STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345354	A. BUILDING _____ B. WING _____	10/29/2015

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PINEY GROVE NURSING AND REHABILITATION CENTER	728 PINEY GROVE ROAD KERNERSVILLE, NC 27284

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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 resident's 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 resident's 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 under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to develop a care plan to address diabetes for 1 of 5 sampled residents (Resident #29) reviewed for unnecessary medications; and, failed to develop a care plan to address the use of an anticoagulant medication for 1 of 5 sampled residents (Resident #29) reviewed for unnecessary medications. The findings included: 1) Resident #29 was admitted to the facility on 3/21/15, with re-entry from a hospital on 6/22/15.	F 279	Piney Grove Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of the findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Piney Grove Nursing and Rehabilitation Center□s response to this Statement of	11/25/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 11/19/2015

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F 279	Continued From page 1 The resident ' s cumulative diagnoses included Type 2 diabetes. A review of Resident #29 ' s medical record revealed the resident returned to the facility from a hospital stay on 9/4/15. The resident ' s 9/4/15 medication orders included 10 units of Levemir insulin (a long-acting insulin) injected subcutaneously (under the skin) every night at bedtime and Novolog insulin (a rapid acting insulin) administered based on a sliding scale twice daily. An order for sliding scale insulin coverage indicated the dose of insulin administered was dependent on the resident's blood sugar (BS) result at a designated time. A review of Resident #29 ' s admission MDS (Minimum Data Set) assessment dated 9/21/15 revealed the resident had intact cognitive skills for daily decision making. She required extensive assistance with all of her Activities of Daily Living (ADLs) with the exception of requiring supervision for locomotion off the unit and total dependence on staff for bathing. The MDS assessment also indicated the resident ' s medications included an insulin injection on 6 out of the previous 7 days during the look back period. A review of Resident #29 ' s care plan (initiated on 9/15/15) revealed a problem area related to diabetes was not addressed for Resident #29. The Resident Care Guide included a notation which read, " Diabetic. " An interview was conducted on 10/29/2015 at 10:02 AM with Nurse #2. Nurse #2 assumed responsibility as the facility ' s MDS Nurse. During the interview, Nurse #2 reported that she was responsible for initiating and reviewing	F 279	Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Piney Grove Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure, and/or any other administrative or legal proceeding. F279 Develop Comprehensive Care Plans Criteria 1 On 10/29/2015, the MDS nurse reviewed and updated Resident #29□s care plan to include the resident□s diagnosis of diabetes. On 10/29/2015, the director of nursing followed-up by verifying Resident #29□s care plan was updated to include the resident□s diagnosis of diabetes. On 10/29/2015, the MDS nurse also updated Resident #29□s Resident Care Guide to reflect the resident□s diagnosis of diabetes and the director of nursing verified the updated Resident Care Guide. On 10/29/2015, the MDS nurse reviewed and updated Resident #29□s care plan to include the resident□s problem area related to the use of an anticoagulant medication. On 10/29/2015, the director of nursing followed-up by verifying Resident #29□s care plan was updated to	

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F 279	Continued From page 2 nursing-related care plans, including those focusing on diabetes. Upon review of Resident #29 ' s care plan, Nurse #2 acknowledged a care plan related to the resident ' s diagnosis of diabetes had not been developed for this resident. The nurse reported a care plan focused on diabetes should have been in place for a resident with this diagnosis and indicated this area of focus had been missed in the care plan for Resident #29. An interview was conducted on 10/29/2015 at 10:50 AM with the facility ' s Director of Nursing (DON). During the interview, the DON noted she reviewed Resident #29 ' s care plan and acknowledged diabetes was not addressed. Upon inquiry, the DON stated she would have expected a diagnosis of diabetes to always be included in a resident's care plan, particularly when insulin was being used. The DON indicated both anticoagulation and diabetes were critical and potentially life-threatening issues that "absolutely" needed to be part of the resident's plan of care. 2) Resident #29 was admitted to the facility on 3/21/15, with re-entry from a hospital on 6/22/15. The resident ' s cumulative diagnoses included a history of pulmonary embolus / deep vein thrombosis (DVT) and long-term anticoagulant use. A review of Resident #29 ' s medical record revealed the resident ' s 6/22/15 admission medication orders included 4.5 milligrams (mg) warfarin (an anticoagulant medication) given as one tablet by mouth once a day. Resident #29 ' s International Normalized Ratio (INR) was monitored periodically and her dose of warfarin	F 279	include the resident□s problem area related to the use of an anticoagulant medication. On 10/29/2015, the MDS nurse also verified Resident #29□s Resident Care Guide included a notation which read Blood Thinner. On 10/29/2015, the director of nursing verified the accuracy of the Resident Care Guide. Criteria 2 On 10/29/2015, a 100% audit was initiated by the MDS nurse of all residents□ care plans and care guides. Care plans and care guides were updated based on findings. The audit was completed on 10/30/2015. On 11/19/2015, the director of nursing initiated an in-service with the MDS nurse regarding the development of care plans to address residents□ current diagnoses, to include diabetes and use of an anticoagulation medication. Criteria 3 On 11/19/2015, the director of nursing, MDS nurse, and/or QI nurse began auditing all new admissions, re-admissions, and any incidents to ensure care plans and care guides are updated, to include diagnosis of diabetes and/or anticoagulant medication. This audit will be completed during clinical meeting Monday □ Friday for one week, then weekly for one month, then monthly	

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F 279	Continued From page 3 adjusted as needed based on the lab results. INR is a laboratory blood test used to assess the level of anticoagulation achieved for a patient. A review of Resident #29 ' s admission MDS (Minimum Data Set) assessment dated 9/21/15 revealed the resident had intact cognitive skills for daily decision making. She required extensive assistance with all of her Activities of Daily Living (ADLs) with the exception of requiring supervision for locomotion off the unit and total dependence on staff for bathing. The MDS assessment also indicated the resident ' s medications included an anticoagulant on 7 out of the previous 7 days during the look back period. A review of Resident #29 ' s care plan (initiated on 9/15/15) revealed a problem area related to the use of an anticoagulant medication was not addressed for Resident #29. The Resident Care Guide included a notation which read, " Blood Thinner. " An interview was conducted on 10/29/2015 at 10:02 AM with Nurse #2. Nurse #2 assumed responsibility as the facility ' s MDS Nurse. During the interview, Nurse #2 reported that she was responsible for initiating and reviewing nursing-related care plans, including those focusing on anticoagulation. Upon review of Resident #29 ' s care plan, Nurse #2 acknowledged a care plan related to the use of an anticoagulant medication had not been developed for this resident. The nurse reported an anticoagulation care plan should have been in place for a resident receiving a medication such as warfarin and indicated this area of focus had been missed for Resident #29.	F 279	for two months. The audit will be documented on the Care Plan QI audit tool. Criteria 4 The director of nursing or quality improvement nurse will report the audit results to the Quality Improvement Committee. The Committee will review the results of the audits monthly and make recommendations as needed for continued compliance in this area and to determine the need for and/or frequency of continued Quality Improvement Committee monitoring.	

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F 279	Continued From page 4 An interview was conducted on 10/29/2015 at 10:50 AM with the facility ' s Director of Nursing (DON). During the interview, the DON noted she reviewed Resident #29 ' s care plan and acknowledged anticoagulation was not addressed. Upon inquiry, the DON stated she would have expected anticoagulation to always be included in a resident's care plan. The DON indicated both anticoagulation and diabetes were critical and potentially life-threatening issues that "absolutely" needed to be part of the resident's plan of care.	F 279		
F 329 SS=D	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 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.	F 329		11/25/15

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F 329	Continued From page 5	F 329		

This REQUIREMENT is not met as evidenced by:
Based on observations, medical record review and staff interviews, the facility failed to complete a laboratory test as ordered to determine the efficacy of a medication regimen for 1 of 5 residents (Resident #23) reviewed for unnecessary medications; and, administering an antibiotic to 1 of 1 resident (Resident #52) without a diagnosis.

The findings included:

1. Resident #23 was initially admitted to the facility on 5/19/15 and re-entered the facility on 6/12/15. The resident ' s cumulative diagnoses included Type 2 diabetes, hyperlipidemia (high levels of cholesterol and/or circulating lipids in the blood) and coronary artery disease.

A review of the resident's 6/12/15 medication orders included, in part: 75 milligrams (mg) clopidogrel (an antiplatelet medication) given as one tablet by mouth once daily; 40 mg rosuvastatin (an antilipemic or lipid-lowering agent) given as one tablet by mouth once daily at bedtime; and insulin aspart (a rapid acting insulin) administered based on a sliding scale regimen before meals and at bedtime. Medication orders written on 7/21/15 also included: 20 units insulin detemir (a long acting insulin) injected subcutaneously (under the skin) every night at bedtime; and 20 mg furosemide (a diuretic) given as one tablet by mouth daily.

Resident #23's most recent quarterly Minimum

F329

Drug Regimen is Free From Unnecessary Drugs

Criteria 1

On 10/29/2015, the director of nursing assessed Resident #23 with no negative findings. On 10/29/2015, the director of nursing contacted Resident #23□s physician regarding an indication for the continued need for a laboratory test as ordered to determine the efficacy of a medication regimen. On 10/29/2015 Resident #23□s physician gave the order for Hgb A1c and CMP. On 10/29/2015 the director of nursing ensured the physician□s order was carried out. On 10/29/2015 the laboratory samples were drawn and sent to Baptist Hospital. On 10/29/2015 the director of nursing verified the laboratory results were added to Resident #23□s medical chart and the physician was notified. On 10/29/2015 the physician gave no new order in response to the new laboratory results.

On 10/28/2015, Resident #52's assigned staff nurse contacted the resident's physician regarding Resident #52's laboratory results for UA/C&S. A new order was received to discontinue the Rocephin and Resident #52 would see the

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F 329	Continued From page 6 Data Set (MDS) assessment was dated 8/6/15. The MDS indicated Resident #23 had moderately impaired cognitive skills for daily decision making. He required extensive assistance from staff for all of his Activities of Daily Living (ADLs), with the exception of requiring limited assistance for locomotion on/off the unit and supervision only for eating. The MDS assessment also revealed Resident #23 received an insulin injection on 7 out of 7 days during the look back period. A review of Resident #23's medical record included a Note to Attending Physician/Prescriber dated 8/24/15 and authored by the facility's consultant pharmacist. The note read, "This resident has an order for insulin. Please obtain a hemoglobin A1c (a laboratory test which is a weighted average of blood glucose levels over the previous 3 months) at the next convenient lab draw, then every three months thereafter per the lab protocol. I also don't see a fasting lipid panel or liver enzymes posted on the chart or in PCC (referring to Point Click Care, the computer software system)." The Note to Attending Physician/Prescriber was signed and dated by the Nurse Practitioner on 9/17/15. On 9/17/15, a physician's order was received and placed on the resident's chart which read, "Hgb A1c (hemoglobin A1c) ...CMP (Comprehensive Metabolic Profile), fasting lipid panel ... " A Comprehensive Metabolic Panel is laboratory blood test which serves as a broad screening tool to evaluate the chemical status of a patient; it is used to review renal function, liver function, and electrolyte and fluid balance. A review of Resident #23's electronic and paper medical record revealed the laboratory test	F 329	physician during the physician's next visit to the facility. On 10/29/2015, the assigned staff nurse assessed Resident #52 with no negative findings. On 10/29/2015, the staff facilitator initiated a lab audit to ensure laboratory tests were completed as ordered by the physician. On 11/19/2015, the director of nursing, the QI nurse, and the day shift staff nurse initiated a 100% audit of pharmacy review recommendations for the past three months to ensure stop dates for medications, discontinuation of medications, indications for usage of medications, and associated laboratory tests were completed as ordered by the physician. Criteria 2 On 10/29/2015, the director of nursing, QI nurse, and staff facilitator initiated a 100% audit of all ordered labs from 09/1/2015 through 10/29/2015 to ensure all labs were obtained as ordered. All identified discrepancies were immediately addressed by the director of nursing, QI nurse, and/or staff facilitator. On 11/19/2015, the director of nursing, QI nurse, and the day shift staff nurse initiated a 100% audit of pharmacy review recommendations for the past three months to ensure stop dates for medications, discontinuation of medications, indications for usage of	

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F 329	Continued From page 7 results ordered on 9/17/15 were not available. On 10/28/15 at 3:30 PM, an interview was conducted with the facility's Director of Nursing (DON) and a request was made for assistance in locating the 9/17/15 laboratory results. An interview was conducted on 10/28/2015 at 5:15 PM with the facility's Director of Nursing (DON) upon her request. At that time, the DON indicated it was discovered the lab work ordered on 9/17/15 had not been done. She stated that Resident #23's Medical Doctor (MD) was notified that afternoon and an order was received for stat (immediate) blood work. The blood work had just been drawn and would be sent to the lab; the laboratory results were expected to be returned the next day on 10/29/15. The DON discussed the facility's procedures for obtaining laboratory tests ordered. She reported once a lab was ordered, the lab request was filed in a lab book. The lab book (binder) was tabbed by date to indicate when the lab needed to be completed. The DON reported that while stat labs were collected on the day they were ordered, routine lab tests were scheduled for the next lab draw day (Mondays and Thursdays of each week). She stated after lab results were returned to the facility, they were put into the MD Communication Book for review. After the resident's MD reviewed these results, they were sent to Medical Records to be scanned and/or placed in the resident's medical record. The DON indicated she would have expected Resident #23's laboratory tests to be done in accordance with the 9/17/15 order. An interview was conducted on 10/29/15 at 9:47 AM with the facility's Charge Nurse. During the	F 329	medications, and associated laboratory tests were completed as ordered by the physician. On 11/19/2015, the director of nursing initiated a 100% in-service of licensed nursing staff on documenting the indication for medications ordered by the physician and discontinuing unnecessary medications. No licensed nursing staff will be allowed to complete a work shift after 11/25/2015 without completing the in-service. All new licensed nursing staff will be educated by the director of nursing and/or QI nurse, during the orientation process, on documenting the indication for medications ordered by the physician and discontinuing unnecessary medications. On 11/19/2015, the director of nursing initiated a 100% in-service of licensed nursing staff on laboratory tests to include how to write a lab order, how to complete a lab requisition form, what to do if a lab sample could not be obtained, how to ensure the lab result was received and the physician notified accordingly. No licensed nursing staff will be allowed to complete a work shift after 11/25/2015 without completing the in-service. All new licensed nursing staff will be educated by the director of nursing and/or QI nurse, during the orientation process, on laboratory test to include how to write a lab order, how to complete a lab requisition form, what to do if a lab sample could not be obtained, how to ensure the lab result was received and the physician	

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F 329	Continued From page 8 interview, the Charge Nurse reviewed the process employed for ordering and obtaining labs. She also indicated a laboratory log in the lab book was found to include the 9/17/15 lab work ordered for Resident #23 and, according to the log, the lab work should have been drawn on 9/21/15. The Charge Nurse reported a lab request form would have been computer-generated or hand-written by the hall nurse; the request form would have served as a communication tool with the lab. Upon inquiry, the Charge Nurse reported a copy of the request form would not have been retained by the facility after the lab was collected. The Charge Nurse identified Nurse #1 as the nurse who had received the 9/17/15 order for Resident #23's lab work and noted these lab tests on the lab log. An interview was conducted on 10/29/15 at 9:48 AM with Nurse #1. Upon inquiry, Nurse #1 reported she thought she may have filled out a hand-written lab request (versus computer-generated) on 9/17/15 and placed it into the lab binder under date tab for Resident #23. A follow-up interview was conducted on 10/29/2015 at 11:51 AM with the DON. Upon inquiry, the DON stated her expectation was for lab work to be done as ordered by the physician and in a timely manner. She also added that if the lab could not be obtained as ordered, she would expect the resident's physician to be notified accordingly. 2. Resident #52 was admitted to the facility on 10/8/13 with diagnoses which included: Alzhimer's disease, dementia with behaviors, anxiety disorder, and cognitive commuenication	F 329	notified accordingly. Criteria 3 On 11/19/2015, the director of nursing initiated the use of the Medication Review QI audit tool. The Medication Review QI audit tool will review: 1)if all ordered laboratory tests were completed, 2) if all medication orders are updated and transcribed correctly and discontinued timely, 3) if care guides and care plans are updated. The audit tool will audit 100% of all new orders. The Medication Review QI audit tool will be completed by the director of nursing and/or QI nurse twice weekly for 4 weeks, twice monthly for 8 weeks, then once monthly for 12 weeks. Any negative findings will be addressed by the director of nursing and/or QI nurse. On 11/23/2015, to protect residents in similar situations, the director of nursing initiated a new system to ensure the problem does not recur by securing the assistance of two licensed nurses to check the new resident admission paperwork and paperwork from other health care provider consultations to ensure orders for laboratory tests are logged in the laboratory schedule book. The licensed nurses are checking 100% of the new resident admission paperwork and paperwork from other health care provider consultations five times weekly. This will be done by the two identified licensed nurses for three months and continued as determined by the Quality	

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F 329	Continued From page 9 deficit. Review of the annual MDS (Minimum Data Set) dated 9/28/15 indicated Resident #52 was severely, cognitively impaired and had verbal, physical, and wandering behaviors with a history of falls. A Review of the clinical record indicated that on 10/23/15 Resident #52 had increased behaviors and refused to take her oral medications. The review of the Physician's telephone orders dated 10/23/15 revealed urinalysis and culture and sensitivity tests were ordered for Resident#52, via in and out catheterization due to the resident's confusion and increased behaviors. An Incident Note dated 10/25/15 revealed Resident #52 had a fall resulting in a hematoma/bruise to her forehead. The resident was agitated/combative during the neurological assessments. The Physician and the resident's Responsible Party were notified. The Nurse also noted that the facility was waiting on the urinalysis and culture and sensitivity results. The Nurse's Note dated 10/25/15 revealed that after visiting with Resident #52, the resident's family wanted her treated for a UTI (urinary tract infection). The family informed the nurse that the resident would frequently develop UTIs, with increased behaviors being an indicator and the resident would hold herself "down there" as if it was bothering her. The Nurse's Note (10/25/15) also revealed that the resident had refused food and fluids all day. The Physician was notified and ordered IM	F 329	Improvement Committee. On 11/23/2015, to protect residents in similar situations and ensure the problem does not recur, the director of nursing and/or QI nurse began bringing the laboratory book to the clinical morning meeting, held five times weekly, for review to ensure laboratory results are obtained, communicated to the physician and physician's response and/or new orders are carried out. Any identified issues are immediately addressed by the director of nursing and/or QI nurse. This revised system will be done for three months and continued as determined by the Quality Improvement Committee. Criteria 4 The director of nursing and/or QI nurse will report the audit results to the Quality Improvement Committee. The Committee will review the results of the audits monthly and make recommendations as needed for continued compliance in this area and to determine the need for and/or frequency of continued Quality Improvement Committee monitoring.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 10 Rocephin (antibiotic medication) 1 gram at that time, and then daily for five days, with order for in and out catheterization. Review of Resident's clinical record revealed no diagnosis for the IM Rocephin. The Nurse's Note dated 10/26/15 indicated a urine sample was collected from Resident #52 for urinalysis and culture and sensitivity, and the Courier was called for lab stat (immediately). Review of the laboratory tests drawn on 10/26/15 revealed the urinalysis and culture and sensitivity results of Resident #52's urine sample were negative for urinary tract infection. On 10/27/15 at 10:30am, Resident #52 was observed propelling herself in a wheelchair near the nurse's station. The resident was continuously standing up and sitting down in her wheelchair, agitated. A staff nurse gave the resident a stuffed animal which calmed her, then the resident slowly propelled herself down the hallway. Review of a Nurse's Note dated 10/28/15 revealed Resident #52 continued with the antibiotic therapy for urinary tract infection. During an interview on 10/29/15 at 1:05pm, the DON (Director of Nursing) stated that her expectation was for the nurse who collected the specimen to either call the Laboratory Courier for specimen pick up or (due to the time of night) pass on the information to the next shift's nurse during shift report.	F 329		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS	F 431		11/25/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345354	A. BUILDING _____ B. WING _____	10/29/2015

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F 431	Continued From page 11 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. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to properly store medication	F 431	F431	

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F 431	Continued From page 12 requiring refrigeration as specified by the manufacturer on one of three medication carts (700 Hall medication cart). The findings included: The manufacturer's product information for Forteo (an injectable medication used for the treatment of osteoporosis) read, in part: "Storage and Handling - · The Forteo delivery device should be stored under refrigeration at 2 to 8 degrees Celsius (36-46 degrees Fahrenheit) at all times. · During the use period, time out of the refrigerator should be minimized; the dose may be delivered immediately following removal from the refrigerator." An observation of the 700 Hall medication cart on 10/29/15 at 7:55 AM revealed one Forteo injection prefilled syringe labeled for Resident #101 was stored in the cart. The syringe was labeled with a pharmacy auxiliary sticker which read, "Refrigerate." It was also labeled as dispensed from the pharmacy on 10/28/15. A review of Resident #101 ' s medical record revealed a current Physician Order was written on 10/28/15 for the Forteo medication. An interview was conducted on 10/29/15 at 8:00 AM with Nurse #1. Nurse #1 was the 700 Hall nurse assigned to the medication cart. Upon review of the Forteo and its labeling, Nurse #1 indicated the Forteo syringe must have been delivered the night before and mistakenly put on the cart. The nurse confirmed the Forteo syringe needed to be refrigerated. An interview was conducted on 10/29/15 at 10:50	F 431	Drug Records, Label/Store Drugs & Biologicals Criteria 1 On 10/29/2015, the 700 hall day shift nurse immediately discarded the Forteo injectable medication for Resident #101. On 10/29/2015, the 700 hall day shift nurse contacted Resident #101□s physician and the pharmacy to secure a replacement Forteo injectable medication. Criteria 2 On 10/29/2015, under the supervision of the director of nursing the staff nurses completed a 100% audit of all medication carts and medication rooms for the proper labeling and storage of drugs and biologicals. Any improperly stored medications were immediately discarded and replacements ordered. On 10/29/2015, the director of nursing initiated a 100% in-service of licensed nursing staff on the proper labeling and storage of drugs and biologicals, including the need to refrigerate Forteo injectable medication, in accordance with the manufacturer□s recommendations and auxiliary information from the pharmacy. On 11/19/2015, the director of nursing initiated an additional in-service for 100% of licensed nurses and medication aides. The in-service covered F431 drug records, label/store drugs and biological, and specifically the manufacturer's	

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F 431	Continued From page 13 AM with the facility ' s the Director of Nursing (DON). During the interview, the storage of the Forteo syringe on the medication cart was discussed. Upon inquiry, the DON indicated she was familiar with the Forteo medication and the need to keep it refrigerated at all times. The DON indicated she would have expected this medication to have been refrigerated in accordance with the manufacturer ' s recommendations and auxiliary information from the pharmacy.	F 431	product information for Forteo storage and handling. Criteria 3 On 10/29/2015, the director of nursing and QI nurse, with the assistance of the medication aide, initiated random visual checks of medication carts, medication room refrigerators, and medication room shelves to ensure medications and biologicals are properly labeled and stored. On 11/19/2015, the Qi nurse, treatment nurse, and staff nurses, with the assistance of the medication aide, initiated 100% audits of all medication carts, all treatment carts, all medication room refrigerators, and all medication room shelves to ensure medications and biological are properly labeled and stored. These audits will be documented on the Medication Storage QI audit tool. The Medication Storage QI audit tool will be completed by the QI nurse and staff nurses, with the assistance of the medication aide, twice weekly for 4 weeks, twice monthly for 8 weeks, then once monthly for 12 weeks. Any negative findings will be immediately addressed by the QI nurse and staff nurses. The director of nursing will review the completed audit tools weekly, signified by the director of nursing□s initials in the lower right corner of the audit tools. Criteria 4	

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F 431	Continued From page 14	F 431	The director of nursing and/or quality improvement nurse will report the audit results to the Quality Improvement Committee. The Committee will review the results of the audits monthly and make recommendations as needed for continued compliance in this area and to determine the need for and/or frequency of continued Quality Improvement Committee monitoring.	