STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345223	A. BUILDING _____ B. WING _____	07/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - HENDERSONVILLE	1510 HEBRON ST HENDERSONVILLE, NC 28739

(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 156 SS=B	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting	F 156	***Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or the 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 156** The Complaint Intake postings were hung in the main hallway on July 23, 2013. No residents were affected. New posters have been ordered from the Ombudsman's office and will be framed and hung on the East Wing and West Wing of the facility no later than August 19, 2013. In the interim, the posting is placed on the Social Service board in the main hallway. The Resident Council President and has been informed of the postings. All staff have been informed of the postings and trained about the Complaint Intake Unit. The Executive Director or the Director of Social Work will audit the placement of the framed posters weekly for three months; then monthly for three months; then quarterly thereafter. All audits will be appropriately initialed/documented on a Placement of State Complaint Number Audit Log.	08-24-2013

DHSR NHL&C Black Mountain WRO Received AUG 23 2013 by: MMH

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Angela K Pauline	Executive Director	08-23-13

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.

Original Signature Date: 8-14-13

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F 156	Continued From page 1 personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by	F 156	The results of this audit will be reviewed by the Executive Director or designee, and then brought to the Quality Assessment Process Improvement Meeting monthly for three months. Any issues or trends identified will be addressed by the Quality Assurance Process Improvement Committee as they arise and the plan will be revised as needed to ensure continued compliance.	

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F 156	Continued From page 2 such benefits. This REQUIREMENT is not met as evidenced by: Based on observations and interviews with a resident and staff the facility failed to post the contact information for filing a complaint with the State licensure and certification agency. (Resident #94) The findings included: A review of all posted contact information throughout the facility on 07/22/13 at 3:50 PM, 07/23/13 at 9:00 AM and 07/24/13 at 5:00 PM revealed the name and contact number of the State licensure and certification agency complaint intake unit was not posted. On 07/24/13 at 5:00 PM the staff members responsible for posting contact information within the facility were interviewed and included the administrator, the business office manager and the social worker. These three staff members all reported the name and number of the State licensure and certification agency was not posted because they were not aware of the complaint intake number or that it was supposed to be posted in the facility. On 07/25/13 at 4:50 PM Resident #94 reported she had been the president of the resident council for approximately two years. She stated she was not aware of the State licensure and certification agency complaint intake unit. Resident #94 noted she was aware of information posted in the facility but had not seen the name or number posted of the complaint intake unit.	F 156		

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F 241 F 241 SS=D	Continued From page 3 483.15(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 observations, record review, resident and staff interview, the facility failed to ensure 1 of 3 sampled residents reviewed for assistance with Activities of Daily Living was provided incontinence care (Resident #65) and that 1 of 4 sampled residents reviewed for assistance with dressing was not left dressed in a hospital gown all day. (Resident #77). The findings included: 1. Resident # 65 was admitted to the facility on 02/10/11 with diagnoses which included vascular dementia with delusions, chronic obstructive pulmonary disease and bipolar disorder. The most recent assessment was a quarterly Minimum Data Set (MDS) dated 07/15/13. Resident #65 was assessed as having moderately impaired skills for daily decision making and impaired short term and long term memory. The MDS indicated Resident #65 required extensive assistance from staff with toileting and was always incontinent of bowel and bladder. The most recent care plan addressed the incontinence and the interventions included: check and change frequently and provide perineal care after each incontinent episode.	F 241 F 241	**F241** The identified affected resident was up and appropriately dressed on 07-26-13. This tag has the potential to affect other residents; therefore the following interventions have been implemented as of July 27, 2013: Audits were conducted by the Social Work Department to determine other residents that may be affected. Residents' Care Plans and the nurse aide Care Cards will be updated to show residents' clothing preferences by 08-23-13. Nursing and nurse aide staff will be educated on ensuring residents are appropriately groomed and dressed at all times per the resident preferences. All staff will be educated on answering the call lights in a timely manner and not turning off the call light until resident needs have been met. All nursing and nurse aide staff will be educated on delivering timely incontinence care. The Executive Director, Director of Nursing Services or the Assistant Director of Nursing will randomly spot check call light responses at least three time per week for three months to ensure timely response and document times on a Call Light Response Audit Log. The Director of Nursing Services, the Assistant Director of Nursing Services, or the Unit Manager will audit at least 10% of at-risk residents each week to ensure compliance with clothing preferences. Newly hired nurses and nurse aides will be in-serviced during orientation on these procedures.	08-24-2013

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F 241	Continued From page 4 During an observation on 07/24/13 at 9:55 AM Resident #65 stated he had wet on himself and needed to be cleaned up. The surveyor encouraged the resident to turn on his call light which he did. Continuous observations were made of the resident's room from 10:00 AM until 10:35 AM. At 10:00 AM the call light was turned off by an unidentified staff member. At 10:02 AM Resident #65 turned his call light on again and Staff #1 entered Resident #65's room, inquired about his needs, turned off the call light and left the room. At 10:05 AM Resident #65 turned his call light back on. At 10:06 AM, a staff member, who was stocking supplies, entered the room, inquired about his needs and turned off the call light. As he left Resident #65's room, he told the resident he would let staff know he needed assistance. At 10:20 AM Resident #65 turned his call light back on. At 10:22 AM Nurse Aide (NA) #4 entered Resident #65's room, inquired about his needs, turned off the call light and left the room. At 10:35 AM NA #4 went in Resident #65's room to provide care. Observation of the incontinence brief revealed it was saturated with urine. An interview on 07/24/13 at 11:12 AM with NA #4 about the delay in providing care to Resident #65 revealed she was assisting another resident. The NA gave no explanation of what she did when more than one resident needed assistance at the same time. An observation on 07/26/13 at 9:18 AM revealed Resident #65's call light was on. Continuous observations were made of the resident ' s room from 9:18 AM until 9:46 AM. At 9:27 AM Staff #1 responded to his call light and Resident #65 told her he needed to be changed. Staff #1 stated she	F 241	The results of these audit tools will be reviewed by the Executive Director or designee, and then brought to the Quality Assessment Process Improvement committee meeting monthly for three months; then as need thereafter. Any issues or trends identified will be addressed by the Quality Assurance Process Improvement committee as they arise and the plan will be revised as needed to ensure continued compliance.	

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F 241	Continued From page 5 checked his incontinence brief and it was "a little wet." She turned the call light off and stated she would make sure he got changed. At 9:32 AM Resident #65 turned his call light back on. Staff #2 entered his room and inquired about his needs. Staff #2 left his room and left his call light on. At 9:33 AM Staff #3 entered his room, inquired about his needs, turned the call light off and left the room. At 9:42 AM Resident #65 turned his call light on again. At 9:44 AM, NA #5 responded to the call light. She summoned another staff member to help her provide care. At 9:46 AM, NA #5 and another staff member entered Resident #65's room to provide care. In an interview on 07/26/13 at 10:54 PM the Director of Nursing (DON) was asked about her expectation of staff that answered a resident's call light and was unable to attend to the resident's request at the time they answered the call light. The DON stated non-nursing staff should notify nursing staff of the resident's need and she would expect the staff who answered the call light to go back and check with the resident to make sure their need was met. When asked if staff should turn the call light off before the need was met, the DON stated staff should turn the call light off if the need was going to be met right away, but otherwise, the call light should be left on. When asked what she thought was a reasonable length of time for a resident to wait for incontinence care after notifying staff they were soiled, the DON stated "no longer than 5 minutes unless staff was providing care for another resident." When asked if it would ever be acceptable for a resident to wait 30 minutes for care after notifying staff they were incontinent of urine, the DON stated it would not be acceptable for a resident to wait that long.	F 241		

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F 241	Continued From page 6	F 241		

An interview on 07/26/13 at 4:20 PM with the Administrator about her expectation for staff response to call lights revealed all staff was expected to respond to call lights because non-nursing staff can take care of simple requests. When asked what staff should do if they were unable to meet the resident's need when they answered the call light, she stated staff should leave the call light on until the need is met. When asked what she felt was a reasonable length of time for a resident to wait for incontinence care after notifying staff they were soiled, the Administrator stated the resident should not have to wait any longer than 5 minutes. She stated if staff was unable to provide incontinence care within 5 minutes, they should notify a co-worker or their nurse that they needed help with meeting the resident's need. She stated it would never be acceptable for a resident to wait 30 minutes for incontinence care.
2. Resident #77 was admitted to the facility on 10/28/12 with diagnoses of Parkinson's Disease, dementia, psychosis, Alzheimer's Disease, heart disease, depression, and diabetes.

A review of the Minimum Data Set (MDS) dated 5/21/13 indicated Resident #77 had severely impaired cognition and his family or significant other was involved in his care discussions. The MDS further indicated Resident #77 required extensive assistance from staff for bed mobility, transfer, and dressing. Also indicated in the MDS was Resident #77 was able to move about the facility in a wheelchair.

Numerous observations were made throughout the first two days of the survey (7/22/13 and 7/23/13) that revealed Resident #77 remained in

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F 241	Continued From page 7 bed, dressed in a hospital gown. Observations made of Resident #77 on 7/24/13 at 9:30AM indicated he was lying in bed in a hospital gown. Resident #77 was also observed at 11:00AM, 1:40PM, and 3:50PM on 7/24/13. Each time he was observed in bed and wearing a hospital gown. During observations made on 7/25/13 at 8:55AM, 10:15AM, 1155AM, and 4:05PM, Resident #77 remained in his room, in bed, and wearing a hospital gown. During an interview on 7/25/13 at 9:05AM with Nurse Aide #3, she indicated Resident #77 was set up in bed or gotten up in a chair if he wanted. She verified Resident #77 was usually dressed in his own clothes because he liked to be dressed. She also verified he was often dressed in his own clothes while he was lying in bed. During an interview with Resident #77 on 7/25/13 at 10:15AM, he indicated he would like to get up and get dressed. During an interview on 7/25/13 at 2:15PM with the Unit Manager, she verified it was her expectation that the staff have residents who need assistance, dressed on a daily basis in their personal clothing unless they refuse. She indicated that when she was on Resident #77's hall, he was usually dressed and up in his chair. She also indicated she would expect staff to dress residents who are confined to their beds, in their personal clothes on most days. During an interview on 7/26/13 at 10:55AM with the Director of Nursing, she verified it was her	F 241		

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F 241	Continued From page 8 expectation for staff to have residents dressed every day in their personal clothes, including shirts, pants, hair combed and groomed, if they were able to be dressed.	F 241		
F 242 SS=E	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation and resident and staff interviews the facility failed to provide showers as scheduled for 3 of 3 dependent residents reviewed for showers for the past 3 months. (Residents #44, #66 and #124) The findings included: 1. Resident #66 was admitted to the facility 02/27/09 and readmitted 12/25/12 with diagnoses which included diabetes, acute renal failure and history of cerebrovascular accidents The current Minimum Data Set (MDS) dated 05/27/13 assessed Resident #66 with minimal cognitive impairment, no rejection of care and requiring extensive assistance of two people for personal hygiene and bathing. The current care plan included a problem area dated 02/28/13 noting a physical functioning deficit related to self care	F 242	**F242** The identified affected residents were immediately given showers on 07-26-13 and 07-27-13 and documentation updated. This tag has the potential to affect other residents; therefore the following interventions have been implemented as of July 27, 2013: The Social Services department has audited all residents to determine their bathing or showering preferences. Residents are also asked about their preferences regarding frequency, days and times. For non-communicative residents, Social Services staff will utilize the Customary and Routine section of the MDS report to determine past preferences when family members cannot offer insight or may not be available. For any new residents admitted, Social Services or Nursing Services will interview the resident and/or family members during the 72-Hour Care Conference to determine the resident's preferences. All Resident Care Plans and Care Cards will be updated by 08-26-13. The Director of Nursing and Assistant Director of Nursing audited resident Shower Books to ensure preferences are noted properly.	08-26-2013

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F 242	Continued From page 9 impairment, mobility impairment and range of motion limitations. Approaches to this problem area included: -encourage choices with care -personal hygiene assistance -total assistance with transfers Review of the shower schedules revealed shower days for Resident #66 were Wednesday and Saturday on second shift. Review of the electronic shower records (as recorded by nurse aides) in conjunction with the skin sheets (which are filled out by nurse aides when showers are given) revealed showers were given to Resident #66 the following days from May 2013 through the time of the survey: May 2013 - Resident #66 received one shower on 05/11/13 of seven scheduled. Partial bed baths or full bed baths were recorded as given on all other days in May. June 2013 - Resident #66 received three showers on 06/01/13, 06/19/13 and 06/26/13 of eight scheduled. Partial bed baths or full bed baths were recorded as given on all other days in June. July 2013 - Resident #66 received one shower on 07/06/13 of seven scheduled. Partial bed baths or full bed baths were recorded on all other days in July. On 07/23/13 at 10:00 AM Resident #66 reported he didn't always get his showers as scheduled and that he did not refuse a shower or refuse to get out of bed. On 07/26/13 at 1:48 PM Resident #66 stated he did not get his shower 07/24/13 (Wednesday) or showers the week prior. Resident #66 stated staff gave him a partial or full bed bath at times but he did not feel that took the place of a shower. Resident #66 stated he felt	F 242	Shower/Bath Sheets have been updated to show resident's preferences. Nursing and nurse aide staff have been educated on the facility policy to provide and appropriately document residents' showers per their preferences. Nursing and nurse aide staff have also been educated on communicating to the licensed nursing staff for any refusals. Nursing staff will then discuss with the resident their preferences and any desire to change frequency, time or day and the resident's Care Plan and Care Card will then be updated to reflect said changes. The Director of Nursing Services or the Assistant Director of Nursing will audit the Shower/Bath sheets to ensure that residents are receiving their showers per their preferences three times per week for three months; then one time per week for three months; then monthly thereafter and document results on a Shower/Bath Audit Log. Newly hired nurses and nurse aides will be in-serviced during orientation on this procedure. The results of these audit tools will be reviewed by the Executive Director or designee, and then brought to the Quality Assessment Process Improvement committee meeting monthly for three months; then as needed thereafter. Any issues or trends identified will be addressed by the Quality Assurance Process Improvement committee as they arise and the plan will be revised as needed to ensure continued compliance.	

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F 242	Continued From page 10	F 242		

dirty and really needed a shower. Resident #66 stated he felt like his hair was very greasy because it didn't get washed when he had a partial or full bed bath. Resident #66 said there had been times he had begged staff for a shower and they would tell him they would see what they could do and then never return. At the time of the interview Resident #66 did not have an odor but his thick light gray hair did have a greasy appearance.

On 07/26/13 at 4:45 PM Nurse Aide (NA) #1 stated he routinely worked second shift. NA #1 stated when showers were given they were recorded in the electronic shower record as well as the skin sheet book. NA #1 stated he had given Resident #66 a shower in the past but could not remember when the last shower was that he gave to the resident. NA #1 stated there were times a bed bath was given to residents instead of a shower due to time limitations.

On 07/26/13 at 10:30 AM the Director of Nursing (DON) stated she expected showers to be given two times a week as scheduled for each resident. The DON stated if a shower was not given she expected the nurse aides to inform the nurse so they could talk to the resident and document it in nursing notes. The DON stated although they had to use a lot of agency nurse aides in recent months she expected them to give showers as scheduled. The DON stated she was not aware of any problems with showers and the electronic shower sheets and skin sheets should reflect when showers or bed baths were given. The DON stated that if a resident requested a bed bath instead of a shower it should be documented on the shower sheet or skin sheet. The shower sheets and skin sheets for Resident #66 were

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reviewed with the DON and she stated she was not aware showers had not been given or any refusal of showers by Resident #66. The DON had no explanation why showers were not given as scheduled in May 2013, June 2013 and July 2013 for Resident #66.

2. Resident #124 was admitted to the facility 05/21/13 with diagnoses which included anxiety, chronic pain, diabetes, coronary artery disease, mental disorder and dementia. The current Minimum Data Set (MDS) dated 05/28/13 determined Resident #124 was not appropriate for a cognitive assessment due to severe memory impairment. Resident #124 was assessed on the 05/28/13 MDS as requiring extensive assistance of two staff for personal hygiene and bathing. The current care plan for Resident #124 was last updated 07/18/13 and included the following problem areas:
1. Impaired neurological and cognitive status related to cerebrovascular accident (CVA), dementia other than Alzheimer's disease
2. Impaired communication due to impaired cognition, confusion, CVA, not always being understood. Approaches to this problem area included:
-anticipate patient's needs
3. Behavioral symptoms risks related to verbally abusive/physically abusive. Approaches to this problem area included:
-maintain consistent daily routine

Review of the shower schedule revealed showers were scheduled for Resident #124 on Tuesday and Friday on second shift.

Review of the electronic shower records (as recorded by nurse aides) in conjunction with the

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	345223	A. BUILDING _____ B. WING _____	07/26/2013

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skin sheets (which are filled out by nurse aides when showers are given) revealed showers were given to Resident #124 the following days from admission on 05/21/13 through the time of the survey:
May 2013 - Resident #124 received no showers of the 3 scheduled. Partial bed baths or full bed baths were recorded as given on all other days in May.
June 2013 - Resident #124 received 2 showers on 06/04/13 and 06/13/13 of the 8 showers scheduled. Partial bed baths or full bed baths were recorded as given on all other days in June.
July 2013 - Resident #124 received 1 shower 07/16/13 of the 7 showers scheduled. Partial bed baths or full bed baths were recorded as given on all other days in July.

Review of all nursing notes in the medical record of Resident #124 noted refusal of mouth care and shaving but no refusals of showers.

On 07/26/13 at 4:32 PM NA # 3 stated she typically worked second shift but wasn't always on the unit where Resident #124 resided. NA #3 stated she did not recall ever giving a shower to Resident #124.

On 07/26/13 at 10:30 AM the Director of Nursing (DON) stated she expected showers to be given two times a week as scheduled for each resident. The DON stated if a shower was not given she expected the nurse aides to inform the nurse so they could talk to the resident and document it in nursing notes. The DON stated although they had to use a lot of agency nurse aides in recent months she expected them to give showers as scheduled. The DON stated she was not aware of any problems with showers and the electronic

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shower sheets and skin sheets should reflect when showers or bed baths were given. The DON stated that if a resident requested a bed bath instead of a shower it should be documented on the shower sheet or skin sheet. The shower sheets and skin sheets for Resident #124 were reviewed with the DON and she stated she was not aware showers had not been given or any refusal of showers by Resident #124. The DON had no explanation why showers were not given as scheduled in May 2013, June 2013 and July 2013 for Resident #124.

3. Resident #44 was admitted to the facility 04/17/07 with diagnoses which included anxiety, Alzheimer's disease and depression. The current Minimum Data Set (MDS) dated 06/28/13 assessed Resident #44 with severe cognitive impairment. The 06/28/13 MDS also assessed Resident #44 as needing extensive assistance of one person for personal hygiene and total dependence of one person for showers. The current care plan for Resident #44 included a problem area last updated 1/13/13 of, Self care impairment related to diagnosis of Alzheimer's disease. Approaches to this problem area included:
-assist in activities of daily living (ADLs) and mobility as needed
-monitor ADLs for assistance and render care as needed

The shower schedule revealed showers were scheduled for Resident #44 on Tuesday and Friday by first shift.

Review of the electronic shower records (as recorded by nurse aides) in conjunction with the skin sheets (which are filled out by nurse aides

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F 242	Continued From page 14 when showers are given) revealed showers were given to Resident #44 the following days from May 2013 through the time of the survey: May 2013 - Resident #44 received a shower on 05/21/13 of the 8 showers scheduled. Partial bed baths or full bed baths were recorded as given on all other days in May. June 2013 - Resident #44 received showers on 06/04/13, 06/07/13, 06/11/13 and 06/25/13 of the 8 showers scheduled. Partial bed baths or full bed baths were recorded as given on all other days in June. July 2013 - Resident #44 received showers on 07/02/13, 07/05/13, 07/09/13 of the 7 showers scheduled. Partial bed baths or full bed baths were recorded as given on all other days in July. On 07/26/13 at 10:30 AM Nurse Aide (NA) #4 stated showers were documented in the electronic shower record and skin sheet. NA #4 stated if a resident refused a shower she would inform the nurse and document the refusal in the electronic shower record and skin sheet. NA #4 stated she was not aware of Resident #44 ever refusing a shower. On 07/26/13 at 10:30 AM the Director of Nursing (DON) stated she expected showers to be given two times a week as scheduled for each resident. The DON stated if a shower was not given she expected the nurse aides to inform the nurse so they could talk to the resident and document it in nursing notes. The DON stated although they had to use a lot of agency nurse aides in recent months she expected them to give showers as scheduled. The DON stated she was not aware of any problems with showers and the electronic shower sheets and skin sheets should reflect when showers or bed baths were given. The	F 242		

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F 242	Continued From page 15 DON stated that if a resident requested a bed bath instead of a shower it should be documented on the shower sheet or skin sheet. The shower sheets and skin sheets for Resident #44 were reviewed with the DON and she stated she was not aware showers had not been given or any refusal of showers by Resident #44. The DON had no explanation why showers were not given as scheduled in May 2013, June 2013 and July 2013 for Resident #44.	F 242		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET 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 medical record review and staff interviews the facility failed to implement physician orders for lab work (Resident #44 and #124) and vitamin supplementation (Resident #124) for 2 of 11 sampled residents. (Residents # 44 and 124) The findings included: 1. Resident #124 was admitted to the facility 05/21/13 with diagnoses which included diabetes, coronary artery disease, hypertension, mental disorder and dementia. Review of the medical record of Resident #124 included lab results dated 06/05/13 which noted a Vitamin D level of 24. The normal level of vitamin D was listed on the lab results with a range of 30-80. On the bottom portion of the lab were	F 281	**F281** The identified affected residents had lab draws conducted immediately and the physician was notified on 07-25-13; no adverse effects noted. This tag has the potential to affect residents; therefore the following interventions have been implemented as of July 27, 2013: Lab books were implemented on each wing (East Wing and West Wing) to facilitate/track lab work initiation and completion. Nursing staff will be educated on proper completion of lab book documentation. Additionally, nursing staff and ward clerk will be educated on proper filing of lab documentation upon receipt; specifically, no lab work, lab orders, or lab results will be filed in the resident's chart(s) until physician and nurse signatures are obtained. The Director of Nursing Services or the Assistant Director of Nursing will audit the Lab Book three times per week for three months; then one time per week thereafter and document results on a Lab Audit Log. Newly hired nurses will be in-serviced during orientation on this procedure.	08-24-2013

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F 281	Continued From page 16 undated handwritten orders from the nurse practitioner which included, "Vitamin D3 50,000 every week. Recheck Vitamin D in 12 weeks." Review of physician orders and the June 2013 and July 2013 Medication Administration Record revealed the Vitamin D3 had not been written as a physician order and therefore had not been given to Resident #124. On 07/24/13 at 3:30 PM the Director of Nursing (DON) stated when the nurse practitioner or physician reviewed resident lab work they typically wrote orders on the bottom of the lab and gave it to the nurse to process. The DON stated if the nurse practitioner/physician did not physically hand the lab work and orders to the nurse they would place it in a box and the nurse that was working the shift was responsible for writing the orders. The DON stated since the order was not dated she could not determine which nurse was responsible for processing the order for Vitamin D and lab work for Resident #124. The DON verified a physician's order should have been written for the Vitamin D and to recheck the lab in 12 weeks. The DON verified neither of the orders had been written and could not explain what happened. Review of progress notes in the medical record of Resident #124 included a nurse's note dated 07/25/13 at 10:51 AM which included, Spoke with nurse practitioner in regards to Vitamin D medication and Vitamin D level. New order for Vitamin D 50,000 every week. Recheck Vitamin D level in 12 weeks. 2. Resident #44 was admitted to the facility 04/17/07 with diagnoses which included Alzheimer's disease and venous	F 281	The results of these audit tools will be reviewed by the Executive Director or designee, and then brought to the Quality Assessment Process Improvement committee meeting monthly for three months; then as needed thereafter. Any issues or trends identified will be addressed by the Quality Assurance Process Improvement committee as they arise and the plan will be revised as needed to ensure continued compliance.	

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F 281	Continued From page 17 embolism/thrombosis. Review of the medical record of Resident #44 included a physician's progress note dated 04/12/13 which noted, "Staff requested today's visit for multiple issues. She continues to lose weight with Hospice despite being on Remeron. She has very little appetite. Her Vitamin D level returned low at 18 despite Vitamin D supplementation. She denies issues but is a very poor historian due to advanced dementia." Physician orders on 04/12/13 included, "Increase Vitamin D from 2000 to 4000 international units daily and repeat level in two months." On 07/25/13 at 10:12 AM the facility ward clerk reviewed the process for obtaining labs. The ward clerk stated the nurse that processes the physician lab order would write the residents name and lab work needed in the calendar book used for obtaining lab work. The ward clerk reviewed the lab calendar book and did not see a listing for a Vitamin D level for Resident #44 on or around 06/12/13. The ward clerk called the lab to see if the repeat Vitamin D level was done and reported the lab did not have another level of Vitamin D for Resident #44 as ordered on 04/12/13. On 07/25/13 at 4:00 PM the Director of Nursing (DON) stated the nurse that processed the order on 04/12/13 should have written the need for the Vitamin D level in the lab calendar on 06/12/13. The DON stated the nurse that processed the order no longer worked for the facility. The DON verified the Vitamin D had been increased as ordered on 04/12/13 but the need for the lab had not been implemented; and, therefore, not done. The DON stated third shift nurses were	F 281		

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F 281	Continued From page 18 responsible for checking each chart every night to ensure all orders were processed. The DON stated after the nurse checks all orders they date and sign the physician order sheet to verify completion. The DON stated the third shift nurse that signed and dated the chart of Resident #44 on 04/13/13 was Nurse #3. The DON stated the nurse practitioner of Resident #44 was notified of the missed lab for a Vitamin D level and requested the level be drawn on 07/26/13. On 07/26/13 at 10:00 AM in a phone interview Nurse #3 stated he was hired in March and, at that time, was not familiar with how to check to ensure lab work was processed. Nurse #3 stated it was his practice to have a co-worker follow-up on orders if he was unfamiliar with how to process them. Nurse #3 stated he could not recall the specifics of the 04/12/13 order for Resident #44 so he could not explain why the Vitamin D level was not done as ordered.	F 281		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced	F 328	**F328** The identified oxygen tank was immediately removed on 07-22-13. This tag has the potential to affect residents; therefore the following interventions have been implemented as of July 27, 2013: All staff will be educated on oxygen security, specifically securing, via back of wheelchair in wheelchair mount or in secure rolling oxygen tank. All staff will be educated about securing oxygen inside the building, whether in use or not, at all times, or 2) removing unused oxygen tanks from the building immediately. Newly hired staff will be in-serviced during orientation on this procedure.	08-24-2013

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F 328	Continued From page 19 by: Based on medical record review, observations and staff interview the facility failed to secure a portable oxygen tank for 1 of 1 sampled resident that utilized portable oxygen. (Resident # 5). The findings included: Resident #5 was admitted to the facility 09/22/11 with diagnoses which included asthma and hypoxemia. Review of July 2013 orders in the medical record of Resident #5 included a physician's order for continuous oxygen at 3 liters a minute. Observations were made of a portable oxygen tank stored in the room of Resident #5 on 07/23/13. The portable oxygen tank was stored in a woven nylon sleeve holder that fit on the back of the resident's wheelchair. The portable oxygen tank was observed stored freestanding, in this nylon sleeve, leaning between the wall and the heating/air conditioning unit in the room of Resident #5. The resident's wheelchair was observed in close proximity of the unsecured oxygen cylinder. These observations occurred on 07/23/13 at 9:15 AM, 11:35 AM, 2:44 PM and 5:00 PM. On 07/23/13 at 5:00 PM Nurse #1 reported portable oxygen tanks should be stored in a rolling holder or in the sleeve attached to the back of the wheelchair. At the time of the interview Nurse #1 (who worked both first and second shift with Resident #5) observed the portable oxygen tank in the room of Resident #5 and reported not being aware it was inappropriately stored and also unaware who had stored it against the wall. Nurse Aide #5 (an agency nurse aide who worked both first and	F 328	The Executive Director or Director of Nursing Services will randomly spot check at least 4 resident rooms three times per week for three months; then one time per week thereafter to ensure that no oxygen is unsecured. Audits will be appropriately initialed/documented on a Oxygen Security Audit Log. The results of this audit will be reviewed by the Executive Director or designee, and then brought to the Quality Assessment Process Improvement committee meeting monthly for three months. Any issues or trends identified will be addressed by the Quality Assurance Process Improvement committee as they arise and the plan will be revised as needed to ensure continued compliance.	

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F 328	Continued From page 20 second shift with Resident #5) was also present in the room and stated she had not placed the portable oxygen cylinder against the wall and wasn't aware who might have placed it there. The portable oxygen cylinder was immediately removed by another nurse and placed in a rolling holder. The nurse that removed the oxygen cylinder from the room of Resident #5 reported the gauge on the tank indicated the tank was "empty". On 07/24/13 at 4:00 PM the Director of Nursing (DON) stated portable oxygen cylinders should be stored in the sleeve on the back of a wheelchair or in a rolling holder. The DON provided a facility policy on oxygen storage; noting the source of the policy was from competencies in the policy book. This policy included, "All cylinder tanks must be secured in a stand or to the wall of the storage room." The DON stated she had been informed of the oxygen cylinder stored unsecured in the room of Resident #5 on 07/23/13 and she was not able to determine who had placed the oxygen cylinder against the wall in the room.	F 328		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews the facility failed to administer the accurate dose of Coumadin to 1 of 11 sampled residents on Coumadin. (Resident # 66)	F 333	**F333** The affected resident had new labs - PT/INR drawn on 07-26-13 and the physician was notified; resident suffered no adverse effects. This tag has the potential to affect residents; therefore the following interventions have been implemented as of 07-27-2013.	08-24-2013

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F 333	Continued From page 21 The findings included: Resident #66 was admitted to the facility 02/27/09 and readmitted 12/25/12 with diagnoses which included diabetes, acute renal failure and history of cerebrovascular accidents. The care plan for Resident #66 included a problem area dated 02/28/13 noting the use of an anticoagulant that put him at risk for bleeding. Approaches to address this problem area included: -monitor medication regimen for medications which could increase effects and -observe for signs/symptoms of bleeding. Review of physician orders in the electronic medical record of Resident #66 noted an order on 07/05/13 to change the administration time of the 10 milligrams (mg) of Coumadin from an AM dose to a PM dose. This order was noted as changed in the facility's electronic system by Nurse #1 on 07/05/13 at 3:17 PM. Review of the July 2013 electronic Medication Administration Record (MAR) for Resident #66 revealed on 07/05/13 he received the 10 mg AM dose as well as the 10 mg PM dose; for a total of 20 mg of Coumadin. On 07/25/13 at 2:25 PM Nurse #1 demonstrated how the electronic MAR worked. Nurse #1 explained that set medication administration times were displayed on the electronic MAR (2:00, 3:00, 4:00....). She stated that during the course of their shift, the staff member administering medications would click on a set time (i.e. 2:00). She stated the electronic system listed all residents with medications due at that time. Nurse #1 explained the system did not open up each residents MAR, just the individual	F 333	Nursing staff will be educated on, and must correctly demonstrate, the Six Rights of Medication by 08-05-13. Nursing staff will also be educated on new E-Mar process for properly entering Coumadin orders, lab results and any changes to said orders by 08-09-13. The Coumadin and PT/INR process has been standardized so that blood draws are done on first shift (7 am to 3 pm) on the day ordered. One the date due, the PT/INR will flag on the first shift E-Mar. After 3 pm on the due date, the E-Mar will flag on second shift (3 pm to 11 pm) to determine if PT/INR was drawn and if new orders were given. If new orders are given, second shift (3 pm to 11 pm) will enter said new orders, prompting each subsequent second shift (3 pm to 11 pm) to administer appropriate Coumadin doses. Newly hired nursing staff will be educated on this procedure during orientation. The Director of Nursing Services will audit the Coumadin logs and lab draw logs three times per week for three months; then weekly for three months and then twice monthly thereafter. Audits will be appropriately initialed and documented on a Coumadin/Lab Draw Audit Log. The results of this audit will be reviewed by the Executive Director or designee, and then brought to the Quality Assessment Process Improvement committee meeting monthly for three months. Any issues or trends identified will be addressed by the Quality Assurance Process Improvement committee as they arise and the plan will be revised as needed to ensure continued compliance.	

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F 333	Continued From page 22 resident and the medication due at that time. Nurse #1 reviewed the July 2013 MAR for Resident #66 and verified she had given the 10 mg AM dose of Coumadin on 07/05/13. She stated at 3:17 PM she entered the order to change the administration time of the 10 mg of Coumadin from an AM dose to a PM dose. Nurse #1 verified she gave the PM 10 mg dose of Coumadin to Resident #66 on 07/05/13. She stated when the dose was changed from an AM dose to a PM dose she entered it in the electronic MAR to be delivered at 4:00 PM. Nurse #1 stated on 07/05/13 when she was doing the medication pass and clicked on the 4:00 PM administration time the display included the 10 mg dose of Coumadin for Resident #66. Nurse #1 stated she was not aware she had given him both doses of Coumadin on 07/05/13. Nurse #1 stated she routinely worked with Resident #66 and wasn't aware of any bleeding from 07/05/13 through the time of the survey on 07/25/13. Nurse #1 stated she would immediately call the physician/nurse practitioner of Resident #66 to inform them of the medication error. Review of the medical record of Resident #66 included all progress notes from 07/05/13 through the time of the annual survey on 07/25/13. There was no indication of any bleeding involving Resident #66 during this time frame. Review of the Prothrombin Time/International Normalized Ratio (PT/INR), a test used to monitor Coumadin and determine dosing changes, for Resident #66 noted tests indicated sub-therapeutic levels which included the following results: 05/06/13 PT/INR: 22.8/2.0 (with 2-3 the normal	F 333		

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F 333	Continued From page 23 limit of INR) 06/03/13 PT/INR: 20.7/1.8 06/28/13 PT/INR: 20.5/1.8 07/05/13 PT/INR: 13.8/1.2 On 07/25/13 at 10:50 AM Nurse #2 found the lab slip for the 07/05/13 PT/INR done on Resident #66 and noted the lab was drawn at 7:00 AM; prior to the resident's AM dose of Coumadin (which was scheduled at 8:00 AM). On 07/25/13 at 4:05 PM the facility Director of Nursing (DON) reviewed the July 2013 MAR for Resident #66 and verified 20 mg of Coumadin had been administered by Nurse #1 on 07/05/13. The DON verified the two 10 mg doses of Coumadin had been given to Resident #66 because there was a "0" after the initials of Nurse #1 on the electronic MAR at 8:00 AM and 4:00 PM which indicated the medication had been administered. The DON stated anything other than a "0" after the nurses initials on the MAR would indicate the medication had not been administered. The DON stated she was not aware until 07/25/13 that Resident #66 had received 20 mg of Coumadin on 07/05/13 instead of 10 mg as ordered. The DON stated when nurses put orders into the electronic MAR the system would automatically default changes to the day the order was entered unless the date was changed. The DON stated Nurse #1 should have changed the start date for the change in the scheduled time of administration of Coumadin for Resident #66 to 07/06/13. On 07/25/13 at 5:00 the DON stated the nurse practitioner of Resident #66 was notified of the medication error involving Coumadin on 07/05/13. The DON stated the nurse practitioner ordered a	F 333		

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F 333	Continued From page 24 PT/INR but felt that the Coumadin would be out of his system at the time she was notified. On 07/26/13 the results of the PT/INR for Resident #66 were 15/3/1.3.	F 333		
F 371 SS=E	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 observations and staff interviews the facility failed to clean an ice scoop holder located in the activity room and failed to remove chipped paint around ceiling vents in the facility kitchen. The findings included: 1. On 7/23/13 at 9:18 AM a clear plastic ice scoop holder was observed attached to the side of the ice machine in the activity room on the 100 hall. A clear plastic ice scoop was observed stored inside the ice scoop holder with the scoop portion in contact with the bottom portion of the holder. The ice scoop holder was located on the side of the ice machine; approximately four feet off the ground. On 07/23/13 at 9:18 AM, 07/24/13 at 11:40 AM,	F 371	**F371** Maintenance removed, cleaned and repainted the ceiling vents on 07-26-13. This tag has the potential to affect residents; therefore the following interventions have been implemented as of 07-27-2013. Ceiling vents have had all paint removed. Ceiling vents are now the natural Stainless Steel, preventing any further chipping. Maintenance will monitor the ceiling vents weekly for four weeks; then monthly for two months. All audits will be appropriately initialed/documented on a Ceiling Compliance Audit Log. The ice scoop and holder have been removed and cleaned as of 07-25-2013. Dietary staff have ordered secondary supplies so that scoop and holder may be removed three times per week for cleaning without interruption of services. Dietary Manager will audit the cleaning schedule weekly for three months; then monthly for three months. The results of this audit will be reviewed by the Executive Director or designee, and then brought to the Quality Assessment Process Improvement committee meeting monthly for three months. Any issues or trends identified will be addressed by the Quality Assurance Process Improvement committee as they arise and the plan will be revised as needed to ensure continued compliance.	08-24-2013

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F 371	Continued From page 25 07/25/13 at 9:45 AM and 07/26/13 at 12:00 PM the bottom left hand side of the clear plastic ice scoop holder had a dark black, textured dime sized matter visible under the ice scoop. On 07/26/13 at 12:00 PM the ice scoop holder was observed with the facility maintenance director. A small hole was observed in the middle of the bottom of the ice scoop holder and the maintenance director stated it had been put there to allow water to drain out from the bottom. There was a small amount of water pooled around the perimeter of the bottom of the ice scoop holder. The interior portion of the ice scoop holder was felt with a bare finger and the dark black, textured dime sized matter was easily removed and floated in the water. The back bottom portion of the ice scoop holder had a slick, slimy feel. The maintenance director observed the blackened matter in the bottom of the ice scoop holder and was not able to identify what the matter was. The maintenance director stated he thought the Food Service Director (FSD) was responsible for cleaning the ice machine, ice scoop holder and scoop. The maintenance director commented the ice scoop holder was designed to be removed from the ice machine for cleaning but, because one of the two screws used to attach it was bigger than the keyhole shaped mounting hole it prevented the ice scoop holder from coming off for cleaning. The maintenance director stated he did not know why or when the larger screw had been put on the ice scoop holder. On 07/26/13 at 12:15 PM the FSD stated his department was responsible for cleaning the ice machine, ice scoop holder and ice scoop. The FSD stated the ice machine was cleaned once a month and the ice scoop holder and scoop were	F 371		

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F 371	Continued From page 26 cleaned once a week. The FSD observed the interior of the ice scoop holder and could not identify what the black matter was on the bottom interior. The FSD stated as part of the weekly cleaning the ice scoop holder would be taken off the ice machine and run through the dish machine. At the time of the interview the FSD attempted to take the ice scoop holder off the ice machine but was unable to do so because of the screw that was larger than the keyhole shaped mounting hole. The FSD stated the ice scoop holder used to come off and was not aware why or when the larger screw had been used to mount the holder. The FSD stated the ice machine was one of two in the facility and used all the time by staff for residents. The FSD stated when staff saw the black matter in the bottom of the ice scoop holder it should have been brought to the attention of dietary staff for cleaning. The FSD stated there was not a check list to know when the ice scoop holder had last been cleaned but he thought it was being done every Friday. 2. An observation on 07/22/13 at 9:18 AM of five ceiling vents in the facility's kitchen revealed the following: Ceiling vent #1, was located above a stove and a food preparation area, had peeling paint and broken ceiling plaster around the vent and the vent itself had flaky paint along its edges. The chipped cracked ceiling around vent #1 was observed to be approximately 6-8 inches long with approximately 1/2 to 1 inch gap of space where it joins to the vent. The chipped plaster paint was bubbled up about 4 inch diameter. The crack extended approximately 12 inch out from vent #1 and was covered with bubbled plaster. Approximately 6 inch from the larger crack there	F 371		

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F 371	Continued From page 27 was chipped paint that was along the edge of the vent with flaky looking chips approximately 1/2 to 1 inch in diameter. Ceiling vent #2 located above the stove area had chipping paint around the vent. Ceiling vent #3, located above the sink drying shelves near the dishwasher, had chipping paint on the vent edges. Ceiling vent #4, located near the kitchen's pot drying shelf had chipping paint on the edges of the vents and around the mounting screws. Ceiling vent #5, located near the kitchen's steam table had chipping paint on the edges of the vents and around the mounting screws. Observation of ceiling vent #5 on 07/22/13 at 11:03 AM revealed a drink cart, with beverages was parked partially under this ceiling vent which had chipped paint around the vent. Further observations of the kitchen's 5 ceiling vents on 07/22/13 at 11:03 AM, 07/24/13 at 10:03 AM, 07/24/13 at 04:35 PM and on 07/25/13 at 11:00 AM revealed chipping paint on each of the 5 ceiling vents. During each of these observations ceiling vent #1 had peeling and blistered paint on it and the ceiling plaster was observed with cracks, and chipped, peeling blistered paint around this vent. Observation on 07/25/13 at 04:35 PM revealed the ceiling plaster repaired around vent #1, but chipped paint was observed on all five ceiling vents. The Administrator confirmed on 07/26/13 prior to the exit conference that the ceiling plaster around vent #1 was fixed yesterday. The Administrator further acknowledged that the ceiling vents were	F 371		

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F 371	Continued From page 28 in need of repair in the kitchen and would be placed on the maintenance list.	F 371		
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 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	**F431** The identified medications were removed from storage and disposed of by the unit coordinator. No residents were affected. An audit of all facility designated areas for the storage of medications was completed by the Director of Nursing from 07/26/13 to 07/30/13 to identify potentially expired medications. No other medications were identified. Licensed nursing staff will be in-serviced by the Director of Nursing and/or the Director of Clinical Education by 08/10/13 on the storage, dating, and expiration of medications and related processes. All new licensed nursing staff will be in-serviced on this procedure during orientation. Med Cart Chart Checks have been implemented on each Med Cart effective 08-01-13. Nursing staff will audit each Med Cart daily ensuring that their cart is free of expired medications. The Director of Nursing Services or the Assistant Director of Nursing Services will audit the Medication Rooms to ensure there are no expired medications weekly for four weeks then monthly for three months. The results of this audit will be reviewed by Director of Nursing and/or the Executive Director and then Quality Assessment Process Improvement Meeting monthly for three months. Any issues or trends identified will be addressed by the Quality Assurance Process Improvement as they arise and the plan will be revised as needed to ensure continued compliance.	08-24-2013

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F 431	Continued From page 29 This REQUIREMENT is not met as evidenced by: Based on observations and staff interview the facility failed to remove expired medications from 2 of 6 medication carts and 1 emergency drug kit. The findings included: A review of the manufacturer's instructions for Lantus insulin indicated vials must be discarded 28 days after opening. 1. Inspection on 07/25/13 at 9:52 AM of the East Wing Medication Cart A revealed a bottle of Lantus Insulin with a date opened label of 06/22/13. An interview on 07/25/13 at 10:15 AM with Nurse #1 revealed the Lantus Insulin should have been discarded on 07/19/13. An interview on 07/25/13 at 3:17 PM with the Director of Nursing (DON) regarding who was responsible for checking the medication rooms and medication carts for expired medications revealed the Unit Manager was expected to check the medication rooms daily and the nurses administering medications were expected to check the medication carts weekly for expired medications. The DON stated expired medications should be discarded and re-ordered from the pharmacy. The DON also stated the pharmacy consultant checked for expired medications once a month. The DON confirmed the insulin should have been discarded on 07/19/13. 2. Inspection on 07/25/13 at 2:45 PM of the facility's emergency supply of narcotic medications revealed 1 tablet of hydrocodone/acetaminophen 5/500 milligrams	F 431		

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F 431	Continued From page 30	F 431		

with an expiration date of June 2013. An interview on 07/25/13 at 2:47 PM with Nurse #3 revealed someone from the pharmacy checked the emergency narcotic supply of medications for expiration dates periodically but she was unable to state how often.

An interview on 07/25/13 at 3:17 PM with the Director of Nursing (DON) regarding who was responsible for checking the medication rooms and medication carts for expired medications revealed the Unit Manager was expected to check the medication rooms daily and the nurses administering medications were expected to check the medication carts weekly for expired medications. The DON stated expired medications should be discarded and re-ordered from the pharmacy. The DON also stated the pharmacy consultant checked for expired medications once a month.

3. Inspection on 07/24/13 at 2:20 PM of the West Wing Medication Cart #2 revealed 4 tablets of Mucinex DM with an expiration date of September 2012.

An interview on 07/24/13 at 2:20 PM with Nurse #2 on the West Wing regarding who was responsible for checking expiration dates on medications revealed she checked the medication cart for expired medications every morning.

An interview on 07/24/13 at 4:00 PM with the Unit Manager regarding who was responsible for checking medication rooms and medication carts for expired medication revealed she or one of the other administrative nurses checked the medication rooms every week and did random

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F 431	Continued From page 31 checks of the medication carts. She stated the nurses who were administering the medications were expected to check the medication carts for expired medication also. An interview on 07/25/13 at 3:17 PM with the Director of Nursing (DON) regarding who was responsible for checking the medication rooms and medication carts for expired medications revealed the Unit Manager was expected to check the medication rooms daily and the nurses administering medications were expected to check the medication carts weekly for expired medications. The DON stated expired medications should be discarded and re-ordered from the pharmacy. The DON also stated the pharmacy consultant checked for expired medications once a month.	F 431		