STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345413	A. BUILDING ______ B. WING ______	02/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLESHERS FAIRVIEW HEALTH CARE	3016 CANE CREEK ROAD FAIRVIEW, NC 28730

(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 241 SS=D	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, medical record review and staff interview the facility failed to assist a resident to eat in a manner to maintain dignity for 1 of 2 sampled dependent residents. (Resident #118) The findings included: Resident #118 was admitted to the facility on 09/16/15 with diagnoses which included diabetes and Alzheimers dementia. The latest Minimum Data Set (MDS) assessment for Resident #118 was a quarterly assessment dated 12/23/15 which noted severe cognitive impairment and extensive assistance of one staff member with eating. The current care plan for Resident #118 dated 01/06/16 included a problem area, Impaired Nutrition related to poor appetite with significant weight loss X 30 days. Approaches to this problem area included: Feed if not feeding self. On 02/16/16 observations were made of Resident #118 during the lunch meal from 12:04 PM-1:57 PM. Resident #118 was in his room at the time of the observations which he shared with another resident. Observations of the lunch meal on 02/16/16 included the following:	F 241	The CNA responsible for dressing the resident has been counseled regarding procedures to have all residents up and dressed by 10 am unless resident request not to get up or orders say otherwise. The CNA responsible for feeding the resident has been counseled on providing privacy and dignity to residents - covering resident, pulling privacy curtains, and closing doors. In service to all CNA's on having residents up and dressed by 10am unless otherwise stated and review of policies/procedures on resident dignity and privacy. QA Coordinator will ensure monitoring of hallways and resident rooms 4 times weekly to ensure residents up and dressed by 10am and privacy and dignity maintained. This will be documented and turned into the QA coordinator weekly for review of compliance and then reviewed in the quarterly QA committee meeting to ensure effectiveness of plan of correction, need for changes, if any. This will continue to be monitored until 3 months of compliance maintained to ensure	3/18/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — Electronically Signed
TITLE
(X6) DATE 03/02/2016

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 241	Continued From page 1 12:35 PM-The lunch trays were delivered to the hall Resident #118 resided. The roommate of Resident #118 was served his lunch tray. Resident #118 was observed in bed, wearing only an incontinent brief, with his upper body and lower body exposed. The privacy curtain was not pulled between Resident #118 and his roommate and the door was open to the room leaving Resident #118 exposed to both his roommate and anyone in the hallway. 1:02 PM-The roommate of Resident #118 had finished eating and the tray for Resident #118 was brought into the room at this time by Nurse Aide #1. Nurse Aide #1 sat at the bedside of Resident #118, placed a napkin on his bare chest and began to feed him. Resident #118 remained clothed only in the incontinent brief and Nurse Aide #1 did not pull the privacy curtain, attempt to cover Resident #118 or shut the door to the room. Resident #118 was fed the entire meal exposed to the roommate and anyone that passed by the doorway. On 02/18/16 at 12:05 PM Nurse Aide #1 stated that during meals nursing assistants either went to the dining room to assist with feeding or stayed on the hall to assist residents that chose to eat in their rooms. Nurse Aide #1 stated on 02/16/16 she was assigned to assist residents on the hall during the lunch meal. Nurse Aide #1 stated she was not responsible for Resident #118 on 02/16/16 but was assisting residents on the wing he resided to distribute trays. Nurse Aide #1 stated she was upset when she saw Resident #118 had not been assisted to eat at 1:02 PM. Nurse Aide #1 stated she knew she should always protect a residents privacy and should have pulled the sheet over Resident #118, pulled the privacy curtain or closed the door to the room	F 241	compliance is achieved and maintained.	

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F 241	Continued From page 2 when she entered the room to assist with feeding. Nurse Aide #1 stated she did not know why Resident #118 was not clothed and was not aware of the resident ever refusing to be clothed. Nurse Aide #1 stated she should not have fed Resident #118 with him exposed to his roommate and the hallway. On 02/19/16 at 12:07 PM Nurse Aide #2 stated she was responsible for Resident #118 on 02/16/16. Nurse Aide #2 stated she had been so busy that morning she was not able to dress Resident #118 until after the lunch meal. On 02/19/16 at 3:45 PM the Director of Nursing (DON) stated she expected residents to be dressed before the lunch meal was served. The DON stated she was not aware of Resident #118 ever refusing to be dressed and that he should not have been left or fed exposed to his roommate or the hallway. The DON stated she would have expected the cover to be placed over Resident #118, the privacy curtain pulled and/or the doorway shut.	F 241		
F 276 SS=D	483.20(c) QUARTERLY ASSESSMENT AT LEAST EVERY 3 MONTHS A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews, the facility failed to complete and submit a quarterly Minimum Data Set (MDS)	F 276	The MDS for the affected resident was completed.	3/18/16

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F 276	Continued From page 3 assessment due 01/28/16 for 1 of 16 residents reviewed (Resident # 52). The findings included: Resident #52 was admitted to the facility on 07/30/15. The admitting Minimum Data Set (MDS) indicated Resident #52 had diagnosis which included Alzheimer's disease and depression. The MDS also indicated Resident #52 required extensive assistance with bed mobility, transfers, dressing, toileting, hygiene and total assistance with bathing. The MDS further indicated Resident #52 was occasionally incontinent of urine and always incontinent of bowel. Review of the medical record on 02/18/16 at 11:55AM revealed an MDS quarterly assessment dated 01/28/16 had not been completed. The quarterly assessment was due to be closed and submitted no later than 02/10/16. None of the areas requiring assessment had been completed in the electronic record. During a staff interview with MDS Nurse #2 on 02/18/16 at 12:01PM it was revealed the MDS Coordinator's put in the sections for Social Services and Dietary after they complete their sections on paper. Both areas had been completed on paper on 01/28/16, but had not been entered into the electronic MDS. MDS Nurse #2 further stated she had not been able to gather her information for the MDS, input the Social Services and Dietary information and was running behind on putting this assessment in. MDS Nurse #2 acknowledged the quarterly MDS for Resident #52 was past due. During an interview on 02/19/16 at 2:37PM, the Director of Nursing (DON) acknowledged the	F 276	The MDS Coordinator responsible for completing the MDS has been counseled regarding the policies and procedures for completing the Quarterly MDS timely. QA Coordinator will ensure monitoring of the Quarterly MDS completion weekly using the list of Quarterlies due that week to make sure they are completed on time. This will be documented and turned into the QA coordinator weekly for review of compliance and then reviewed in the quarterly QA committee meeting to ensure effectiveness of plan of correction, need for changes, if any. This will continue to be monitored until 3 months of compliance maintained to ensure compliance is achieved and maintained.	

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F 276	Continued From page 4 MDS had not been completed during the quarter and she expected the assessments to be completed as they were due.	F 276		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the	F 278	The MDS Coordinators were counseled	3/18/16

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F 278	Continued From page 5 facility failed to accurately assess 2 of 19 sampled residents utilizing the Minimum Data Set (MDS) in the area of pressure ulcers (Resident #115) and area of active diagnoses (Resident #21). The findings included: 1. Resident #115 was admitted to the facility on 10/6/15 with a pressure ulcer. A record review of the hospital discharge summary dated 10/06/15 indicated Resident #115 had a stage II sacral pressure ulcer. Nurse's notes dated 10/7/15 revealed Resident #115 had a stage II pressure ulcer. The physician's history and physical dated 10/08/15 indicated Resident #115 had a sacral pressure ulcer. The admission MDS dated 10/13/15 indicated Resident #115 was coded under Section M/Skin Conditions as having no unhealed pressure ulcer (s) at stage I or higher. On 02/19/16 at 9:11 AM an interview was conducted with MDS Nurse #1 who stated she reviewed the hospital discharge summary, nurse's notes, and physician's history and physical and missed that Resident #115 had a pressure ulcer. MDS Nurse #1 stated she miscoded the admission MDS dated 10/13/15 and should have coded Resident #115 had a stage II pressure ulcer. On 02/19/16 at 9:39 AM an interview was conducted with the Director of Nursing (DON)	F 278	on accuracy of MDS and Diagnosis listed on the MDS. QA coordinator will ensure monitoring of accuracy and diagnosis listed on the MDS. Charts of all resident's having pressure ulcers will be reviewed weekly to ensure they are documented accurately on the MDS. Charts of all new admissions will be reviewed against the completed MDS to verify that diagnosis are correct weekly as new admission MDS are completed. This will be documented and turned into the QA coordinator weekly for review of compliance and then reviewed in the quarterly QA committee meeting to ensure effectiveness of plan of correction, need for changes, if any. This will continue to be monitored until 3 months of compliance maintained to ensure compliance is achieved and maintained.	

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F 278	Continued From page 6	F 278		

who stated her expectation was that MDS Nurse #1 would have coded the admission MDS assessment dated 10/13/15 correctly to reflect Resident #115 had a pressure ulcer. The DON stated her expectation was that MDS Nurse #1 would have communicated with the wound care nurse and would have accurately coded the admission MDS assessment to reflect Resident#115 had a pressure ulcer.

2. Resident #21 was admitted to the facility 12/07/15. The admitting Minimum Data Set (MDS) assessment dated 12/17/15 had no diagnoses listed. The MDS further revealed Resident #21 required extensive assistance with bed mobility, dressing, eating, personal hygiene, toileting, transfers and total assistance with bathing.
Medical records reviewed on 02/18/16 at 8:47AM revealed a faxed copy of the FL-2 (a list of resident information, diagnoses, medications and special care factors information completed by a physician) was noted in the chart with received date of 11/24/15. The diagnoses listed on the FL-2 included Traumatic Brain Injury (TBI), hypothyroidism, hyperlipidemia and hypertension. None of these diagnoses are listed on the admitting MDS.

During an interview with MDS Nurse #2 on 02/18/16 at 10:01AM, it was revealed the diagnoses for the initial assessment were gathered from information from the hospital, a previous facility or an FL-2. MDS Nurse #2 stated there was some confusion about listing the diagnoses on the admitting MDS, therefore she did not list them in the assessment.

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F 278	Continued From page 7 During an interview with the Director of Nursing (DON) on 02/19/16 at 2:37PM, the DON acknowledged her expectations were for the MDS coding to be accurate.	F 278		
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 resident and staff interviews and medical record review the facility failed to administer medications consistent with orders sent on admission for 1 of 6 sampled residents with medications reviewed. (Resident #85). The findings included: Resident #85 was admitted to the facility 10/14/15 after hospitalization for surgical repair of a femur fracture. Hospital records located in the medical record of Resident #85 noted a diagnosis of hyperthyroidism with a daily dose of 10 milligrams of Methmazole used for treatment. Hospital discharge records included a list of medications for Resident #85 on admission to the facility. These discharge records included the 10 mg of Methmazole. Review of the facility admission physician orders and Medication Administration Records (MARS) from October 2015-February 2016 noted the Methmazole had not been ordered or administered for Resident #85.	F 281	TSH level was drawn on the affected resident and medications started as ordered. The nurse making the transcription error has been counseled. A new system was put in place in January 2016 where DON/ADON or other designated nurse double checks and verifies that all orders from hospital are transcribed to the facility admission records to ensure they are accurate. The affected resident was admitted prior to that date. QA coordinator to ensure monitoring of admission orders on all admissions and re-admissions to double check and verify that all orders from hospital discharge record are transcribed accurately to the facility admission records. This will be documented and turned into	3/18/16

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F 281	Continued From page 8 Review of labwork in the medical record of Resident #85 noted a thyroid stimulating hormone (TSH) level drawn on 10/23/16 with a level of .414 with a normal reference range of .40-5.40. On 02/18/16 at 3:50 PM the Director of Nursing (DON) reviewed the hospital discharge records and admission orders for Resident #85 and verified the Methmazole had been omitted when the admission orders were written. The DON called the Family Nurse Practitioner (FNP) of Resident #85 to inform her of the omission and the FNP requested a TSH level drawn to determine the dosage of Methmazole to initiate for Resident #85. On 02/19/16 at 9:56 AM Nurse #1 verified she admitted Resident #85 on 10/14/15 and wrote the admission physician orders. Nurse #1 reviewed the hospital discharge orders that were used to write the admission physician orders for Resident #85 and stated she missed the order for the Methmazole. On 02/19/16 a TSH was drawn on Resident #85 and the results were .396 with a normal reference range of .4-5.4. In an interview on 02/19/16 at 3:55 PM the DON stated the FNP was informed of the TSH results for Resident #85 with orders to obtain another TSH level in 2 months and begin 5 mg of Methmazole.	F 281	the QA coordinator weekly for review of compliance and then reviewed in the quarterly QA committee meeting to ensure effectiveness of plan of correction, need for changes, if any. This will continue to be monitored until 3 months of compliance maintained to ensure compliance is achieved and maintained.	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of	F 282		3/18/16

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F 282	Continued From page 9 care. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews the facility failed to obtain weights for 2 of 5 sampled residents reviewed for nutritional concerns. (Resident #85 and #118). The findings included: 1. Resident #118 was admitted to the facility on 09/16/15 with diagnoses which included diabetes and Alzheimers dementia. The admission weight for Resident #118 was 183 pounds. Orders on admission included, weekly weights for four weeks. The current care plan for Resident #118 included the problem area, Impaired Nutrition related to poor appetite with significant weight loss X 30 days (current weight 173). Approaches to this problem area included:-monitor weights as indicated. A progress note by the facility Registered Dietician (RD) on 12/23/15 read, "Resident noted to have had significant weight loss X 30 days; oral intake decreased and there are times that resident refuses to open mouth to eat; takes liquids better. Not belligerent when refusing to eat, he just stares blankly without responding; will continue weekly weights, add supplement and review tray card to ensure high calorie beverages available. Review of the weight record in the electronic medical record of Resident #118 noted the	F 282	The CNA's responsible for obtaining the weights have been counseled. In-service done with all CNA's regarding policies and procedures for obtaining and documenting weights. New procedures put in place to help with communicating what weights are ordered. Dietician will give her weekly weight list to the bath team who obtains the weights and to the DON. If orders are written by the physician a copy of these orders will be placed in the Dietician box so that she is aware to add them to her list that she distributes. QA Coordinator will ensure monitoring of weights obtained as ordered. Resident's with weekly weights ordered will be checked weekly to ensure they were performed and documented. All residents' records will be checked monthly to ensure that the monthly weight was performed and documented. This will be documented and turned into the QA coordinator weekly for review of compliance and then reviewed in the quarterly QA committee meeting to ensure effectiveness of plan of correction, need for changes, if any. This will continue to be monitored until 3 months of compliance maintained to ensure	

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following weights:

10/02/15-183 pounds
10/09/15-185 pounds
10/20/15-184 pounds
11/02/15-185 pounds
12/08/15-173 pounds
12/15/15-173 pounds
12/21/15-171 pounds
12/22/15-171 pounds
12/28/15-173 pounds

On 02/18/16 at 3:15 PM the RD stated she had just received the February weight sheet which noted an undated February weight for Resident #118 of 156 pounds. The RD reviewed the January 2016 monthly weight sheet and stated she did not realize Resident #118 had not been weighed in the month of January. In a follow-up interview on 02/19/16 at 8:10 AM the RD stated she was unable to find any weekly weights for Resident #118 from 12/28/15 until the monthly weight was done in February. The RD stated she was responsible for providing a list to the team of nursing assistants that weigh residents. The RD could not explain why weights had not been done for Resident #118 since 12/28/15 though she noted interventions had been put into place to address the resident's weight loss. On 02/19/16 at 4:00 PM the RD stated a re-weight had just been done on Resident #118 and that weight was 163 pounds.

On 02/19/16 at 3:25 PM the Director of Nursing (DON) stated she expected all residents to be weighed at least monthly with results placed in the electronic medical record. The DON stated the RD generated a list of residents that needed to be weighed weekly and those weights would

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F 282	Continued From page 11	F 282		

also be placed in the electronic medical record. The DON stated she expected monthly and weekly weights to be done as recommended.

2. Resident #85 was admitted to the facility 10/14/15 with diagnoses which included anemia, fractured femur with repair, hyperthyroidism and Chron's disease. The admission weight for Resident #85 was 195 pounds. The care plans for Resident #85 (with review dates of 10/20/15 and 01/18/16) did not address nutritional concerns.

Review of the weight record in the electronic medical record of Resident #85 included the following weights since admission:

11/02/15-187 pounds
12/08/15-181 pounds
01/07/16-181 pounds
02/16/16-178 pounds

Review of physician orders noted an order written on 01/06/16 to, Obtain weekly weights, record in caretracker (the electronic medical record). Report unexplained weight loss if more than five pounds to physician.

Review of the caretracker electronic medical record revealed weekly weights had not been done on Resident #85 after the weight of 01/07/16. Review of the "Vital Sign and Weight Record" sheet in the medical record of Resident #85 did not include weekly weights from 01/07/16-02/16/16.

Review of the Medication Administration Record (MAR) for Resident #85 noted the need for weekly weights was included with dates blocked off and signed as completed by Nurse #4 on

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	345413	A. BUILDING ______ B. WING ______	02/19/2016

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F 282	Continued From page 12	F 282		

01/07/16, 01/14/16, 01/21/16, 02/04/16, 02/11/16 and 02/18/16. On 02/18/16 at 2:30 PM Nurse #4 stated when she signed the MAR for weekly weights for Resident #85 it indicated she informed the nursing assistant assigned to the resident to obtain a weight. In a follow-up interview on 02/19/16 at 10:26 AM Nurse #4 stated she depended on the nursing assistant to obtain the weight and document the weight in the caretracker electronic system. Nurse #4 stated if the nursing assistant reported the weight to her she would also document it on the Vital Sign and Weight Record sheet in the resident's medical record. Nurse #4 stated she was not aware the nursing assistants had not obtained the weights on 01/14/15, 01/21/16, 02/04/16 and 02/11/16.

On 02/18/16 at 2:43 PM the Registered Dietician (RD) stated she was not aware Resident #85 had a 01/06/16 order for weekly weights. The RD stated she did not receive orders from nursing staff for weekly weights and the weekly weights she requested were for residents' with significant weight changes and new admissions. The RD indicated nursing staff were responsible for weekly weights ordered by the physician noting the need would be placed on the individual resident's MAR.

On 02/19/16 at 3:25 PM the Director of Nursing (DON) stated she expected all residents to be weighed at least monthly with results placed in the electronic medical record. The DON stated if a resident needed to be weighed weekly and the need was not generated by the RD, the nursing assistants were responsible for obtaining the weight and documenting it in the electronic medical record. The DON stated she expected weekly weights to be done as ordered by the

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F 282	Continued From page 13 physician.	F 282		
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 remove boxes containing food items from the freezer floor, label and date previously opened food items in the freezer, and discard dairy items out of date in the refrigerator. The findings included: During the initial tour of the kitchen with the Dietary Manager (DM) beginning at 9:40AM on 02/16/16, the following was revealed: 1) In the freezer 3 cardboard boxes containing 48 4 oz. containers of ice cream were stacked on top of each other on the floor. 2) In the freezer 1 cardboard box containing 75 4 oz. cartons of a nutritional shake was sitting on the floor. 3) In the freezer an open bag containing 3 chicken patties and an open bag containing popcorn shrimp were unlabeled and undated. 4) In the refrigerator a gallon of milk with less than 25 percent of the contents had an expiration date on 12/17/15 and a 5 lb. plastic container of	F 371	Items stored improperly on floor have now been stored properly. Unlabeled and undated or outdated items were discarded. In-service done with all dietary staff regarding proper storage, labeling and dating of food as well as discarding outdated foods reviewed. QA Coordinator will ensure monitoring of food storage areas for proper storage, labeling/dating and outdated items 3 times weekly. This will be documented and turned into the QA coordinator weekly for review of compliance and then reviewed in the quarterly QA committee meeting to ensure effectiveness of plan of correction, need for changes, if any. This will continue to	3/18/16

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F 371	Continued From page 14 Sour Cream with less than 25 percent of its contents had an expiration date of 02/09/16. During the initial tour the DM also acknowledged the boxes should not be on the floor in the freezer, opened food should be labeled and dated in the freezer and out of date items should be thrown away. During a second interview with the DM on 02/19/16 at 3:38 PM, it was indicated that the ice cream and nutritional shakes had been delivered the morning of 02/16/16. The DM further indicated she had told staff in the last week, including that morning, not to put the boxes on the floor, but to put the stock on the shelves.	F 371	be monitored until 3 months of compliance maintained to ensure compliance is achieved and maintained.	
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.	F 431		3/18/16

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F 431	Continued From page 15 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, record review, and staff interviews, the facility failed to label one bottle of nystatin powder with resident name and indication for use, two plastic punch cards of extra strength simethicone anti-gas capsules with resident name and indication for use in 2 of six medication carts viewed, and an opened vial of tuberculin vaccination with date vial had been opened in one of two medication room refrigerators viewed. Findings included: Centers for Disease Control and Prevention Guidelines for the disposal of a multi-dose vial: · If a multi-dose has been opened or accessed, the vial should be dated and discarded within 28 days unless the manufacturer specifies a different date for that opened vial. An observation of the medication cart for the 600 hall on 02/19/16 at 1:00 PM revealed one bottle of nystatin topical powder 15 gram (GM) with no pharmacy label. Further observation revealed the	F 431	The unlabeled and undated items have been removed and discarded. In-service with nurses regarding labeling of medication and dating of medication vials once opened. Reviewed specifically leaving the medication in the original box or bag that has the resident name and dispensing instructions, etc. and keeping it in the box or bag once opened. QA Coordinator will ensure monitoring of medication carts and medication storage refrigerators weekly to check that all items are properly dated and labeled. This will be documented and turned into the QA coordinator weekly for review of compliance and then reviewed in the quarterly QA committee meeting to ensure effectiveness of plan of correction, need for changes, if any. This will continue to be monitored until 3 months of compliance maintained to ensure	

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F 431	Continued From page 16 400 hall medication cart had two plastic punch packets of extra strength simethicone anti gas capsules with no pharmacy label, and were not in any packaging to indicate use. Further observation of the refrigerator located in the medication room on the Floren Unit revealed an open vial of tuberculin vaccination, with no label to indicate when the bottle had been opened. An interview with Nurse #3 on 02/19/16 at 1:05 PM verified one bottle of nystatin topical powder and two plastic punch packets of extra strength simethicone anti gas capsules found in the medication carts were not properly labeled with the resident's name and indication for use. She further stated the nystatin powder was for a resident, but did not know for sure which resident. She stated she did not know who the extra strength simethicone capsules were for, or even why they were in the medication cart. She stated any medication not properly labeled should have been taken out of the medication cart and put in the pharmacy box to be returned. An interview with Nurse # 2 on 02/19/16 at 2:45 PM verified one bottle of tuberculin vaccination had been opened and did not have a label on the bottle or box to indicate when it had been opened. She stated the medication nurse who had opened the bottle of tuberculin vaccination should have labeled it with the date it had been opened. She stated she did not know when it had been opened. She stated when a vial of tuberculin vaccination has been opened it is only good for 28 days. She stated it was the responsibility of all the nurses working the medication cart to check for correct labeling of medications. An interview with the Director of Nursing on	F 431	compliance is achieved and maintained.	

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F 431	Continued From page 17 02/19/16 at 3:50 PM revealed medication nurses should have checked the medication carts and medication rooms for expired, unlabeled, or undated medications every shift. She further stated her expectation would be for all nurses to follow the facility policy for medication labeling, and expected medications to be labeled and dated, and any open injectable vial of medication should have been labeled with the date it had been opened.	F 431		