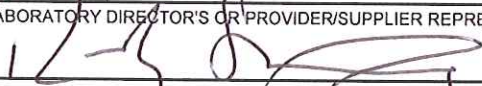


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NAME OF PROVIDER OR SUPPLIER BRIAN CTR HEALTH & REHAB/GASTO	STREET ADDRESS, CITY, STATE, ZIP CODE 969 COX RD GASTONIA, NC 28054
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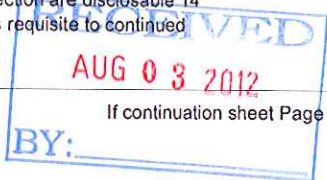
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F 156 SS=B	<p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5) (i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes:</p>	F 156	<ol style="list-style-type: none"> 1. Corrective action has been accomplished for the alleged deficient practice in regards to resident # 14 and resident # 251 have been informed of the reason for Medicare services being stopped and their rights to appeal and how to apply for Medicaid. Resident # 14 and resident #251 have also been informed of care cost for continued stay. 2. Residents with the potential to be affected by the same alleged deficient practice have been identified through audit of current residents receiving Medicare or Medicare replacement benefits by the Social Worker and Business Office Manager. 3. Measures put in place to ensure the alleged deficient practice does not recur include: The Administrator will in-service Admission Director, Social Workers and Business Office Manager on Medicare and Medicare replacement benefits and notifications. Social Work Director will keep a log of all Medicare and Medicare Replacement residents to insure notice is given timely and record dates. Interdisciplinary Team will review logs in daily stand up meeting Monday – Friday for (4) weeks then weekly thereafter. Administrator will review all notices prior to delivery for assurance of correct notice type and that all information is included as well as effective date. <p>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state laws.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 8-1-2012
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Original signature 7/24/12 nh



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F 156	<p>Continued From page 1</p> <p>A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. 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 individual's option, formulate an advance directive. This</p>	F 156	<p>4. Social Service Director will report findings to the Quality Assurance & Performance Improvement committee (QA PI) for evaluation of any trends/patterns for (3) three months. The QA PI committee will amend based on negative trends to ensure continued compliance.</p> <p>5. Date of Completion August 9, 2012</p> <p>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state laws.</p>		

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F 156	<p>Continued From page 2</p> <p>includes a written description of the facility's policies to implement advance directives and applicable State law.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to provide the two (2) of three (3) sampled residents Medicare Non-Coverage notices with the complete information as required and/or within the required time frame. Residents #14 and #251.</p> <p>The findings are:</p> <p>1. Review of the Notice of Medicare Non-Coverage letters revealed Resident #14's medicare covered services ended 5/31/12. This notice did not include the reason medicare services were ending and what the expected costs of care would be subsequently. The form used did not include a place for this required information. In addition, Resident #14 signed the notice on 6/27/12.</p>	F 156		

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F 156	<p>Continued From page 3</p> <p>Review of the social service notes in the medical record revealed the only note pertaining to medicare notices was dated 6/27/12 which stated "Resident made aware of medicare-non-coverage. Update data (Form) in chart."</p> <p>On 7/12/12 at 10:16 AM, the Business Office Manager stated she had no involvement in the notification letters for Medicare non-coverage and that she only kept a copy of the notice once social service staff provided her with one.</p> <p>An interview with the social worker (SW) who wrote this note and was responsible for sending this notice was conducted on 7/12/12 at 11:11 AM. She stated she usually sent the notice out as soon as possible once the Social Service Director or the Business Office Manager informed her of the dates of non-coverage. SW stated that at times, she was given the dates of non-coverage the very date that medicare services ended. She further stated she did not receive notice that Resident #14's medicare coverage was ending until the very day Resident #14 signed the form on 6/27/12. The SW also stated she worked part time and often did not know the reason the services were ending so she could not include the reason in the notices.</p> <p>On 7/12/12 at 2:31 PM the Social Service Director stated that sometimes the Business Office Manager was informed of the date of expected noncoverage before the social workers. She further stated the social service department was educated regarding the notification process in April 2012 after which time the social workers became responsible for sending out the Medicare</p>	F 156			

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F 156	<p>Continued From page 4</p> <p>Non-Coverage letters. This education included a bullet point presentation, which she showed the surveyor indicating which form was required for each possible scenario. The Social Service Director stated there was a lack of communication between departments regarding dates Medicare ended and the reason. She stated she knew of the required information and time frames but had not developed an effective system to ensure the notices were timely and included all the necessary information, including the expected future costs.</p> <p>2. Review of the Notice of Medicare Non-Coverage letters revealed Resident #251's medicare covered services ended 6/29/12. This notice did not include the reason medicare services were ending and what the expected costs of care would be subsequently. The form used did not include a place for this required information.</p> <p>An interview with the social worker (SW) who wrote this note and was responsible for sending this notice was conducted on 7/12/12 at 11:11 AM. She stated she worked part time and often did not know the reason the services were ending so she could not include the reason in the notices.</p> <p>On 7/12/12 at 2:31 PM the Social Service Director stated that sometimes the Business Office Manager was informed of the date of expected noncoverage before the social workers. She further stated the social service department was educated regarding the notification process in April 2012 after which time the social workers became responsible for sending out the Medicare</p>	F 156		

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F 156	Continued From page 5 Non-Coverage letters. This education included a bullet point presentation, which she showed the surveyor, indicating which form was required for each possible scenario. The Social Service Director stated there was a lack of communication between departments regarding so that notices could be provided in the two day required time period and the reason would be known to place on the form. She stated she knew of the required information and time frames but had not developed an effective system to ensure the notices were timely and included all the necessary information, including the expected future costs.	F 156		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews, the facility failed to provide a supplement at the honey consistency as ordered by the physician for one (1) of one (1) sampled resident. Resident #53. The findings are: Resident #53 was admitted to the facility on 7/21/11 with diagnoses including a closed head	F 309	<ol style="list-style-type: none"> Corrective action has been accomplished for the alleged deficient practice in regards to resident # 53 by insuring thicken liquids are provided as ordered by the physician. Residents with the potential to be affected by the same alleged deficient practice have been identified through audit of diet orders and physician orders for residents receiving thicken liquids by Dietary Manager and Director of Nursing. Measures put in place to ensure alleged practice does not recur include: Director of Nursing and Staff Development Coordinator will in-service all nursing staff on thicken liquid orders and RCS assignment sheets for diet orders. Director of Nursing and or Nurse Managers will audit (5) five trays daily Monday-Friday for (4) weeks, then (5) five trays weekly for (4) weeks then (5) five trays monthly for (3) months thereafter for correct fluids. Dietary Manager will in-service all dietary staff on tray cards and diet orders. Dietary Manager will audit (5) five thicken liquid trays daily for (4) weeks then (5) trays weekly for (4) weeks then (5) trays monthly for (3) <p>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state laws.</p>	

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F 309	<p>Continued From page 6</p> <p>trauma, severe progressive Alzheimer's Disease, hypertensive cardiovascular disease, chronic obstructive pulmonary disease, diabetes, and hypothyroidism.</p> <p>The June 2012 computerized physician orders included Resident #53 was on a pureed, thin liquid diet. On 6/14/12, Resident #53 was ordered Med Plus 2.0 (a liquid supplement) twice a day and a supplement shake three times a day with meals.</p> <p>Resident #53's annual Minimum Data Set (MDS) dated 6/7/12 coded her with having long and short term memory impairments and severely impaired decision making skills. The MDS coded her as requiring extensive assistance with eating and receiving no therapies.</p> <p>Physician orders dated 6/23/12 included an evaluation by Speech Therapy (ST) with subsequent orders for ongoing treatment 5 times per week for 4 weeks for treatment of dysphagia, increase safe by mouth intake and education of staff. Another physician order dated 6/23/12 changed Resident #53's diet from thin liquids to nectar thick liquids.</p> <p>ST notes dated 7/5/12 noted Resident #53 exhibited aspiration with puree, nectar and honey consistencies. ST modified her diet to pureed with honey thick liquids and a fiber-endoscope evaluation (swallowing test) to be performed at bedside. A physician's telephone order dated 7/5/12 included a diet change from nectar thickened liquids to honey thickened liquids.</p> <p>On 7/10 at 8:25 AM Resident #53 was observed</p>	F 309	<p>months to ensure liquids are served as ordered by the physician. Dietary department will thicken liquids prior to meal service as ordered by physician.</p> <p>4. Director of Nursing and Dietary Manager will report findings to the QA</p> <p>PI committee for review of trends/patterns and evaluate for any adjustments as needed. QA PI committee will review for (3) three months.</p> <p>5. Date of completion August 09, 2012</p> <p>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state laws.</p>	

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F 309	<p>Continued From page 7</p> <p>sitting upright in her wheelchair being fed by nursing assistant (NA) #1. She had several liquids on her tray which were in containers identified as prethickened to honey consistency. She also had a carton of shake supplement on her tray which was opened. NA #1 stated she had added nothing (no thickener) to the shake as it was considered "thick enough". The shake carton did not specify on the label any consistency. NA #1 stated the shake was "alright" for honey consistency. Resident #53 was not observed coughing or having any trouble swallowing during this observation.</p> <p>On 7/10/12 at 10:07 AM Licensed Nurse (LN) #2 was observed assisting Resident #53 drink a med pass supplement which was thickened to honey consistency. Resident #53 was observed coughing while trying to swallow the supplement. Interview with LN #2 on 7/10/12 at 10:10 AM revealed anytime Resident #53 was given any liquids, they should be thickened to honey consistency.</p> <p>Nursing notes dated 7/10/12 at 3:30 PM noted Resident #53 was given honey thickened med pass this shift and increased coughing was observed during administration of small sips. This was reported to speech therapy.</p> <p>On 7/11/12 at 8:16 AM, Resident #53's tray was set up by NA #2. The liquids on the tray included two prethickened containers of juice, a container of prethickened honey milk, a cup of coffee thickened to honey consistency and a shake supplement that had no indication on the label indicating it was any specific consistency. At 8:29 AM, NA #2 was observed giving Resident #53</p>	F 309		

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F 309	<p>Continued From page 8</p> <p>sips of the shake supplement directly out of the carton. Resident #53 was observed taking multiple sips of the shake supplement with the assistance of NA #2 without any coughing or noted swallowing problems. At 8:31 AM, NA #2 stated she did not add thickener to the shake supplement because it was already thickened correctly.</p> <p>On 7/11/12 at 11:59 AM, Resident #53 was positioned at an overbed table in the small dining room and the Speech Therapist (ST) set up her tray. The resident's food was in bowls and she was provided prethickened liquids, a shake supplement and a frozen nutritional treat (similar to ice cream). ST stated he had been working with Resident #53 for approximately a week and a half. ST picked up the shake supplement and removed it from the tray stating that he was not going to give it to the resident. ST was observed instructing NA #2, who was assisting another resident at a nearby table that Resident #53 needed small bites and staff needed to see her Adam's apple move to ensure she swallowed between bites. ST stated he had observed it taking Resident #53 up to 55 seconds to swallow. ST stated the shake supplements were considered thin to nectar consistency but not a honey consistency. ST further stated Resident #53 has shown signs of aspiration even with honey thickened liquids and staff should be thickening the shake to honey consistency.</p> <p>Follow up interview with LN #2 on 7/11/12 at 12:14 PM revealed usually ST informed the nurse aides of the change in consistency. LN #2 stated nurse aides had been trained to alert the nurse if the liquids were not served at the correct</p>	F 309		

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F 309	<p>Continued From page 9</p> <p>thickness, as the nurses were trained in thickening liquids. LN #2 stated the confusion may be that shakes were considered thickened as they were acceptable for nectar consistencies.</p> <p>Follow up interview with ST on 7/11/12 at 12:26 PM revealed he expected nurse aides to be able to tell the difference between nectar and honey consistencies. He planned to do an inservice between dietary and nurse aides soon.</p> <p>Follow up interview on 7/11/12 at 12:30 PM with NA #2 revealed no one had ever told her that the shakes needed to be thickened.</p> <p>Interview on 7/11/12 at 2:31 PM with the Staff Development Coordinator (SDC) revealed usually the thickened liquids come directly from the kitchen and nurse aides were expected to check to ensure all liquids served were at the correct consistency. Nurse aides had an assignment sheet which will inform them of residents requiring thickened liquids and the specific consistency. SDC stated if the nurse aide questioned the consistency of any liquid they were to verify the consistency with the nurse. SDC further stated nurse aides were not permitted to add thickener to liquids.</p> <p>On 7/11/12 at 2:50 PM, unit manager licensed nurse #2 stated nurse aides were responsible for ensuring the liquids served were the correct consistency per the assignment sheet. If the liquids were not at the correct consistency, nurse aides were to return them to the kitchen for correction. Nurse aides were not permitted to thicken liquids unless they have been trained. The unit manager further stated she suspected</p>	F 309		
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F 309	<p>Continued From page 10</p> <p>nurse aides assumed the shakes came at the correct consistency as the shakes were sent on the trays from the kitchen.</p> <p>The Assistant Dietary Manager (ADM) was interviewed on 7/11/12 at 3:00 PM. She stated that most liquids come in a variety of pre-thickened consistencies, i.e. juices and milks. Coffee was thickened in the kitchen with packets of thickener, made for coffee, specified for various consistencies. Per the ADM, shake supplements and fortified juices don't come thickened and would need thickener added to ensure correct consistencies. The ADM stated that if the shake supplement was provided on the meal trays, it would be the kitchen's responsibility to thicken the shake supplement. Review of the tray card revealed Resident #53 was to receive honey thick liquids. ADM further stated the dietary staff should have thickened the shake supplement to a honey consistency before sending it on the tray to the resident.</p> <p>On 7/12/12 at 8:38 PM, the Director of Nursing (DON) stated the liquids coming from the kitchen should have been sent at the correct consistency and if nurse aides were not sure if the consistency was correct, they should verify the consistency with the nurses.</p> <p>Follow up interview with NA #1 on 7/12/12 at 8:40 PM revealed she was not aware the shake supplement was not prethickened to the correct consistency.</p> <p>On 7/12/12 at 10:49 AM, the corporate Registered Dietician stated shake supplements were not honey thick. She further stated that</p>	F 309		

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F 309 F 371 SS=E	<p>Continued From page 11</p> <p>since the shakes came in a closed container, the dietary staff would not thicken them in the kitchen in order to preserve the temperature.</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>The facility must -</p> <p>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations and staff interviews the facility failed to dispose of unusable food items, implement a system to label and date food products so they were used within the required period and failed to discard expired medication pass supplements.</p> <p>The findings were:</p> <p>1. Observations of the kitchen's walk-in refrigerator on 07/09/12 at 10:20 AM, revealed a cardboard box that contained fifty-five (55) four-ounce grape juice cartons that were ready for use.</p> <p>Observations of the sides, tops and bottoms of the grape juice cartons revealed each carton contained patches of a light green to dark green wooly residue.</p>	F 309 F 371	<ol style="list-style-type: none"> 1. Corrective action has been accomplished for the alleged deficient practice by ensuring the identified juices, supplements, and Med pass were discarded promptly. 2. Facility residents have the potential to be affected by the same alleged deficient practice. The Dietary Manager has conducted an audit of all supplies to identify any additional concerns related to juices, supplements and Med Pass for expiration dates. 3. Measures put in place to ensure the alleged deficient practice does not recur include: Dietary Manager will in-service all dietary staff on proper handling and dating of supplies. Dietary Manager will monitor coolers and freezers daily Monday – Friday for (4) four weeks then weekly for (3) three months then monthly thereafter for proper dates and clean products. Dietary Manager will monitor nourishment refrigerators daily for (4) four weeks then weekly thereafter for out of date products. Results will be reviewed daily Monday- Friday by Interdisciplinary Team for results and adjustments. <p>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state laws.</p>	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 371	<p>Continued From page 12</p> <p>Further observations of the kitchen's walk in refrigerator on 07/11/12 at 9:35 AM revealed the same box with fifty-five (55) four-ounce containers of grape juice covered with the patchy light to dark green wooly residue remaining on the cartons.</p> <p>An interview with the Assistant Dietary Manager (ADM) was conducted on 07/11/12 at 9:49 AM. The ADM stated the kitchen staff was to check the refrigerated storage areas at least weekly to monitor for expired food products and signs of spoilage. She further stated when supplies were delivered weekly, products placed in the refrigerated storage areas needed to be labeled with arrival date and placed behind any previous product. The ADM further indicated it was her expectation that all kitchen staff check product expiration dates and for signs of spoilage and remove such items from the walk in refrigerator. When the ADM was shown the box of grape juice cartons, she could not recall when they had been used last and was unsure of how the patchy residue, which she referred to as mold, had been overlooked. The ADM stated facility kitchen staff should have checked the cartons for spoilage and removed it.</p> <p>An interview was conducted on 07/12/12 at 9:39 AM with the facility consulting registered dietitian (RD). She stated the A.M. cook had a responsibility to check, organize and clean the walk in refrigerator on a weekly basis every Thursday. During this cleaning the RD indicated the shelves were to be wiped down, boxes checked for expiration dates and spoilage and the floor swept and mopped. She reported that once</p>	F 371	<p>4. Dietary Manager will report findings to the QA PI committee for review of any trends / patterns for any needed improvement or corrective action. QA PI will review for three months.</p> <p>5. Date of completion August 09, 2012</p> <p>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state laws.</p>	

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F 371	<p>Continued From page 13</p> <p>the A.M. cook has cleaned the walk in refrigerator they were to sign the cleaning schedule indicating it has been completed.</p> <p>2. Observations of the kitchen's walk- in refrigerator on 07/11/12 at 9:35 AM revealed a box labeled supplemental vanilla shakes with twenty-four (24), four-ounce cartons inside. The label on each carton stated the product was only good for fourteen days once thawed.</p> <p>Observations of the cartons and the box revealed no date that the supplemental shakes had been thawed. Furthermore, no date could be found on the cartons or box that was within a 14 day time period. All cartons of supplemental shakes could be shaken easily and the carton sides were soft to touch indicating they had been thawed completely.</p> <p>An Interview was conducted with Dietary Aide #1 on 07/11/12 at 9:46 AM. She stated it was the responsibility of all kitchen staff to check the refrigerators for expired products. When asked about the routine for thawing, labeling and use of supplemental shakes she stated once the case is removed from the freezer the shakes should be labeled with an expiration date, which needed to be fourteen days after the supplemental shakes were thawed. The Dietary Aide stated she could not see a date on the box indicating when the box was opened or thawed.</p> <p>An interview with the Assistant Dietary Manager (ADM) was conducted on 07/11/12 at 9:49 AM. The ADM stated the kitchen staff was to monitor the refrigerated storage areas at least weekly to check for expired food products. When asked</p>	F 371		

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F 371	<p>Continued From page 14</p> <p>about the routine for supplemental shakes she explained the staff was to check all products as they remove it for use to assure it was not expired or past the use by date. The ADM further stated the supplemental shakes would be disposed of because staff did not place an expiration date on the box.</p> <p>3. On 7/11/12 at 5:23 PM observations were made of the nourishment room on the 500 hall. Observations revealed two (2) of fourteen (14) Med Pass 2.0 cartons (supplements) were opened in the refrigerator. One was dated as being opened 6/23/12 and the other was dated as being opened on 6/27/12.</p> <p>Interview with the licensed nurse (LN) #1 stated the hand written dates indicated the date the cartons were opened. She stated she was unsure how long the supplement was good after opening the carton. She stated she normally used the entire carton during her medication pass and had no left over supplement to store. She further stated she was not sure who was responsible for ensuring the items in the refrigerator were within the expiration timeline but stated they should have been thrown away. She then discarded the opened supplements.</p> <p>Interview on 7/12/12 at 9:32 AM with the unit manager LN #1 revealed she thought the supplement was good for twenty four hours after opening when not refrigerated and longer when refrigerated. She further stated most of the time, the nurses use an entire container of supplement during their medication pass.</p> <p>On 7/12 12 at 10:49 AM, the corporate</p>	F 371		

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F 371	Continued From page 15 Registered Dietician stated the Med Pass supplements were good for 48 hours after being opened. She confirmed the two in the 500 nourishment room were expired and expected the nursing staff to know the expiration times. She further stated the dietary staff were responsible for cleaning the refrigerator and restocking milks and checking those dates. Both nursing and dietary should monitor the dates of med pass but nurses were more involved with the day to day usage of med pass.	F 371		
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