ Designee have re-educated the culinary staff on food storage policy/procedure and sanitizing procedures The Executive director/designee will complete random weekly audits on food storage and kitchen sanitization. 	03/03/2016	
F 371	483.35(i) FOOD PROCURE, SS=F STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and	F 371			

F371 POC accepted 3/2/16 MTHiggins R4/1/16

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F 371 Continued From page 10
(2) Store, prepare, distribute and serve food under sanitary conditions

F 371

This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview and record review, the facility failed to store, prepare, distribute and serve food under sanitary conditions. Findings include:

1. Per review of facility documentation on 2/2/16 at 8:56 AM, the three bay sink sanitizer levels were not recorded on 121 occasions between 11/1/15 - 1/31/16. Sanitizer levels are supposed to be checked three times daily.
 2. Walk in refrigerator temperatures were not recorded on 39 occasions between 11/1/15 - 1/31/16.
 3. Walk in freezer temperatures were not recorded on 38 occasions between 11/1/15 - 1/31/16.
- The Dietary mgr confirmed the above on 2/2/16 at 9:00 AM
4. On 2/1/16, a five pound package of raw ground beef with a use by date of 1/28/16 was observed on top of a cardboard box containing ground beef. The Dietary Manager stated that the ground beef should have been discarded after 1/28/16.

The Dietary mgr confirmed the above on 2/2/16 at

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

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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 02/03/2016
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 371	Continued From page 11 9:00 AM	F 371		
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 ensure that the Consultant Pharmacist reported any medication irregularities to the attending Physician and the Director of Nursing for 1 of 5 residents in the sample (Resident # 177). Findings include: Per record review on 2/2/16, Resident #177 had physician orders for 3 "as needed" (PRN) medications that did not have adequate parameters for their use to prevent unintentional overdose. The orders (initiated on 9/4/15) were Morphine Sulfate (Concentrate) Solution (an opioid) 20 mg/ml, give 1 ml (20 mg) by mouth every 2 hours as needed for mild pain; Morphine Sulfate (Concentrate) Solution 20 mg/ml give 2 ml (40 mg) by mouth every 2 hours as needed for moderate pain and Morphine Sulfate (Concentrate) Solution 20 mg/ml give 3 ml (60 mg) by mouth every 2 hours as needed for	F 428 Flag 428	<ul style="list-style-type: none"> Resident # 177 narcotic medication regimen was reviewed by facility consultant pharmacist and parameters were recommended to attending physician. House audit on all residents on narcotics was completed by the consultant pharmacist to ensure no other patients affected The SDC/designee re-educated the consultant pharmacist on the requirement to make Physician recommendations on narcotic parameters when completing 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. 	03/03/2016

F428 POC accepted 3/6/16 Milliggin/SPH/AME

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F 428	Continued From page 12 severe pain. All of the medications were ordered without an indication of how many times they could be administered within a 24 hour period; there were no parameters to indicate a total daily dose (not to be exceeded amount); and there were no parameters to limit or avoid duplicate administration of the same medication. Per review of the Pharmacist's MMR (monthly medication review) record under the section considerations, the pharmacist had circled hospice; however, the resident's physician had discharged the resident from hospice on 9/17/16 and per interview with the UM (Unit Manager), the resident was working towards a discharge to the community. On 2/2/16 at 4:00 PM, a facility UM confirmed the above information and that the pharmacist had not reported the irregularity related to a lack of parameters for the use of the 3 PRN morphine orders.	F 428			
F 431 SS=D	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	F 431			

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

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F 431	<p>Continued From page 13</p> <p>appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>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.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure that all medications were properly stored and labeled or discarded when they reached their expiration date in accordance with accepted professional principles on 3 of 7 medication carts for 3 residents receiving insulin (Residents #62, #10 and #81). Findings include:</p> <p>Per observation on 2/2/16 at 4:42 PM, the medication cart for the Champlain Unit L hall contained 1 NovoLog FlexPen for Resident #81 that was marked with the manufacturer's direction to "use within 28 days of opening;" however, the pen was not dated when opened or when it should be discarded. (NovoLog FlexPen = an</p>	F 431	<p>Ftag 431</p> <ul style="list-style-type: none"> Resident # 10 received a new insulin pen. Resident # 81 received a new insulin pen with the correct label to include proper open and discard date. Resident # 62 insulin now has corrected date to discard on label. House audit of all insulin completed to ensure no other patient affected by this practice. The SDC / designee has re-educated the nursing staff on policy/procedure for insulin storage. The DNS/ designee will complete daily insulin audits mon-fri x 30 days then monthly x 90 days. The results of these audits will be reviewed monthly with the QAPI committee x 90 days to ensure compliance. <p>F431 POC accepted 3/2/16 M Higgins/RA/PMU</p>	03/03/2016

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F 431 Continued From page 14
injectable insulin). On 2/2/16 at approximately 4:49 PM, the medication cart for the Champlain long hall contained 1 NovoLog FlexPen for Resident #10 that was dated as opened on 12/30/15; the pen was also labeled to use within 28 days of opening but had not been discarded. On 2/3/16 at 12:10 PM, the L medication cart on the Mansfield unit had a Lantus Solostar pen for Resident #81 that was dated as opened on 2/1/16 and had a written discard date of 3/2/16 (an interval of 30 days). According to the manufacturer's package insert, Lantus insulin, if not refrigerated can be stored and in use for up to 28 days and then should be discarded. The staff nurse assigned to each of the medication carts confirmed the above findings at the time of the observations.

F 431