STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345557	A. BUILDING _____ B. WING _____	C 09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZALEA HEALTH & REHAB CENTER	3800 INDEPENDENCE BOULEVARD WILMINGTON, NC 28412

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E 000	Initial Comments An unannounced recertification survey was conducted on 09/20/21 through 09/23/21. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # IVXX11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investion survey was conducted from 09/20/21 through 09/23/21. Event ID# IVXX11. 5 of the 5 complaint allegations were not substantiated.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other	F 578		9/28/21

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

Electronically Signed | 10/14/2021

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F 578	Continued From page 1 entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to have accurate advance directives documented throughout the medical record for 1 of 5 sampled Residents (Resident #1) reviewed for advanced directives. The findings included: Resident #1 was admitted to the facility on 4/28/2017 with diagnoses that included cerebral infarction (stroke) and breast cancer. The Minimum Data Set (MDS) dated for 9/8/2021 indicated Resident #1 was cognitively intact. Review of Resident #1's advanced directive care plan, revealed it was last reviewed on 6/9/2021 and indicated Resident had chosen "Full Code" status. With goals that included her wishes would be honored daily through the next care plan review. Interventions included the Resident chooses to change code status, necessary	F 578	Preparation and submission of this POC is required by state and federal law. This poc does not constitute an admission for purpose of general liability, professional malpractice or any other court proceeding. 1)The medical record of resident #1 was updated on 9/23/21 to reflect current advanced directive of DNR. 2) To identify other residents that have the potential to be affected, an audit of all current residents' advanced directives was validated by checking the order with the care plan with the code book that is kept on the nursing unit. This was completed on 9/24/21. Any inconsistencies were corrected immediately. 3) To prevent this from recurring the	

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F 578	Continued From page 2 protocol will be completed including a new order, update documentation/care plan. Review of progress notes revealed a note written by the Physician's Assistant (PA) dated for 8/4/2021 that indicated Resident #1 requested to update her code status to a "DNR". Review of Resident #1's Physician Orders revealed her code status was updated to a "DNR" on 8/4/2021. During an interview on 9/23/2021 at 1:20 pm the Social Worker (SW) explained she followed up with Resident #1 and her daughter on 8/5/2021. Daughter verified the change of code status to DNR. A progress note dated for 8/5/2021 written by the SW was noted in Resident #1's electronic medical record. The note indicated the SW spoke with Resident #1 verifying her decision to change her code status to a "DNR". The SW was unable to explain why she did not update the care plan when the code status change. An interview with the Administrator on 9/23/2021 at 12:29 pm revealed it is her expectation a Resident's code status physician orders will correspond with information in his/her care plan.	F 578	licensed nurses and Director of Social Services were reeducated on 9/23/21 by the DON/ designee concerning making sure that advanced directives are current and accurate in the medical record. Any licensed staff that cannot be reached within the initial reeducation time frame of 24 hours, will not take an assignment until they have received this reeducation by the DON or designee. Agency licensed nurses and newly hired licensed nurses will have this education during their orientation by Director of Nursing or designee. #4 To monitor and maintain ongoing compliance, the Director of Nursing or designee will review new orders to ensure that any change of advanced directive are in the medical record and the code book at the appropriate nursing station. This will be validated by checking the orders vs the care plan and the code book on the nursing units. Monitoring began 9/24/21 and will be documented 5x week for 1 week then weekly for 11 weeks. #5 The DON will report the results of the monitoring to the QAPI committee for review and recommendations for the time frame of the monitoring period or as it is amended by the committee. Will be reviewed monthly for 100% compliance for 3 months.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans	F 656		9/27/21

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F 656	Continued From page 3	F 656		

§483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -
(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and
(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this

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F 656	Continued From page 4 section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to update the care plans for 2 of 8 residents (Resident #3 and Resident #9) reviewed for code status. Findings included: 1. Resident #9 was admitted to the facility on 3/20/21 with diagnoses that included dementia. Record review of the physician's order dated 3/20/21 revealed Resident #9 was full code. Review of the admission care plan dated 3/20/21 revealed Resident #9 was a full code. Review of the admission MDS dated 3/26/21 revealed Resident #9 was severely cognitively impaired and required extensive one-person physical assistance with activities of daily living (ADLs). Review of the electronic health record (EHR) for Resident #9 revealed a physician's order on 3/21/21 for do not resuscitate (DNR) with MOST (Medical Order for Scope of Treatment). Interview with the MDS nurse on 9/23/21 at 9:00 AM revealed the care plan for Resident #9 was completed before she received the physician's order for DNR with Most. Interview on 9/23/21 at 9:14 AM with the Social Worker confirmed she was responsible for updating the code status in the care plan. She stated when she verified the DNR with MOST	F 656	1) The care plans for resident #3 and #9 were updated with the current code status on 9/23/21. 2) To identify other residents that have the potential to be affected, an audit of current resident care plans was performed by the Director of Social Services on 9/24/21 to ensure care plans were accurate with current code status. 3) To prevent this from recurring. the DON reeducated the Director of Social Services and the IDT team on the code status Audit process policy. 4) To monitor and maintain on going compliance the Director of Social Services/ designee will monitor resident care plans to ensure the current code status is accurate. Monitoring will occur weekly for 12 weeks. 5) The Administrator will report results from the monitoring to the QAPI committee for review and recommendation during the time period as it is recommended by committee. Will be reviewed for 100% compliance for 3 months	

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F 656	Continued From page 5	F 656		

order she must have forgotten to change the care plan.

Interview with the Administrator on 9/23/21 at 12:29 PM revealed she expected the resident's code status orders to match the care plan.

2. Resident #3 was admitted to the facility on 9/3/20 with diagnoses that included dementia.

Record review of the physician's order dated 9/3/20 revealed resident #3 was a full code.

The admission Minimum Data Set (MDS) dated 9/9/20 revealed Resident #3 was severely cognitively impaired and required extensive one-person physical assistance with bed mobility and transfer, dressing, eating, and personal hygiene.

The admission care plan dated 9/9/20 revealed Resident #3 was a full code.

Record review of the physician's order dated 11/11/20 revealed Resident #3 had a do not resuscitate (DNR) order.

Interview on 9/23/21 at 9:03 AM with the MDS Nurse revealed the care plan was completed before the DNR order was put in the chart.

Interview on 9/23/21 at 9:20 AM with Social Worker revealed she had not updated the care plan for Resident #3 after the DNR order was put in the computer. She stated she was responsible for updating the care plan and she must have forgotten to do it.

Interview on 9/23/21 at 9:23 AM with the

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F 656	Continued From page 6 Administrator revealed she expected the care plan to reflect the current code status of the resident.	F 656		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and	F 758		10/4/21

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F 758	Continued From page 7 §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, Consultant Pharmacist interview and the Physician Assistant interview, the facility failed to discontinue an as needed (PRN) psychotropic medication for 1 of 5 Residents (Resident #1) reviewed for unnecessary medications. The findings included: Resident #1 was admitted to the facility on 4/28/2017 with diagnoses that included anxiety disorder and depressive disorder. The quarterly Minimum Data Set (MDS) dated for 9/8/2021 indicated Resident #1 was cognitively intact. She had no behaviors or rejection of care. Resident #1 was not coded as receiving antianxiety medication during the assessment period. A physician's order dated for 6/24/2021 indicated Xanax (antianxiety medication) 0.5miligrams as needed (PRN) every 24 hours for Resident #1. There was no stop date for this PRN Xanax	F 758	1) Resident #1 suffered no harm as a result of the PRN psychotropic medication not being discontinued. The PRN psychotropic medication was never administered. 2) To identify other residents that have the potential to be affected a 100% audit of all residents receiving PRN medications was performed to ensure there was a 14 stop date. No negative findings were identified. 3) To prevent this from recurring the Director of Nursing or designee reeducated all licensed nurses on the CMS regulatory changes with the use of PRN psychotropic medications and the requirement of a 14 day stop date. Any licensed staff that cannot be reached within the initial reeducation time frame of 24 hours will not take an assignment until they have received this education.	

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F 758	Continued From page 8 order. A pharmacy consultation report dated 8/11/2021 indicated Resident #1 had a PRN Xanax order in place for greater than 14 days without a stop date. The pharmacy recommendation was to discontinue or taper the medication. The Physician Assistant (PA) agreed with recommendation of limiting the medication to 14 days and then notify her. The PA signed the order on 8/25/2021. Resident #1's current physician orders were reviewed on 9/21/2021 and the Xanax PRN order for Resident #1 was still in place with no stop date. An interview was conducted with the Director of Nursing (DON) on 9/22/2021 at 2:00pm. She stated it was her role to follow through on pharmacy consultations once the facility Physician has signed them. She stated she must have missed completing this one. She further indicated when she realized the pharmacy consultation dated for 8/11/2021 was not followed through she informed the facility PA on 9/22/2021 and received the order to discontinue the PRN Xanax. An interview with the Physician Assistant (PA) was completed on 9/23/21 at 12:10 pm. She indicated with PRN psychotropics; she prescribed them with a stop date 14 days after initial prescribing date and was uncertain why there was no stop date on Resident #1's PRN Xanax order. An interview was conducted on 9/23/21 at 12:51 pm with the Consulting Pharmacist. She stated a pharmacy consultation report should be signed by the Physician and followed up on by the facility	F 758	Any agency licensed nurses and newly hired licensed nurses will have this education during their orientation. 4) To monitor and maintain on-going compliance the DON/ designee will monitor all new psychotropic medication orders in the morning clinical meeting to ensure there is a 14 day stop date with the order. Monitoring will occur 5x weekly for 12 weeks. 5)The Administrator will report the results of the monitoring to the QAPI committee for review and recommendations for the time frame of the monitoring period or as it is amended by the committee. Will be reviewed monthly for 100% compliance for 3 months.	

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F 758	Continued From page 9 within 30 days of the report being written. During an interview on 9/23/2021 at 1:50 pm with the Administrator, she indicated it was her expectation that all pharmacy consultations are completed timely.	F 758		
F 760 SS=E	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, and physician assistant interview the facility failed to hold blood pressure medication when blood pressure was below parameter as ordered by physician for 1 of 1 resident reviewed for administered medications (Resident #45). Findings included: Resident #45 was admitted to the facility on 12/20/17 with diagnoses that included hypertension, heart failure, and diabetes. A physician order dated 08/31/21 for hydralazine HCl 100 mg tablet to give 1 tablet three times a day for hypertension. And to hold if systolic blood pressure (SBP) less than 140 mmHg. Record review of Physician Assistant (PA) note dated 08/31/21 revealed that Resident #45 had a SBP of 132 with her normal SBP in the 150's. Resident #45 denied any dizziness, headache, or acute concerns. The PA reported that the blood pressure was retaken with a manual blood	F 760	1) Resident #45 suffered no harm as a result of the blood pressure not being held based on the parameters. 2) To identify other residents that have the potential to be affected, an audit of current residents with orders to hold blood pressure medications based on parameters was performed by the Unit Manager. 3) To prevent this from recurring, the DON/ designee reeducated all licensed nurses on following Physicians orders as written. Any licensed nurse that cannot be reached within the initial reeducation time frame of 24 hours will not take an assignment until they have received this reeducation by the DON/ designee. Agency licensed nurses and newly hired nurses will have this education during their orientation period by the DON/ designee.	10/4/21

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F 760	Continued From page 10 pressure cuff by nurse and Resident #45 had a SBP of 150. The PA planned to change administration time of the medication. Record review of the Medication Administration Record (MAR) for September 2021 revealed Resident #45 was administered hydralazine 11 times with a SBP less than 140 mmHg. The MAR record report revealed the following dates, times, and blood pressure readings: 09/01/21 at 8:00 pm SBP was 138 mmHg. 09/02/21 at 8:00 pm SBP was 135 mmHg. 09/03/21 at 8:00 am SBP was 138 mmHg. 09/03/21 at 8:00 pm SBP was 137 mmHg. 09/04/21 at 8:00 am SBP was 132 mmHg. 09/07/21 at 8:00 pm SBP was 132 mmHg. 09/11/21 at 2:00 pm SBP was 138 mmHg. 09/11/21 at 8:00 pm SBP was 138 mmHg. 09/12/21 at 8:00 am SBP was 136 mmHg. 09/12/21 at 2:00 pm SBP was 134 mmHg. 09/12/21 at 8:00 pm SBP was 132 mmHg. Record review of Resident #45's Blood Pressure Summary revealed no negative outcome related to hydralazine being administered outside of parameters. Attempts to contact Nurse #2 and Nurse #10, who were assigned to Resident #45 on 09/2/21, 09/4/21, 09/7/21, 09/08/21, and 09/11/21 were not successful. During an interview on 09/23/21 at 12:47 pm Nurse #1 revealed that blood pressure parameters were written in the physician order and required the blood pressure to be documented when the medication was administered. She stated that the nurse obtained	F 760	4) To monitor and maintain ongoing compliance, the DON or designee will monitor all physician orders with parameters 5x per week during the clinical morning meeting to ensure the parameters were followed as written. This will be validated by checking the Medication Administration Records of any resident orders with parameters. Monitoring will occur 5 x week for 3 weeks, then 3 x weekly for 3 weeks, then 2 x week for 3 weeks then weekly for 3 weeks. 5)The DON will report the results of the monitoring to the QAPI committee for review and recommendations for the time frame of the monitoring period or as it is amended by the committee. Will be reviewed monthly for 100% compliance for 3 months.	

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F 760	Continued From page 11 the blood pressure and if the blood pressure was out of range the medication was not administered. Nurse #1 was unable to remember if she administered the medication to Resident #45 on 09/03/21 but stated it was documented on the MAR as administered. Nurse #1 was not able to state why she administered hydralazine to Resident #45 with a SBP under 140 mmHg on 09/03/21 at 08:00 am. During an interview on 09/22/21 at 12:36 pm the Director of Nursing (DON) reviewed Resident #45's MAR and confirmed that hydralazine was administered to Resident #45 for SBP outside the order parameters and was a medication administration error. She stated that nurses are educated on medication pass, to verify physician order prior to administering, and to follow medication parameters. During an interview on 09/23/21 at 11:49 am the Physician Assistant revealed the new order with parameters to hold for SBP less than 140 mmHg was in response to Resident #45's recent low blood pressure on 08/31/21. She stated when the medication was given to Resident #45 with a SBP less than 140 mmHg there was a risk of dizziness, fatigue, and fainting. The PA stated that Resident #45's blood pressure was normally elevated, and she was not notified of a concern related to low blood pressure.	F 760		
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 labeled in accordance with currently accepted professional principles, and include the	F 761		10/4/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345557	A. BUILDING _____ B. WING _____	C 09/23/2021

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F 761	Continued From page 12 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 and staff interviews the facility failed to: 1) discard expired medications in 2 of 2 medication carts, 2) keep medications cart drawers free of loose medications for 1 of 2 medication carts (200 Hall) and 3) discard expired medications in 1 of 2 medication storage rooms (100 Hall) observed for storage of medications. Findings included: 1.a. Manufacturer's instructions not dated, on the boxes for Ipratropium Bromide with Albuterol Sulfate Solution vials revealed: Unit dose must always remain within foil package and once exposed, use individual vials within 2 weeks, and	F 761	761 1) No residents suffered any harm as a result of expired medications on medication carts, loose medications on the medication carts, or expired medications in the medication rooms. 2)To identify other residents that have the potential to be affected, an audit of all medication carts and medications rooms was performed by the Director of Nursing to ensure no expired medications were present and no loose medications were present on the carts. No negative findings were present.	

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F 761	Continued From page 13 protect from light. On 9/23/21 at 10:44 AM Observation of the 100 Hall medication cart with Nurse #7 revealed: -1 bottle of nitroglycerin with the expiration date of 7/30/21 -4 boxes of opened Ipratropium Bromide with Albuterol Sulfate Solution: -1 box opened 6/17/21 (expired 7/2/21) -2 boxes opened 8/17/21 (expired 9/1/21) -1 box opened 8/31/21 (expired 9/15/21). Interview with Nurse #7 on 9/23/21 at 10:44 AM revealed it was the Nurses' responsibility to check the carts for expired medications. She removed the expired medications. She indicated no expired medications had been given to any residents. b. Observation of the 200 Hall medication cart on 9/23/21 at 11:16 AM with Nurse #5 revealed the following: -12 pills of assorted sizes and colors laying at bottom of cart drawer where resident medications were stored -1 box of 12-hour allergy pills with expiration date of 4/21 -1 bottle of loratadine 10mg tablets with expiration date of 8/21 -1 bottle of probiotics with expiration date of 4/21 -2 boxes of Ipratropium Bromide and Albuterol Sulfate Solution: -1 box opened 12/21/20 (expired 1/4/21) -1 box opened 4/9/21 (expired 4/24/21) Interview with Nurse #5 on 9/23/21 at 11:16 AM revealed she was unaware that Ipratropium Bromide and Albuterol Sulfate Solution expired 14 days after the box was opened. She stated the nurses and a Pharmacist had just checked the carts for expired medications and must have missed these. She stated the nurses were	F 761	3)To prevent this from recurring, the Director of Nursing/designee reeducated all licensed nurses on removing any expired medications from the medication carts and medication rooms. Any licensed nurse that cannot be reached within the initial reeducation time frame of 24 hours will not take an assignment until they have received this reeducation by the Director of Nursing/ designee. Agency licensed nurses and newly hired licensed nurses will have this education during their orientation period by the Director of Nursing/designee. 4)To monitor and maintain ongoing compliance, the DON or designee will monitor medication carts and medication rooms to ensure no expired medications are present and no loose pills are present on the carts. Monitoring will occur 3x week for 2 weeks and weekly for 10 weeks. 5) The DON will report the results of the monitoring to the QAPI committee for review and recommendations for the time frame of the monitoring period or as it is amended by the committee. Will be reviewed monthly for 100% compliance for 3 months.	

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F 761	Continued From page 14	F 761		

responsible for checking the medication carts for expired medications. She further stated that no expired medications were administered to any residents on her shift.

2. Inspection of the 100 Hall medication storage room occurred on 9/23/21 at 11:35 AM with Nurse #7 and revealed 2 boxes of earwax remover with expiration date of 4/21, and 2 bottles of saline nasal spray with expiration date of 5/21.

Interview with Nurse #7 on 9/23/21 revealed the stock medications were rotated by the central supply person and with the closest to the expiration date in front.

Interview with the Administrator on 9/23/21 at 12:11 PM revealed the nurses were to follow medication storage protocols and to dispose of expired medications.

Interview with the Central Supply person on 9/23/21 at 1:22 PM indicated she must have missed the expired medications when she rotated the stock. She stated she checks with the nurses as needed to replace stock medications. She further stated she rotated the medications when new stock was delivered to the facility.