STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345523	A. BUILDING _____ B. WING _____	C 10/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/RAMSEUR	7166 JORDON ROAD RAMSEUR, NC 27316

(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 000	INITIAL COMMENTS There were no deficiencies cited as a result of the complaint investigation (NC 119070).	F 000		
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 care. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff interview, the facility failed to follow the care plan intervention for fortified cereal for a resident who had significant weight loss for 1 of 3 residents (Resident #109) reviewed for nutrition. The findings included: Resident #109 was admitted to the facility on 7/22/16 with multiple diagnoses that included Alzheimer's and heart failure. The admission Minimum Data Set (MDS) assessment dated 7/29/16 indicated he had significantly impaired cognition. Resident #109 was assessed as requiring the limited physical assistance of one person for eating. A review of Resident #109's dietary orders indicated he received a regular, no salt added diet with thin liquids. His diet was supplemented with 4 ounces of Medpass (fortified nutritional drink) twice daily. The plan of care for Resident #109, initiated on 8/3/16, included a problem area for the risk of	F 282	Submission of this response to the statement of deficiencies does not constitute an admission that the deficiencies exist and/or were correctly cited or required correction. F 282 The following was accomplished for resident #109 who was affected by the practice: A new dietary order form was written on 10-5-16 by the ADON for resident #109 to have fortified cereal each morning. The Dietary Manager put fortified cereal on the tray card so that dietary staff would know to serve fortified cereal to resident #109. Resident #109 is receiving fortified cereal per physician order and care plan. The Charge Nurse and the Certified Nursing Assistants on resident #109's unit were in-serviced by the Dietary Manager on 10-7-16 on the appearance of fortified cereal and shown a bowl of the cereal. All	10/28/16

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

Electronically Signed | 10/20/2016

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F 282	Continued From page 1 progressive decline of nutritional status related to the diagnosis of Alzheimer's. The Nutrition and Dehydration Risk Assessment dated 8/12/16 for Resident #109 indicated he was on a physician prescribed weight gain regimen. A review of Resident #109's weight history revealed he had a significant weight loss (greater than 5% in 30 days) of 5.9% from 8/5/16 (170 pounds) to 9/6/16 (160 pounds). A dietary note dated 9/7/16 indicated Resident #109 lost 10 pounds in 30 days which was equal to 5.9%. The recommendation was made for the addition of fortified cereal with breakfast to aid in weight stability for Resident #109. A physician's order dated 9/15/16 indicated fortified cereal with breakfast for weight loss for Resident #109. Resident #109's plan of care related to nutritional status was updated on 9/15/16 with an intervention for the addition of fortified cereal to his diet. An observation was conducted on 10/5/16 at 8:30 AM of Resident #109 at breakfast in the dining room of the 400 hall. His meal tray had not included fortified cereal. His dietary card had not indicated fortified cereal. A second observation was conducted on 10/5/16 at 9:00 AM of Resident #109 at breakfast. Nurse #1 assisted Resident #109 with eating. An interview was conducted with Nurse #1 on 10/5/16 at 9:10 AM. She indicated she was	F 282	licensed and unlicensed nursing staff will be in-serviced on the appearance of fortified cereal by the Dietary Manager, Director of Nursing, Assistant Director of Nursing or the Staff Development Coordinator by 10-28-16. The following was accomplished for other residents who have the potential to be affected by the same practice: All licensed nurses on site were in-serviced on 10-6-16 by the SDC, and all other licensed nurses were in-serviced prior to reporting to work by the Staff Development Coordinator regarding the new procedures for supplement orders. This education included obtaining a physician order, transcribing the order to the Medication Administration Record, completing the Dietary order form, attaching a copy of the physician's order to the dietary order form and forwarding to the Dietary Manager. The Charge Nurse and Certified Nursing Assistants on resident #109's unit were in-serviced by the Dietary Manager on 10-7-16 as to the appearance of fortified cereal and shown a bowl of fortified cereal. All other nursing staff will be in-serviced on the appearance of fortified cereal by 10-28-16. The medical records of a current residents on supplements were audited on 10-12-16 by the DON and ADON to ensure that orders are in place for each supplement and the ordered supplements are on the care plan. There were no other negative findings as a result of these	

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F 282	Continued From page 2 unaware if Resident #109 had an order for fortified cereal. The physician's order for fortified cereal for Resident #109 was reviewed with Nurse #1. She indicated she had not seen fortified cereal on Resident #109's breakfast tray when she assisted him with breakfast that morning. She stated she was not in the dining room at the beginning of breakfast and was unaware if Resident #109 had received fortified cereal. She indicated there were three Nursing Assistants (NAs) who assisted with breakfast that morning (NA #1, NA #2, ad NA #3). An interview was conducted with NA #1 on 10/5/16 at 9:15 AM. NA #1 indicated she had not known if Resident #109 received fortified cereal. An interview was conducted with NA #2 at 9:16 AM. NA #2 indicated he had not seen fortified cereal on Resident #109's meal tray. An interview was conducted with NA #3 at 9:18 AM. NA #3 indicated she had not seen fortified cereal on Resident #109's meal tray. An interview was conducted with the Dietary Manager (DM) on 10/5/16 at 9:45 AM. The DM reviewed the process that was involved when a resident was ordered fortified cereal. She indicated when a dietician made a recommendation for fortified cereal the nursing staff obtained a physician's order. The nursing staff member that had completed the order for the fortified cereal then gave a copy of the order to her (the DM). She stated she added the fortified cereal to the resident's dietary card. She indicated the dietary card was how the kitchen staff knew what to include on the resident's meal tray. She revealed that if the fortified cereal was	F 282	audits. The Director of Nursing and and Assistant Director of Nursing will also audit the last three months of Registered Dietician recommendations to ensure that all recommendations were followed through as appropriate. This audit will completed by 10-25.16 On 10-17-16 the Dietary Manager reconciled all supplement orders with the tray cards to ensure that residents are receiving supplements as ordered and care planned. The following measures/systems were put in place to ensure that the practice does not recur: The Registered Dietician will continue to provide a list of all dietary recommendations to the Dietary Manager. Director of Nursing and Assistant Director of Nursing for proper follow-up. Effective 10-6-16 the dietary order form and a copy of the corresponding physician' order for supplements are forwarded to the Dietary Manager by the licensed nurse who writes the order. The licensed nurse also transcribes the order on the MAR. A copy of the physician's order is forwarded to the DON by the Charge Nurse writing the order by placing it in the Director of Nursing's box. The Dietary Manager, per current	

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F 282	Continued From page 3 not on the resident's dietary card that the resident had not received the fortified cereal. The physician's order dated 9/15/16 for fortified cereal for Resident #109 was reviewed with the DM. She indicated she had not known if Resident #109 had received the fortified cereal. She stated she was going to check her records. A follow up interview was conducted with the DM on 10/5/16 at 10:58 AM. She revealed Resident #109 had not received fortified cereal at any time since the physician's order was written on 9/15/16. She stated that she had not received the physician's order and she had not added it to Resident #109's dietary card. She indicated an order was written today (10/5/16) and Resident #109 was going to begin to receive the fortified cereal as of tomorrow (10/6/16). She stated she was already in the process of completing a plan of correction for the error. A second interview was conducted with Nurse #1 on 10/5/16 at 11:10 AM. She reviewed the process that was followed when a new dietary order was completed. She stated a physician's order was written by the nurse on duty and then a diet requisition form was completed by the nurse who had written the order. She indicated the diet requisition form had two pieces, one white and one yellow. She stated the white copy was placed in the resident's hard copy medical record and the yellow copy was given to the dietary department. The physician's order dated 9/15/16 for fortified cereal for Resident #109 was reviewed with Nurse #1. She indicated the order was written by Nurse #2. The hard copy medical record was reviewed and revealed there was no diet requisition form for fortified cereal for Resident #109.	F 282	protocol, will enter the order on the resident' tray card for the appropriate ordered supplement to be delivered on the resident' meal tray. Effective 10-19-16, the Dietary Manager and the Director of Nursing reconcile these supplement orders daily Monday through Friday to ensure that both disciplines have knowledge of the orders. Should the DON or Dietary Manager not be available the ADON and a dietary staff member will reconcile the new orders. The DON will then give the orders to the Staff Development Coordinator who is tasked with updating the care plans with these interventions and verifying the orders are correct on the Medication Administration Record. The following monitoring initiative was put in place on 10/12/16 to ensure that the corrective action is achieved and sustained and evaluated for its effectiveness. The initiative is integrated into our Quality Assurance system: Effective 10/12/16, the DON, ADON and/or the SDC began to audit the Medication Administration Records of all residents on supplements to ensure that the documentation verifies that the care plan is being followed. This audit will be twice weekly for three weeks, then, one time weekly for three weeks and then monthly for two months. Findings of the audits will be presented to	

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F 282	Continued From page 4 A phone interview was conducted with Nurse #2 on 10/5/16 at 11:34 AM. She reviewed the process that she followed when a new dietary order was completed. She stated she completed the physician's order and then filled out a diet requisition form. She indicated the diet requisition form had two pieces, one white and one yellow. She stated the white copy was placed in the resident's hard copy medical record and the yellow copy was given to the dietary department. She indicated if a diet requisition form was not filled out then the dietary department would not have been informed of the new order. The physician's order dated 9/15/16 that was signed by Nurse #2 for fortified cereal for Resident #109 was reviewed with Nurse #2. She stated she was unable to recall writing that order. She indicated she was unable to remember if she had written a diet requisition form to correspond to the order. She stated if she had written a diet requisition form that she would have placed the white copy in the resident's hard copy medical record and the yellow copy would have been given to the dietary department. Nurse #2 was informed there was no diet requisition form for fortified cereal in the hard copy medical record of Resident #109. She revealed she was unable to explain what happed. An interview was conducted with the Administrator on 10/5/16 at 11:50 AM. She indicated she expected dietary orders to be given to the dietary department and for the orders to be followed. An interview was conducted with the Director of Nursing (DON) on 10/5/16 at 11:56 AM. She indicated she expected dietary orders to be given	F 282	the Qualilty Assurance Performance Improvement Committee by the Director of Nursing or Assistant Director of Nursing for review a the monthly meeting for three months, or until the pattern of compliance is maintained for three months. the plan will be revised by the committee as needed.	

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F 282	Continued From page 5 to the dietary department and for the orders to be followed. She stated the facility was already working on a plan of correction for the error. A follow up interview was conducted with the DON on 10/5/16 at 12:13 PM. She indicated she expected the care plan to be followed.	F 282		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff interview, the facility failed to follow the physician's order to provide a fortified nutritional supplement (fortified cereal) to aid in weight stability for a resident who had a significant weight loss of 5.9 percent (%) in 30 days for 1 of 3 residents (Resident #109) reviewed for nutrition. The findings included: Resident #109 was admitted to the facility on 7/22/16 with multiple diagnoses that included Alzheimer's and heart failure. The admission Minimum Data Set (MDS) assessment dated	F 325	F 325 The following corrective action was accomplished for resident #109 found to have been affected by the practice: On 10-5-16 the Assistant Director of Nursing wrote the dietary order form for fortified cereal and gave it it to the Dietary Manager so that the order would be carried through. The order for fortified cereal was added to resident#109's tray card on 10-5-16 by the Dietary Manager	10/28/16

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F 325	Continued From page 6 7/29/16 indicated he had significantly impaired cognition. Resident #109 was assessed as requiring the limited physical assistance of one person for eating. A review of Resident #109's dietary orders indicated he received a regular, no salt added diet with thin liquids. His diet was supplemented with 4 ounces of Medpass (fortified nutritional drink) twice daily. The plan of care for Resident #109, initiated on 8/3/16, included a problem area for the risk of progressive decline of nutritional status related to the diagnosis of Alzheimer's. The Nutrition and Dehydration Risk Assessment dated 8/12/16 for Resident #109 indicated he was on a physician prescribed weight gain regimen. A review of Resident #109's weight history revealed he had a significant weight loss (greater than 5% in 30 days) of 5.9% from 8/5/16 (170 pounds) to 9/6/16 (160 pounds). A dietary note dated 9/7/16 indicated Resident #109 lost 10 pounds in 30 days which was equal to 5.9%. The recommendation was made for the addition of fortified cereal with breakfast to aid in weight stability for Resident #109. A physician's order dated 9/15/16 indicated fortified cereal with breakfast for weight loss for Resident #109. The order additionally indicated the amount of the fortified cereal consumed by Resident #109 was to be documented. Resident #109's plan of care related to nutritional status was updated on 9/15/16 with an	F 325	to ensure that the dietary staff would know to provide the cereal. Resident #109 is receiving fortified cereal per physician's order. On 10-7-16 the Dietary Manager in-serviced the Charge Nurse and the Certified Nursing Assistants on resident #109's unit on the appearance of fortified cereal and showed them a bowl of fortified cereal. Other licensed and unlicensed staff will be in-service on the appearance of fortified cereal by 10-28-16 by the Dietary Manager, Director of Nursing, Assistant Director of Nursing or Staff Development Coordinator The following corrective action was accomplished for those residents having the potential to be affected by the same practice: All licensed nurses on site were in-serviced on 10-6-16 by the Staff Development Coordinator, and all other licensed nurses were in-serviced prior to reporting to work by the Staff Development Coordinator regarding the correct procedures for supplement orders. Education included obtaining physician's for recommended supplementation, transcribing the order to the MAR, completing a dietary order form for every approved supplement recommendation, attaching a copy of the physician's order to the dietary order form and forwarding it to the Dietary Manager. Licensed nursed and certified nursing assistants not in-serviced on the appearance of fortified cereal will be in-serviced by the Director of Nursing, Dietary Manager, Assistant	

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F 325	Continued From page 7 intervention for the addition of fortified cereal to his diet. A review of Resident #109's Medication Administration Record (MAR) indicated the addition of fortified cereal with breakfast on 9/15/16. On 9/24/16 the nursing staff began to document the percentage of the fortified cereal that was consumed by Resident #109. An observation was conducted on 10/5/16 at 8:30 AM of Resident #109 at breakfast in the dining room of the 400 hall. His meal tray had not included fortified cereal. His dietary card had not indicated fortified cereal. A second observation was conducted on 10/5/16 at 9:00 AM of Resident #109 at breakfast. Nurse #1 assisted Resident #109 with eating. An interview was conducted with Nurse #1 on 10/5/16 at 9:10 AM. She indicated she was unaware if Resident #109 had an order for fortified cereal. The physician's order for fortified cereal for Resident #109 was reviewed with Nurse #1. She indicated she had not seen fortified cereal on Resident #109's breakfast tray when she assisted him with breakfast that morning. She stated she was not in the dining room at the beginning of breakfast and was unaware if Resident #109 had received fortified cereal. She indicated there were three Nursing Assistants (NAs) who assisted with breakfast that morning (NA #1, NA #2, ad NA #3). An interview was conducted with NA #1 on 10/5/16 at 9:15 AM. NA #1 indicated she had not known if Resident #109 received fortified cereal.	F 325	Director of Nursing or Staff Development Coordinator Medical Records of all residents with supplements were audited by the DON and ADON on 10/12/16 to ensure that supplements are on the current MARs along with proper documentation that the supplement is being provided per order and that supplementation interventions are on the Care Plan. Dietary Recommendations from the Registered Dietician for the last three months will be audited by the Director of Nursing and the Assistant Director of Nursing to ensure that there was follow through for all previous recommendations and physician orders of those approved are on the Medication Administration Record. This audit will be completed by 10-25-16. The following measures were put into place and systemic changes made to ensure that the practice will not recur: After the charge nurses obtain physician's order for a supplement, they are required to make a copy of the physician's supplement order and attach it to the completed dietary order form; these are then forwarded to the Dietary Manager as appropriate. The Dietary Manager will add the order to the resident's tray card. The SDC will confirm with the Dietary Manager when a new supplement order has been received by nursing management to ensure the Dietary Manager has also received the order.	

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F 325	Continued From page 8 An interview was conducted with NA #2 at 9:16 AM. NA #2 indicated he had not seen fortified cereal on Resident #109's meal tray. An interview was conducted with NA #3 at 9:18 AM. NA #3 indicated she had not seen fortified cereal on Resident #109's meal tray. An interview was conducted with the Dietary Manager (DM) on 10/5/16 at 9:45 AM. The DM reviewed the process that was involved when a resident was ordered fortified cereal. She indicated when a dietician made a recommendation for fortified cereal the nursing staff obtained a physician's order. The nursing staff member that had completed the order for the fortified cereal then gave a copy of the order to her (the DM). She stated she added the fortified cereal to the resident's dietary card. She indicated the dietary card was how the kitchen staff knew what to include on the resident's meal tray. She revealed that if the fortified cereal was not on the resident's dietary card that the resident had not received the fortified cereal. The physician's order dated 9/15/16 for fortified cereal for Resident #109 was reviewed with the DM. She indicated she had not known if Resident #109 had received the fortified cereal. She stated she was going to check her records. A follow up interview was conducted with the DM on 10/5/16 at 10:58 AM. She revealed Resident #109 had not received fortified cereal at any time since the physician's order was written on 9/15/16. She stated that she had not received the physician's order and she had not added it to Resident #109's dietary card. She indicated an order was written today (10/5/16) and Resident #109 was going to begin to receive the fortified	F 325	The SDC will also ensure that the order is on the MAR and the dietary order is on the care plan. The following monitoring initiative was put in place to ensure that the correction is achieved and maintained. This plan has been implemented and the corrective action will be evaluated for its effectiveness. The plan of correction will be integrated into our quality assurance system: For eight weeks, 5 times weekly, the Dietary Manager will bring a copy of all supplement orders she receives from nursing to the morning meeting. The Dietary Manager or (Dietary staff) will give the copy to the DON (or ADON) who will match the order from dietary with the order the DON receives from the charge nursing writing the order to ensure that both nursing and the dietary department have the same orders. A daily log will be maintained by the Director of Nursing or Assistant Director of Nursing in the DON's absence to document the reconciled orders and instances of disparity. Negative findings will be corrected immediately by the Director of Nursing. Findings will be brought to the Quality Assurance Improvement Committee for review by the Director of Nursing or Assistant Director of Nursing at the monthly meeting for two months or until a pattern of compliance is maintained for two months. The plan will be revised as needed.	

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F 325	Continued From page 9	F 325		

cereal as of tomorrow (10/6/16). She stated she was already in the process of completing a plan of correction for the error.

A second interview was conducted with Nurse #1 on 10/5/16 at 11:10 AM. She reviewed the process that was followed when a new dietary order was completed. She stated a physician's order was written by the nurse on duty and then a diet requisition form was completed by the nurse who had written the order. She indicated the diet requisition form had two pieces, one white and one yellow. She stated the white copy was placed in the resident's hard copy medical record and the yellow copy was given to the dietary department. The physician's order dated 9/15/16 for fortified cereal for Resident #109 was reviewed with Nurse #1. She indicated the order was written by Nurse #2. The hard copy medical record was reviewed and revealed there was no diet requisition form for fortified cereal for Resident #109.

The interview with Nurse #1 continued. The MAR for Resident #109 that indicated fortified cereal had been administered to Resident #109 with percentages of consumption documented from 9/24/16 through 10/4/16 was reviewed with Nurse #1. She revealed she had documented percentages of consumption for fortified cereal onto the MAR for Resident #109 that were not actually for fortified cereal. She indicated she had not known at the time of her documentation that Resident #109 had not received the fortified cereal. She revealed the percentages she documented were for grits consumed by Resident #109 rather than the fortified cereal. She indicated this was a mistake as she had not known what the fortified cereal looked like in

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comparison to the grits and therefore had not realized Resident #109 had not received fortified cereal.

A phone interview was conducted with Nurse #2 on 10/5/16 at 11:34 AM. She reviewed the process that was followed when a new dietary order was completed. She stated she completed the physician's order and then filled out a diet requisition form. She indicated the diet requisition form had two pieces, one white and one yellow. She stated the white copy was placed in the resident's hard copy medical record and the yellow copy was given to the dietary department. She indicated if a diet requisition form was not filled out then the dietary department would not have known about the order. The physician's order dated 9/15/16 that was signed by Nurse #2 for fortified cereal for Resident #109 was reviewed with Nurse #2. She stated she was unable to recall writing that order. She indicated she was unable to remember if she had written a diet requisition form at that time or not. She stated if she had written a diet requisition form that she would have placed one copy in the resident's hard copy medical record and one copy would have been given to the dietary department. Nurse #2 was informed there was no diet requisition form for fortified cereal in the hard copy medical record of Resident #109. She revealed she was unable to explain what happed.

An interview was conducted with the Administrator on 10/5/16 at 11:50 AM. She indicated she expected dietary orders to be given to the dietary department and for the orders to be followed. She additionally stated that the nursing staff documentation on the MAR for Resident

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F 325	Continued From page 11 #109 that indicated percentages consumed of fortified cereal from 9/24/16 through 10/4/16 were errors. She explained that staff had mistakenly documented the percentage of grits consumed by Resident #109. She indicated nursing staff had assumed the grits were fortified cereal. An interview was conducted with the Director of Nursing on 10/5/16 at 11:56 AM. She indicated she expected dietary orders to be given to the dietary department and for the orders to be followed. She stated the facility was already working on a plan of correction for the error.	F 325		
F 431 SS=E	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		10/28/16

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F 431	Continued From page 12 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 record review, observation and staff interview, the facility failed to discard expired medications and failed to date the Pulmicort when opened in 3 of 4 medications carts (100/200 &300) and in 1 of 2 medication room refrigerators (400). Findings included: 1. On 10/5/16 at 9:25 AM, the 300 hall medication cart was observed with Nurse #3. There were 2 medications observed that were expired. Miralax powder (a laxative) was noted with an expiration date of 6/4/16 and a bottle of Calcium (calcium supplement) 600 milligrams (mgs) tablets with an expiration date of 9/16. On 10/5/16 at 9:30 AM, Nurse #3 was interviewed. She stated that nurses were supposed to be checking the medication cart for expired medications and the pharmacy was also checking the medication carts once a month for expired medications. Nurse #3 acknowledged that the Calcium and the Miralax were already expired. On 10/5/16 at 10:10 AM, the Director of Nursing (DON) was interviewed. She stated that nurses were expected to check the medication carts for	F 431	F 431 The following corrective action has been accomplished for those residents found to have been affected by the practice: On 10-5-16 all medication carts, stock meds, and medication refrigerators were audited by the DON and ADON. All expired medications were sent back to pharmacy and reordered or replaced from stock medications. Undated open medications were discarded and reordered. The following action has been accomplished for those resident having the potential to be affected by the same practice: All licensed nurses were in-serviced in person or by phone including part-time and PRN licensed staff on 10-6-16 by the Staff Development Coordinator. Education included the requirement to check medication carts for expired medications	

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F 431	Continued From page 13 expired medications and the pharmacy also was supposed to be checking the medication carts once a month for expired medications. 2. The facility's policy on medication storage dated 1/20/14 was reviewed. The policy indicated that Humulin R insulin was good for 28 days after opening. On 10/5/16 at 9:25 AM, the 300 hall medication cart was observed with Nurse #3. There was a used Humulin R insulin (use to treat Diabetes) vial with an opened date of 8/19/16. On 10/5/16 at 9:30 AM, Nurse #3 was interviewed. She stated that Humulin R was good for 28 days after opening. She acknowledged that the used Humulin R insulin was already expired. On 10/5/16 at 10:10 AM, the Director of Nursing (DON) was interviewed. She stated that nurses were expected to check the medication carts for expired medications and to follow the facility's policy on medication storage. 3. The facility's policy on medication storage dated 1/20/14 was reviewed. The policy indicated that Pulmicort was good for 2 weeks once the aluminum package was opened. On 10/5/16 at 9:25 AM, the 300 hall medication cart was observed with Nurse #3. There was an opened foil/package of Budesonide/Pulmicort (a steroid drug used to treat asthma) that was undated. The instruction on the package of the Budesonide indicated that once the foil/envelope was opened to use the vial/ampule within 2 weeks. On 10/5/16 at 9:30 AM, Nurse #3 was interviewed. She stated that the foil should have been dated when opened and was good for 2 weeks after opening.	F 431	daily, as well as the medication refrigerator for expired or undated medications, and to check the expiration date of medications immediately prior to medication administration. The education also included checking the expiration dates of stock meds weekly and dating all medication when opened. The following measures were put into place and systemic changes made to ensure that the practice will not recur: It will now be the responsibility of the third shift licensed nurses on Sunday night to do an entire cart audit of all med carts and med refrigerators to ensure that expired medications are removed and returned to pharmacy and reordered as necessary. This weekly audit will be recorded on an audit form and forwarded to the DON for review weekly. In addition, it will be the responsibility of the third shift licensed nurses on Tuesday nights to check all stock meds to ensure they are in date and to return them to pharmacy if they are expired. Results of this weekly audit will be recorded on an audit form and forwarded to the DON weekly for review. The following monitoring initiative has been put in place to ensure that the correction is achieved and maintained. The plan has been implemented and the corrective action is being evaluated for its effectiveness. The POC is integrated into out quality assurance system:	

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F 431	Continued From page 14 On 10/5/16 at 10:10 AM, the Director of Nursing (DON) was interviewed. She stated that nurses were expected to date the Budesonide when opened and to follow the facility's policy on medication storage. 4. On 10/5/16 at 9:40 AM, the 400 hall medication room refrigerator was observed with Nurse #1 and the DON. The following expired medications were observed: Haldol (antipsychotic drug) liquid (15 milliliter (ml) bottle) 2 milligrams (mgs) per ml - one bottle with an expiration date of 6/24/16 and one bottle with an expiration date of 9/21/16. Prochlorperazine (used to treat nausea and vomiting) 10 mgs tablet - 6 tablets with an expiration date of 8/17/16 and six tablets with an expiration date of 5/28/16. Hyoscyamine (reduce fluid secretion) 0.25 mgs tablet - 12 tablets with an expiration date of 2/28/16 and 12 tablets with an expiration date of 3/20/16. Lorazepam (antianxiety drug) 3 ml gel - 9 syringes with an expiration date of 3/16/16. ABH (Ativan/Benadryl/Haldol) -used to treat nausea and vomiting- 21 syringes with an expiration date of 9/16. Ativan (antianxiety drug) 0.5 mg/ml - 44 syringes with an expiration date of 9/16. On 10/5/16 at 10:05 AM, Nurse #1 was interviewed. She stated that nurses were supposed to be checking the medication room and the refrigerator for expired medications and the pharmacy was also checking the medication room and the refrigerator once a month for expired medications. Nurse #1 acknowledged that the Haldol, Prochlorperazine, Hyoscyamine,	F 431	For 6 weeks, one time per week, and then every two week for 6 weeks the DON, ADON or SDC will audit all medication carts, stock meds and med refrigerators to ensure there are no expired medications or undated medications. Any negative findings will be corrected immediately and discipline/education will occur with the licensed nurse(s) involved. Findings will be documented on an audit form. Results of the audit will be presented by the Director of Nursing or Assistant Director of Nursing to the Quality Assurance Improvement Committee for review at the monthly meeting. The plan will continue for three months or until a pattern of compliance is demonstrated. The plan will be revised as needed	

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Lorazepam, ABH and Ativan were already expired.
On 10/5/16 at 10:10 AM, the Director of Nursing (DON) was interviewed. She stated that nurses were expected to check the medication room including the refrigerator for expired medications and the pharmacy also was supposed to be checking the medication rooms including the refrigerator once a month for expired medications. The DON verified that the Haldol, Prochlorperazine, Hyoscyamine, Lorazepam, ABH and the Ativan were already expired.
5. On 10/5/16 at 10:10AM, an observation of the 200 hall medication cart was conducted with Nurse #5. A bottle of ASA (Aspirin) 325 milligrams was noted with approximately fifteen (15) tablets in the bottle. The expiration date on the bottle was 9/16.

On 10/5/16 at 10:10AM, Nurse #5 stated all nursing staff were responsible to check the cart for expired medications and check for the expiration date before administering medications. She said she did not realize the ASA medication had expired.

On 10/5/2016 at 10:20 AM, an interview was conducted with the Director of Nursing. She stated the nurses were supposed to check the medication carts and refrigerator for expired medications. She said she expected nursing staff to check a medication for the expiration date to see if it was expired prior to administration and nursing staff should remove expired medications so they could be sent back to the pharmacy.

6. On 10/5/16 at 10:15AM, an observation of the 100 hall medication cart was conducted with Nurse #4. There was an opened Novolog insulin

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flexpen with the date opened documented as 8/24/16 and the expiration date was 9/21/16. The flexpen contained 200 units of insulin.

Manufacturer's instructions for the Novolog flexpen stated Novolog flexpen could be stored opened at room temperature for twenty-eight (28) days.

On 10/5/16 at 10:15AM, Nurse #4 stated she did not personally look at the flexpen because she did not administer the medication on her shift.

On 10/5/2016 at 10:20 AM, an interview was conducted with the Director of Nursing. She stated the nurses were supposed to check the medication carts and refrigerator for expired medications. She said she expected nursing staff to check a medication for the expiration date to see if it was expired prior to administration and nursing staff should remove expired medications so they could be sent back to the pharmacy.