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	345343	A. BUILDING _____ B. WING _____	C 12/14/2018

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BRIAN CENTER HEALTH AND REHABILITATION/GOLDSBORO	1700 WAYNE MEMORIAL DRIVE GOLDSBORO, NC 27534

(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 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessments for: 1) the classification of a medication received by 1 of 27 sampled residents reviewed for the accuracy of assessments (Resident #105); and, 2) nutritional approaches provided for 1 of 27 sampled residents reviewed for the accuracy of assessments (Resident #36). The findings included: 1) Resident #105 was admitted to the facility on 11/5/18 from a hospital. Her cumulative diagnoses included a history of cerebral infarction (stroke). A review of the resident ' s 11/5/18 admission medication orders included 75 milligrams (mg) clopidogrel (an antiplatelet medication) to be given as one tablet by mouth once daily. A review of Resident #105 ' s admission Minimum Data Set (MDS) assessment dated 11/12/18 was completed. Section N of the MDS indicated the resident received an anticoagulant medication on 7 out of 7 days during the look back period. An interview was conducted on 12/13/18 at 3:30 PM with MDS Coordinator #1. During the interview, the MDS Coordinator reported she had completed Resident #105 ' s admission MDS	F 641	Resident #105 MDS was modified and transmitted on 12/14/18. Resident #36 MDS was modified and transmitted on 12/14/18. All current resident's on Plavix and all residents on Plavix the previous 90 days were audited on 12/14/18 and all MDS' that required modification to reflect no anticoagulant due to Plavix administration were modified and transmitted. All current resident's who had received IV fluids the previous 90 days were audited on 12/14/18 and all MDS' that required modification to reflect appropriate coding of IV medications were modified and transmitted. In-servicing by the resident care management director was completed for the MDS coordinators on 12/14/18. In-service included to not code Plavix (clopidogrel) as an anticoagulant as it is an anti-platelet medication and accurate coding of IV medications in the MDS. Resident care management director or designee will audit all residents on Plavix (clopidogrel) weekly times four then monthly times two beginning on 1/2/19 to ensure that Plavix is not coded as an	1/11/19

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

Electronically Signed | 01/09/2019

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F 641	Continued From page 1 assessment. She reviewed Section N of the assessment and confirmed this MDS indicated the resident received an anticoagulant medication on 7 out of 7 days during the look back period. MDS Coordinator #1 reported she would have coded clopidogrel as an anticoagulant. However, the MDS Coordinator stated she needed to check with the Resident Care MDS Director as to whether or not this was coded correctly. An interview was conducted on 12/14/18 at 10:54 AM with the facility ' s Resident Care MDS Director in regards to the coding of clopidogrel as an anticoagulant on Resident #105's MDS assessment. During the interview, the MDS Director confirmed clopidogrel should not have been coded as an anticoagulant. She reported the resident ' s admission MDS had been coded incorrectly and stated this assessment has now been corrected. An interview was conducted on 12/14/18 at 2:06 PM with the facility's Director of Nursing (DON). During the interview, the coding of the residents ' MDS assessments were discussed. The DON reported she was told about the concerns identified with the coding of the assessments. She stated her expectation would be, "For the MDS coding to be done correctly and that we are fully educated on how to code the MDS." 2) Resident #36 was admitted on 9/18/17 with re-entry to the facility on 11/8/17 from a hospital. Her cumulative diagnoses included non-Alzheimer ' s dementia. A review of Resident #36 ' s quarterly Minimum Data Set (MDS) assessment dated 10/29/18 was completed. Section K of the MDS indicated	F 641	anticoagulant. Resident care management director or designee will audit all residents who received IV fluids weekly times four then monthly times two beginning on 1/3/19 to ensure accurate coding of received IV fluids in the MDS. The resident care management director or designee will report audit findings to the facility Quality Assurance and Performance Improvement committee weekly times four and monthly times two. The committee will evaluate the results and implement additional interventions as needed to ensure continued compliance.	

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F 641	Continued From page 2	F 641		

Resident #36 received parenteral/intravenous feeding while a resident in the facility within the last 7 days. However, a review of Resident #36 ' s medical record revealed there was no documentation to indicate the resident received parenteral/intravenous feeding while she was a resident in the facility between 10/23/18 and 10/29/18.

An interview was conducted on 12/13/18 at 3:30 PM with MDS Coordinator #1. During the interview, the MDS Coordinator reported she had completed Resident #36 ' s quarterly MDS assessment dated 10/29/18. She reviewed Section K of the assessment and confirmed this MDS indicated the resident received parenteral/intravenous feeding while she was a resident in the facility within the previous 7 days. MDS Coordinator #1 requested an opportunity to review the resident's medical records more carefully before commenting on the coding of this MDS assessment.

An interview was conducted on 12/14/18 at 10:54 AM with the facility ' s Resident Care MDS Director in regards to the coding of Section K on Resident #36's MDS assessment. During the interview, the Director reported the 10/29/18 MDS assessment had already been corrected to reflect that no parenteral/intravenous fluids were provided to Resident #36 during the 7-day look back period while she stayed at the facility. Upon further inquiry, the MDS Director confirmed the quarterly MDS dated 10/29/18 had not been coded correctly.

An interview was conducted on 12/14/18 at 2:06 PM with the facility's Director of Nursing (DON). During the interview, the coding of the residents '

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F 641	Continued From page 3 MDS assessments were discussed. The DON reported she was told about the concerns identified with the coding of the MDS. She stated her expectation would be, "For the MDS coding to be done correctly and that we are fully educated on how to code the MDS."	F 641		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review, the facility failed to have a medication error rate of less than 5% as evidenced by 2 medication errors out of 26 medication opportunities, resulting in a medication error rate of 7.6% for 2 of 5 residents (Resident #77 and Resident #68) observed during medication pass. The findings included: 1) Resident #77 was admitted to the facility on 9/19/18 with a cumulative diagnoses which included chronic obstructive pulmonary disease. A review of Resident #77 ' s active Physician Orders included a current order for 20/100 micrograms (mcg) / activation of Combivent Respimat to be administered as one inhalation four times daily (initiated 9/19/18). Combivent Respimat is an inhaled medication containing a combination of two medications, ipratropium and albuterol. It is used for the management of	F 759	Resident # 68 was assessed on 12/12/2018 by the Director of Nursing for signs and symptoms of fungus infection (thrush). The attending physician was notified on 12/12/2018 that resident did not have any signs of fungus infection in mouth. Resident #77 physician was notified regarding combivent inhaler used without properly being primed; no new orders received. The facility licensed nurses and medication aids will be provided re-education regarding priming of Combivent inhaler , to include manufacture recommendations regarding priming of a new the inhaler by the Staff development coordinator or designee. The facility licensed nurses and medication aids will be provided re- education administration	1/11/19

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F 759	Continued From page 4 chronic obstructive pulmonary disease. On 12/12/18 at 4:26 PM, Medication Aide (Med Aide) #1 was observed as she prepared to administer 20/100 mcg Combivent Respimat to Resident #77. The med aide opened a box containing a new 20/100 mcg Combivent Respimat inhaler. After she inserted the cartridge into the delivery mouthpiece, she primed the system by depressing the actuator one time only; a fine mist (spray) was observed at that time. The Combivent Respimat inhaler was brought to Resident #77 and one puff of the medication was administered. A review of the manufacturer ' s instructions on the preparation for use and priming of the Combivent Respimat inhaler was conducted. These instructions read, in part: "Instruct patients that priming Combivent Respimat is essential to ensure appropriate content of the medication in each actuation. When using the unit for the first time, the Combivent Respimat cartridge is inserted into the Combivent Respimat inhaler and the unit is primed. Combivent Respimat patients are to actuate the inhaler toward the ground until an aerosol cloud is visible and then repeat the process three more times. The unit is then considered primed and ready for use." An interview was conducted on 12/12/18 at 4:45 PM with Med Aide #1. During the interview, the manufacturer ' s instructions were taken out of the Combivent Respimat inhaler ' s box and the directions for priming the inhaler were reviewed. Upon inquiry, the med aide reported she primed the inhaler by actuating it one time only. She	F 759	of Symbicort inhaler , to include rinsing the mouth with water and not shallowing after use by the staff development coordinator or designee. Any licensed nurses and/or medication aid that does not receive the re- education will receive prior to working the their next scheduled shift. The facility newly hired licensed nurses or medication aids will received the education during orientation The facility staff development coordinator and / clinical manager (Director of Nursing, Assist Director of Nursing and unit coordinator) will complete two medication observation weekly times four, bi monthly times two , to ensure that new Combivent inhalers are primed per manufacture recommendation prior to use and Symbicort inhalers are administrator and resident mouth rinse per recommendations. The Facility Director of Nursing will report findings to QAPI monthly times three. The QAPI will review and analyze the finding to determine if further action is needed.	

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F 759	Continued From page 5	F 759		

confirmed the manufacturer ' s directions indicated this process needed to be repeated three more times in order to prime the inhaler.

An interview was conducted on 12/13/18 at 3:16 PM with the facility ' s Director of Nursing (DON). During the interview, the DON reported her expectation was for her nurses (and med aides) to know how to administer the medications they were giving. The DON also stated she would expect for them to receive the education and have the knowledge to administer the medications properly.

2) Resident #68 was admitted to the facility on 3/17/14 with a cumulative diagnoses which included chronic obstructive pulmonary disease. A review of Resident #68 ' s active Physician Orders included a current order for 80 microgram (mcg) / 4.5 mcg Symbicort to be administered as two puffs inhaled two times a day (initiated 6/22/18). The physician ' s order included the following instructions, "Rinse mouth with water after use. Do not swallow." Symbicort is an inhaled medication containing a combination of two medications, budesonide (a steroid) and formoterol. It is used for the management of asthma and/or chronic obstructive pulmonary disease.

On 12/12/18 at 8:25 AM, Nurse #1 was observed as she prepared and administered medications to Resident #68. The medications pulled for administration included 80 mcg / 4.5 mcg Symbicort. The resident was observed as she inhaled two puffs of the aerosol medication. The nurse did not prompt the resident to rinse her mouth out with water; no water was offered to the resident after the Symbicort inhaler was used.

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F 759	Continued From page 6 A review of the package insert from the manufacturers of Symbicort (Revised 12/2017) included the following Administration Information, in part: "Symbicort should be administered as 2 inhalations twice daily (morning and evening, approximately 12 hours apart), every day by the orally inhaled route only. After inhalation, the patient should rinse the mouth with water without swallowing." Additionally, the Patient Information Guide (Revised 12/2017) for Symbicort specified the following administration guidelines: "Rinse your mouth with water and spit the water out after each dose (2 puffs) of Symbicort. Do not swallow the water. This will help to lessen the chance of getting a fungus infection (thrush) in the mouth and throat." An interview was conducted on 12/12/18 at 8:45 AM with Nurse #1. During the interview, the nurse confirmed she did not provide water or instruction to Resident #68 to rinse her mouth with water after using the Symbicort inhaler. An interview was conducted on 12/13/18 at 3:16 PM with the facility ' s Director of Nursing (DON). During the interview, the DON reported her expectation was for her nurses (and med aides) to know how to administer the medications they were giving. The DON also stated she would expect for them to receive the education and have the knowledge to administer the medications properly.	F 759		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be	F 761		1/11/19

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F 761	Continued From page 7 labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) 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. §483.45(h)(2) 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 observations, staff interviews, and record review, the facility: 1) failed to remove expired medications from 1 of 3 medication carts observed (200 West Med Cart); 2) failed to label medications with a shortened expiration date in 1 of 3 medication carts observed (200 West Med Cart); and, 3) failed to store medications as specified by the manufacturer in 2 of 3 medication carts observed (100 Hall Med Cart and 200 West Med Cart). The findings included: 1-a) Accompanied by Nurse #1, an observation	F 761	Nurse #1 removed and discarded 0.005% Latanoprost ophthalmic solution from the 200 West cart on 12/12/2018. Nurse #1 removed and discarded Novolog flexpen that was dispensed on 11/6/18 for Resident #62 0n 12/12/2018. Nurse # 1 removed and discarded budesonide inhalation suspension vial that was observed stored outside of the foil pouch without date on 200 West cart on 12/12/2018.	

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F 761	Continued From page 8 of the 200 West Medication Cart was conducted on 12/12/18 at 8:17 AM. The observation revealed an opened bottle of 0.005 % latanoprost ophthalmic solution (an eye drop medication used to treat glaucoma) labeled for Resident #57 was stored on the cart. A hand-written notation on the bottle indicated the lantanoprost eye drops were opened on 9/4/18. An auxiliary label placed on the lantanoprost eye drop bottle by the pharmacy read, "Refrigerate until opened. Discard 6 weeks after opening." Nurse #1 confirmed both the date the latanoprost bottle was opened and the presence of the pharmacy auxiliary sticker which indicated the opened bottle of latanoprost had a shortened expiration date. Based on date the latanoprost had been opened, the shortened expiration date of the eye drops was 10/16/18. A review of the manufacturer ' s storage instructions for latanoprost ophthalmic solution indicated once opened, the container may be stored at room temperature up to 25o C (77o F) for 6 weeks. A review of Resident #57 ' s current Physician Orders revealed there was a current order for 0.005% latanoprost eye drops to be instilled as one drop in each eye at bedtime. An interview was conducted on 12/13/18 at 2:45 PM with the facility ' s Director of Nursing (DON). During the interview, the DON reported her expectation was for all medications to be dated appropriately as to when they were opened and when there was an expiration date, as well. She stated an expired medication needed to be disposed of or sent back to the pharmacy. 1-b) Accompanied by Nurse #1, an observation	F 761	Nurse #1 removed and discarded Latanoprost eye drops that observed on 12/12/18 stored unopened in medication cart verses per manufacture recommendation of refrigeration until open. Nurse #2 removed and discarded 5% Xiidra ophthalmic solution that was observed on 12/13/18 sotred outside the foil pack without date on 12/12/2018. The facility Director of Nursing completed an audit for all medication cart and medication refrigerators to ensure that Xiidra, Latanoprost eye drops, budesonide inhalation suspension and Novolog flexpen were stored per manufacture and pharmacy recommendation. The licensed nurses and medication aids will be provided re- education on the storage and labeling of medication by the staff development coordinator. Any licensed nurses and/or medication aid that does not receive the re- education will receive it prior to working the their next scheduled shift. The facility newly hired licensed nurses or medication aids will received the education during orientation. The director of nursing or designee will complete 1 □ 2 medication cart observations weekly times four and bi □ monthly times two to ensure medications are stored and labeled per manufacture recommendations to include Xiidra, Latanoprost eye drops, budesonide inhalation suspension and Novolog	

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F 761	Continued From page 9	F 761		

of the 200 West Medication Cart was conducted on 12/12/18 at 8:17 AM. The observation revealed an opened Novolog Flexpen (a rapid-acting insulin) dispensed by the pharmacy on 11/6/18 and labeled for Resident #62 was stored on the medication cart. A hand-written notation on the Novolog Flexpen appeared to indicate the pen was opened on 11/1/18 (which would indicate the insulin ' s shortened expiration date was 11/29/18). Nurse #1 was asked to carefully review the hand-written date to help determine if the pen was possibly opened on 11/7/18 (which would indicate the insulin expired on 12/5/18). However, Nurse #1 stated the insulin pen appeared to be dated as having been opened on 11/1/18.

A review of the manufacturer ' s storage instructions for a Novolog Flexpen indicated once in use, the insulin pen should be stored at temperatures less than 30o C (86o F) and used within 28 days.

A review of Resident #62 ' s current Physician Orders revealed there was a current order for Novolog insulin to be injected as 8 units subcutaneously (under the skin) three times a day before meals.

An interview was conducted on 12/13/18 at 2:45 PM with the facility ' s Director of Nursing (DON). During the interview, the DON reported her expectation was for all medications to be dated appropriately as to when they were opened and when there was an expiration date, as well. She stated an expired medication needed to be disposed of or sent back to the pharmacy.

2) Accompanied by Nurse #1, an observation of

flexpen.

The Facility Director of Nursing will report findings to QAPI weekly times four and then monthly times three. The QAPI will review and analyze the finding to determine if further action is needed.

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F 761	Continued From page 10	F 761		

the 200 West Medication Cart was conducted on 12/12/18 at 8:17 AM. The observation revealed a box of 0.25 milligrams (mg) / 2 milliliters (ml) budesonide inhalation suspension vials (an inhaled steroid medication used in the treatment of asthma or chronic obstructive pulmonary disease) dispensed from the pharmacy on 11/7/18 for Resident #61 was stored on the med cart. The box contained one opened, undated foil pouch with 4 vials of budesonide. Five additional vials of budesonide inhalation suspension were stored in the box outside of a foil pouch (there was no empty foil pouch in the box). Nurse #1 confirmed the observed storage of the budesonide inhalation suspension vials inside of the undated foil pouch and the vials stored without a foil pouch.

A review of the manufacturer ' s storage instructions for budesonide inhalation suspension indicated once the aluminum package was opened, the solution should be used within 2 weeks.

A review of Resident #61 ' s current Physician Orders revealed there was a current order for 0.25 mg/2ml budesonide suspension to be administered as one inhalation via nebulizer two times a day.

An interview was conducted on 12/13/18 at 2:45 PM with the facility ' s Director of Nursing (DON). During the interview, the DON reported if there is a foil pouch for inhalation solutions, the medication needed to be stored inside of that foil pouch. She also stated her expectation was for all medications to be dated appropriately as to when they were opened and when there was an expiration date as well. She stated an expired

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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 761	Continued From page 11	F 761		

medication needed to be disposed of or sent back to the pharmacy.

3-a) Accompanied by the facility ' s Administrator and joined by Nurse #2, an observation of the 100 Hall Medication Cart was conducted on 12/12/18 at 9:30 AM. The observation revealed two vials of 0.5 milligram (mg)-2.5 mg / 3 milliliter (ml) ipratropium/albuterol inhalation solution (an inhaled medication used for the management of chronic obstructive pulmonary disease) were stored outside of the foil pouch and placed on top of a manufacturer ' s box inside the medication cart.

A review of the manufacturer ' s storage instructions for ipratropium/albuterol inhalation solution indicated vials should be protected from light before use. Unused vials should be placed in the foil pouch for storage.

An interview was conducted on 12/13/18 at 2:45 PM with the facility ' s Director of Nursing (DON). During the interview, the DON reported if there is a foil pouch for inhalation solutions, the medication needed to be stored inside of that foil pouch.

3-b) Accompanied by the facility ' s Administrator and joined by Nurse #2, an observation of the 100 Hall Medication Cart was conducted on 12/12/18 at 9:30 AM. The observation revealed two single-use containers of 5% Xiidra ophthalmic solution (an eye medication used to treat dry eye disease) were lying outside of and on top of the foil pouch while stored in the medication cart. The Xiidra ophthalmic solution was labeled as having been dispensed for Resident #34.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345343	A. BUILDING _____ B. WING _____	C 12/14/2018

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According to the product manufacturer, single-use containers of Xiidra should be stored in the original foil pouch.

A review of Resident #34 ' s current Physician Orders revealed there was a current order for 5% Xiidra ophthalmic solution to be instilled as one drop in both eyes one time a day.

An interview was conducted on 12/13/18 at 2:45 PM with the facility ' s Director of Nursing (DON). During the interview, the DON reported if there is a foil pouch, the medication needed to be stored inside of that foil pouch.

3-c) Accompanied by Nurse #1, an observation of the 200 West Medication Cart was conducted on 12/12/18 at 8:17 AM. The observation revealed an unopened bottle of 0.005 % latanoprost ophthalmic solution (an eye drop medication used to treat glaucoma) labeled for Resident #58 was stored on the cart. The labeling on the latanoprost bottle indicated it had been dispensed from the pharmacy on 12/6/18. A pharmacy auxiliary sticker placed on the latanoprost read, "Refrigerate until opened. Discard 6 weeks after opening."

A review of the manufacturer ' s storage instructions for latanoprost eye drops indicted intact (unopened) bottles should be stored under refrigeration at 2o Celsius (C) to 8o C or 36o Fahrenheit (F) to 46o F.

An interview was conducted on 12/13/18 at 2:45 PM with the facility ' s Director of Nursing (DON). During the interview, the DON reported she expected medications would be stored in the refrigerator when indicated and pulled from the

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F 761	Continued From page 13 refrigerator when they were needed.	F 761		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: FACILITY QAA and QAPI Based on staff interview and record review, the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor the interventions the committee put into place following the recertification survey of 01/12/2018. This was for one deficiency which was recited during the recertification survey of 12/14/2018 in F761. The continued failure of the facility during two federal surveys of record shows a pattern of the facility's inability to sustain an effective Quality Assessment and Assurance program. The findings included: This citation is cross referenced to: F761 Based on observations, record review and staff interviews the facility failed to 1) failed to remove expired medications from 1 of 3 medication carts observed (200 West Med Cart); 2) failed to label medications with a shortened expiration date in 1 of 3 medication carts observed (200 West Med Cart); and, 3) failed to store medications as	F 867	The facility QAPI team to include the Administrator , Director of Nursing, Unit managers, Social Worker, Rehab Manager and Dietary Manager were provided re- education regarding the Quality Assurance and Performance Improvement process by district clinical Director. Nurse #1 removed and discarded 0.005% Latanoprost ophthalmic solution from the 200 West cart on 12/12/2018. Nurse #1 removed and discarded Novolog flexpen that was dispensed on 11/6/18 for Resident #62 0n 12/12/2018. Nurse # 1 removed and discarded budesonide inhalation suspension vial that was observed stored outside of the foil pouch without date on 200 West cart on 12/12/2018. Nurse #1 removed and discarded Latanoprost eye drops that observed on 12/12/18 stored unopened in medication	1/11/19

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F 867	Continued From page 14 specified by the manufacturer in 2 of 3 medication carts observed (100 Hall Med Cart and 200 West Med Cart). From the previous survey of 01/12/2018, the facility failed to dispose of expired medications. On 12/14/18 at 4:30 PM the Administrator acknowledged understanding of the reciting of the repeated deficiency F761 from the recertification survey of 01/12/2018 . The Administrator stated he was aware of medication storage issues, and they were addressing concerns on an ongoing basis.	F 867	cart verses per manufacture recommendation of refrigeration until open. Nurse #2 removed and discarded 5% Xiidra ophthalmic solution that was observed on 12/13/18 sotred outside the foil pack without date on 12/12/2018. The facility Director of Nursing completed an audit for all medication cart and medication refrigerators to ensure that Xiidra, Latanoprost eye drops, budesonide inhalation suspension and Novolog flexpen were stored per manufacture and pharmacy recommendation. The licensed nurses and medication aids will be provided re- education on the storage and labeling of medication by the staff development coordinator. Any licensed nurses and/or medication aid that does not receive the re- education will receive it prior to working the their next scheduled shift. The facility newly hired licensed nurses or medication aids will received the education during orientation. The director of nursing or designee will complete 1 □ 2 medication cart observations weekly times four and bi □ monthly times two to ensure medications are stored and labeled per manufacture recommendations to include Xiidra, Latanoprost eye drops, budesonide inhalation suspension and Novolog flexpen. The Facility Director of Nursing will report	

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F 867	Continued From page 15	F 867	findings to QAPI weekly times four and then monthly times three. The QAPI will review and analyze the finding to determine if further action is needed.	