STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345281	A. BUILDING _____ B. WING _____	07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANLY MANOR	**625 BETHANY CHURCH ROAD BOX 38 ALBEMARLE, NC 28001**

(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 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that -- (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to check the tube placement prior to administering the medications for 1 (Resident #1) of 2 sampled residents with feeding tube. Findings included: Resident #1 was admitted to the facility on 1/29/09 with multiple diagnoses including anoxic brain damage. The annual Minimum Data Set (MDS) assessment dated 5/20/15 indicated that Resident #1 had a feeding tube. The physician's orders for July, 2015 was reviewed. The orders included " check	F 322	For Resident #1, all licensed nursing staff (Full Time/Part Time/ PRN) providing services to resident #1 will receive in-service education for medication administration from the Staff Development Coordinator, or Consultant Pharmacist on placement of enteral tube prior to administration of medication on 8/5, 8/6,8/10,and 8/11/2015 Nurse #1 was removed from assignment with instructions to complete in-service training with Pharmacy Consultant on	8/19/15

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

Electronically Signed | 08/05/2015

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F 322	Continued From page 1 gastrostomy (G) tube for placement prior to medications, flushes or boluses. " The order was written on 6/19/14. On 7/22/15 at 10:30 AM, Resident # 1 was observed during the medication pass. Nurse #1 was observed to administer the medications via G tube without checking the tube placement. On 7/22/15 at 10:35 AM, Nurse #1 was interviewed. She stated that she should have checked the tube placement prior to administering the medications but she did not. On 7/23/15 at 10:05 AM, administrative staff #1 was interviewed. She stated that her expectation was for the nurse to check the tube placement prior to administering the medications.	F 322	Medication Administration via the enteral route prior to re-assignment. The in-service was completed 7/30/2015 with 100% compliance. The Consultant Pharmacist observed medication administration via enteral route with Nurse #1 on resident #1 and resident #4 on 7/30/2015 All nurses on all shifts full-time/part-time/ PRN/ will receive in-service education from the Staff Development Coordinator,or Pharmacist on identifying placement of enteral tube during administration of medication. This education will be provided to ensure residents having the same potential as resident #1 will not be affected. The following measures will be put in place as a systemic change to ensure proper medication administration via the enteral route: All new licensed nursing staff hired after 7/23/2015 will receive education during orientation on proper placement and flushing of enteral tube during medication administration. Licensed Nursing Staff, (Full Time/Part-Time/ PRN) will receive annual education on proper placement and flushing via the enteral route during medication administration. The facility will have the Consultant Pharmacist,Director of Nursing, Assistant Director of Nursing or Staff Development Coordinator complete one enteral medication audit on one resident per	

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F 322	Continued From page 2	F 322	week x 1 month, and then one enteral medication audit on one resident every 2 weeks x 1 month, then one enteral medication audit monthly on one resident until compliance is sustained x 3 months rotating shifts and days, identifying placement of enteral tube prior to administration of medication to ensure compliance. The reviews will focus on checking for tube placement prior to administering medications. The Director of Nursing or Assistant Director of Nursing will review audits and discuss monthly at Quality Assurance meetings until three months of compliance is sustained. Audits will occur one enteral medication audit on one resident per week x 1 month, and then one enteral medication audit on one resident every 2 weeks x 1 month, then one enteral medication audit monthly on one resident until compliance is sustained x 3 months rotating shifts and days, identifying placement of enteral tube prior to administration of medication to ensure compliance. The reviews will focus on checking for tube placement prior to administering medications.	
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced	F 332		8/19/15

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F 332	Continued From page 3 by: Based on record review, observation and staff interview, the facility failed to maintain the medication error rate at 5% or below by not flushing the gastrostomy tube (GT) with water prior to administering the medications on 2 (Resident #1 & #4) of 2 sampled residents with GT. There were 2 errors of 26 opportunities for error resulting in a 7.69 % error rate. The findings include: 1. Resident #4 was admitted to the facility on 12/8/03 with multiple diagnoses including encephalopathy and dysphagia. On 7/22/15 at 8:00 AM, Nurse #1 was observed to prepare and to administer the medications for Resident #4. Resident # 4 was scheduled to receive medications including Ferrous Sulfate liquid (drug used to treat iron deficiency anemia)) at 9:00 AM. Nurse #1 started to pour the Ferrous Sulfate liquid into the syringe (attached to the GT) without flushing the tube first with water. On 7/22/15 at 8:05 AM, Nurse #1 was interviewed. She stated that she should have flushed the tube first with water before administering the medication (Ferrous Sulfate) but she did not. On 7/23/15 at 10:05 AM, administrative staff #1 was interviewed. She stated that her expectation was for the nurse to flush the tube with water before and after each medications. 2. Resident #1 was admitted to the facility on 1/29/09 with multiple diagnoses including anoxic brain damage. On 7/22/15 at 10:30 AM, Nurse # 1 was observed to prepare and to administer the medications for Resident #1. Resident # 1 was scheduled to receive medications including Nexium (a drug used to treat certain stomach and esophagus problems) at 10:00 AM. Nurse #1	F 332	For Resident #1 and Resident #4 all licensed nursing staff providing medication administration to these residents received in-service education from the Staff Development Coordinator, or Pharmacist on flushing of enteral tube before and after each medication is administered on 8/5, 8/6,8/10 and 8/11/2015. Nurse #1 was removed from assignment with instructions to complete in-service training with pharmacy consultant on Medication Administration via the enteral route prior to re-assignment. The Consultant Pharmacist training was held for this nurse on 7/30/2015 with 100% compliance. All licensed nursing staff on all shifts Full Time/Part Time/PRN have received in-service education from the Staff Development Coordinator, or Pharmacist on flushing the enteral tube before and after each medication is administered. This education was provided to ensure residents having the same potential as resident #1 and resident #4 will not be affected. In-services held by Consultant Pharmacist or Staff Development on 8/5,8/6,8/10, and 8/11/2015. The following measures will be put in place as a systemic change to ensure medication administration via the enteral route: All new licensed nursing staff hired after 7/23/2015 will receive education during orientation on proper placement	

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F 332	Continued From page 4 started to pour water into the syringe (attached to the GT) and immediately followed with the powdered Nexium. The nurse was not observed to flush the tube first with water. The medication was stuck at the tip of the syringe and was not flowing into the tube. Nurse #1 had to pour the contents of the syringe into a cup and had to clear the tip of the syringe before she administered the medications. On 7/22/15 at 10:35 AM, Nurse #1 was interviewed. She stated that she should have flushed the tube first with water before administering the medication (Nexium) but she did not. On 7/23/15 at 10:05 AM, administrative staff #1 was interviewed. She stated that her expectation was for the nurse to flush the tube with water before and after each medications.	F 332	and flushing of enteral tube during medication administration. Licensed Nursing Staff, (Full Time/Part-Time/ PRN) will receive annual education on proper placement and flushing via the enteral route during medication administration. The facility will have the Consultant Pharmacist, Director of Nursing, Assistant Director of Nursing or Staff Development Coordinator complete one enteral medication administration audit on one resident per week x 1 month, and then one enteral medication audit every 2 weeks on one resident x 1 month, then one enteral medication audit on one resident monthly until compliance is sustained x 3 months rotating shifts and days, identifying proper flushing of enteral tube prior to administration and during administration of medication to ensure compliance. The reviews will focus on proper flushing of enteral tube before and after each medication is administered. These audits will be monitored by the Director of Nursing or Assistant Director of Nursing and discussed at the facility's Quality Assurance meetings. Audits will occur on one resident per week x 1 month, and then one enteral medication audit every 2 weeks on one resident x 1 month, then one enteral medication audit on one resident monthly until compliance is sustained x 3 months rotating shifts and days, identifying proper flushing of enteral	

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F 332	Continued From page 5	F 332	tube prior to administration and during administration of medication to ensure compliance. The reviews will focus on proper flushing of enteral tube before and after each medication is administered.	
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal	F 334		8/19/15

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F 334	Continued From page 6 immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to document in the resident's medical records that education regarding the benefits and potential side effects of influenza	F 334	For Resident #1 and Resident #11 the residents responsible party's were notified and educated on the risk versus benefits, and side effects of the pneumococcal and	

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F 334	Continued From page 7 and pneumococcal immunizations was provided to the resident or legal representatives for 2 (Residents #1 & #11) of 5 sampled residents reviewed. Findings include: 1. Resident #1 was admitted to the facility on 1/29/09 with multiple diagnoses including anoxic brain damage. The immunization records for Resident #1 was reviewed. The record indicated that Resident #1 has received pneumococcal vaccine on 6/26/15. There was no documentation in the records that education regarding the benefits and the potential side effects of the pneumococcal immunization was provided to the legal representative. On 7/22/15 at 4:20 PM, administrative staff #1 was interviewed. She stated that if it was not documented it was not done. 2. Resident #11 was admitted to the facility on 2/14/14 with multiple diagnoses including Congestive Heart failure and Hypertension. The immunization records for Resident #11 was reviewed. The record indicated that Resident #11 has received influenza vaccine on 10/2/14. There was no documentation in the records that education regarding the benefits and the potential side effects of the influenza immunization was provided to the resident or legal representative. On 7/22/15 at 4:20 PM, administrative staff #1 was interviewed. She stated that if it was not documented it was not done.	F 334	influenza vaccine in September 2014 an addendum was placed in the chart documenting these conversations. All current charts were audited to ensure pneumococcal and influenza vaccine was present and documented prior to administration by the Director on Nursing on 8/5/2015. All licensed nursing staff Full Time/Part Time/ PRN, have received education from the Staff Development Coordinator or Consultant Pharmacist on the following dates 8/5,8/6,8/10 and 8/11/2015 on the following: - Before offering the influenza and/or pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; - Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; - Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; -As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident	

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F 334	Continued From page 8	F 334	or the resident's legal representative refuses the second immunization. -The resident or the resident's legal representative has the opportunity to refuse immunization; and - The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza and/or pneumococcal immunization; and (B) That the resident either received the influenza and/or pneumococcal immunization or did not receive the influenza immunization due to medical contraindications or refusal. The following measures will be put in place as a systemic change to ensure proper documentation of the influenza and/or pneumococcal immunization: a weekly chart audit will be completed on one new resident per week X 1 month, then an audit will be completed on one new resident every 2 weeks x 1 month, then an audit will be completed 1 new admission a month until 3 months of compliance is sustained. The audit will be completed by the Director of Nursing, Assistant Director of Nursing or Medical Record Director to ensure compliance with the education given. These audits will be monitored, reviewed and discussed by the Director of Nursing or Assistant Director of Nursing at the	

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F 334	Continued From page 9	F 334	facility's Quality Assurance meetings until three months of compliance is sustained for all audited chart reviews. The audits will include the following: a chart audit will be completed on one new resident per week X 1 month, then an audit will be completed on one new resident every 2 weeks x 1 month, then an audit will be completed 1 new admission a month until 3 months of compliance is sustained. The audit will focus on the above criteria of documentation needed above for the pneumonia and influenza vaccine.	
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors.	F 356		8/18/15

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F 356	Continued From page 10 The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to post daily staffing information that was accurate. The findings included: On 7/21/15 at 8:53 AM, an initial tour of the facility was conducted. The staff posting located at the central nursing station stated the census was 92. The census included skilled nursing residents and assisted living residents. On 7/22/2015 at 8:01 AM, staff posting information was observed and the census was documented as 92. The census included skilled nursing residents and assisted living residents. On 7/22/2015 at 8:05 AM, staff posting information was observed and the census was documented as 91. The census included skilled nursing residents and assisted living residents. On 7/22/15 at 8:01 AM, Administrative staff #1 stated the ward secretary on day shift completed and posted the staff posting form with the census information. On 7/22/15 at 8:05 AM, the ward secretary stated she filled out the staff posting and the census was in the computer that gave her the total number of residents that were in the facility at midnight. She said that census that she posted on the staff posting sheet was the total number of skilled nursing residents (SNF) and the number of	F 356	No residents were noted to be affected by having the total census reported on the daily posting of staffing information. The daily posting was corrected to show the census for skilled nursing and the census for home of the aged during the DSHR survey. No potential residents were noted to be affected by having the total census reported on the daily posting. The daily posting of staffing information was corrected to show the census for skilled nursing and the census for home of the aged. The systematic change put in place was the modification of the daily posting of staffing information form to include a break out of census for the skilled level of care census and home for the aged census. The ward secretary, ward clerk or charge nurse will complete on each shift and each day including weekends the Daily Posting of staffing.	

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F 356	Continued From page 11 assisted living residents (ALF) in the facility. The ward secretary stated she was directed by the previous ward secretary to put the total census number (residents in the building at midnight (SNF and ALF) on the staff posting sheet.	F 356	In-service education will be provided by the Staff Development Coordinator or Director of Nursing to the charge nurses, ward clerk and ward secretary on how to properly complete the Daily Staffing Posting for all days, all shifts, including weekends. In-services will be completed by 8/18/2015. The Director of Nursing, Administrator or Assistant Director of Nursing will audit one posting per week x one month, then will audit one posting every two weeks x one month and then audit once posting monthly per month until compliance is sustained. The focus will be for accuracy of census being broken out between the skilled level of care and home for the aged. These audits will be reviewed and discussed at the facility's QA meetings by the Director of Nursing or Assistant Director of Nursing until three months of compliance is sustained to ensure the correct census is reflected. The audit schedule will be as follows: Audit one posting per week x one month, then will audit one posting every two weeks x one month and then audit once posting monthly per month until compliance is sustained. The focus will be for accuracy of census being broken out between the skilled level of care and home for the aged.	
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371		8/19/15

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F 371	Continued From page 12 The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on record reviews, staff interviews and observations, the facility failed to monitor freezer temperatures in two of two nourishment refrigerators (200-500 halls and 600 hall) and the facility failed to maintain the refrigerator temperature between 36 degrees and 46 degrees Fahrenheit for one of two nourishment refrigerators (600 hall). The findings included: 1. An observation of the 200-500 hall nourishment freezer was made on 7/22/15 at 3:03 PM. No thermometer was observed in the 200-500 hall nourishment freezer. Sixteen 4 ounce containers of ice cream, two boxes each containing six Klondike bars and one box containing three Klondike bars were observed in the 200-500 hall nourishment freezer. An observation of the 600 hall nourishment freezer was made on 7/22/15 at 2:51 PM. Four 4 ounce containers of sugar free ice cream and three 4 ounce magic cups were observed in the 600 hall nourishment freezer.	F 371	The facility immediately placed thermometer in freezer in the nourishment refrigerator and discarded the 600 hall college size refrigerator during the DHSR survey. Maintenance Director checked the refrigerator in nourishment room and found it to be working properly. The following measures will be put in place as a systemic change to ensure proper temperature is maintained in nourishment refrigerators/freezer and accurate recordings are taken: The Dietary Manager on 7/30/2015 provided education to the housekeeping staff on how to read a thermometer and the acceptable temperature ranges. The Dietary Manager also gave instructions on promptly contacting maintenance with any concerns regarding the temperatures of the nourishment refrigerator/freezer. A new daily temperature sheet was created for documenting the refrigerator and	

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F 371	Continued From page 13 A review of the Refrigerator/Freezer Temperature Record Log for the 200-500 hall and 600 hall nourishment refrigerators revealed the freezer temperatures were not monitored. An interview was conducted with Housekeeper #1 on 7/22/15 at 3:31 PM. She stated the housekeeping staff was responsible for monitoring the temperatures in the nourishment refrigerators. She stated she was not instructed to monitor the temperatures in the nourishment freezers. The Housekeeper stated she had not been monitoring the temperatures in the nourishment freezers. She also stated she did not observe a thermometer in the 200-500 hall nourishment freezer. An interview was conducted with Administrative Staff # 3 on 7/22/15 at 4:10 PM. She stated the housekeeping staff were not expected to monitor the temperatures in the nourishment refrigerators. An interview was conducted with Housekeeper #2 on 7/22/15 at 4:24 PM. She stated she was not instructed to monitor the temperatures in the nourishment freezers. 2. A review of the Refrigerator/Freezer Temperature Record Log dated 6/3/15 to 7/22/15 for the 600 hall nourishment refrigerator was conducted. The acceptable temperature range for the nourishment refrigerator was not referenced on the Refrigerator/Freezer Temperature Record Log. A temperature reading equal to 50 degrees Fahrenheit was documented on 6/3/15. A temperature reading equal to 50 degrees Fahrenheit was documented on 6/18/15. A temperature reading equal to 32 degrees	F 371	freezer temperatures. The facility will have the Dietary Manager or Assistant Dietary Manager to complete a weekly audit of nourishment refrigerator/freezer temperature logs for one month, then audit every two weeks X 1 month, then audit once a month until three months of compliance is sustained. This audit will be reviewed and discussed at the Quality Assurance Committee meeting by the Dietary Manager or Assistant Dietary Manager. The reviews will focus on proper temperature documentation. Audits will be reviewed and discussed by the Dietary Manager or Assistant Dietary Manager at the Quality Assurance Committee Meetings until three months of compliance is sustained for 3 monthly reviews. Audit schedule will be as follows: Complete a weekly audit of nourishment refrigerator/freezer temperature logs for one month, then audit every two weeks X 1 month, then audit once a month until three months of compliance is sustained. This audit will be reviewed and discussed at the Quality Assurance Committee meeting by the Dietary Manager or Assistant Dietary Manager. The reviews will focus on proper temperature documentation.	

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F 371	Continued From page 14 Fahrenheit was documented on 6/21/15. A temperature reading equal to 30 degrees Fahrenheit was documented on 6/29/15. A temperature reading equal to 32 degrees Fahrenheit was documented on 6/30/15. A temperature reading equal to 30 degrees Fahrenheit was documented on 7/2/15. A temperature reading equal to 32 degrees Fahrenheit was documented on 7/3/15. A temperature reading equal to 30 degrees Fahrenheit was documented on 7/4/15. A temperature reading equal to 30 degrees Fahrenheit was documented on 7/5/15. A temperature reading equal to 26 degrees Fahrenheit was documented on 7/7/15. A temperature reading equal to 28 degrees Fahrenheit was documented on 7/8/15. A temperature reading equal to 28 degrees Fahrenheit was documented on 7/9/15. A temperature reading equal to 30 degrees Fahrenheit was documented on 7/10/15. A temperature reading equal to 28 degrees Fahrenheit was documented on 7/12/15. A temperature reading equal to 26 degrees Fahrenheit was documented on 7/13/15. A temperature reading equal to 20 degrees Fahrenheit was documented on 7/14/15. A temperature reading equal to 20 degrees Fahrenheit was documented on 7/16/15. A temperature reading equal to 24 degrees Fahrenheit was documented on 7/17/15. A temperature reading equal to 52 degrees Fahrenheit was documented on 7/20/15. A temperature reading equal to 50 degrees Fahrenheit was documented on 7/21/15. An observation of the 600 hall nourishment refrigerator on 7/22/15 at 2:51 PM revealed the refrigerator contained three pasteurized raw	F 371		

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F 371	Continued From page 15 eggs, containers of thick it, containers of juice and cans of soda. An interview was conducted with Housekeeper #1 on 7/22/15 at 3:31 PM. She stated the housekeeping staff was responsible for monitoring the temperatures in the nourishment refrigerators. She stated she was unaware of the acceptable temperature range for the nourishment refrigerators. She stated she verbally informed Administrative Staff #2 on 7/22/15 of the recent elevated temperature readings for the 600 hall nourishment refrigerator. An interview was conducted with Administrative Staff # 3 on 7/22/15 at 4:10 PM. She stated the housekeeping staff were expected to monitor the temperature of the nourishment refrigerators daily. She stated the nourishment refrigerators were expected to be maintained at 50 degrees Fahrenheit or below. She stated she was not made aware that the 600 hall nourishment refrigerator temperature was equal to 52 degrees Fahrenheit on 7/20/15 and equal to 50 degrees Fahrenheit on 7/21/15. She stated the housekeeping staff were expected to inform her of all abnormal temperature readings. She would then inform the maintenance director of the abnormal temperature reading. An interview was conducted with Housekeeper #2 on 7/22/15 at 4:24 PM. She stated the housekeeping staff were expected to monitor the temperature of the nourishment refrigerators daily. She stated the nourishment refrigerators were expected to be maintained between 32 to 34 degrees Fahrenheit. She stated she verbally informed Administrative Staff #1 and Administrative Staff #2 on 7/21/15 of the elevated	F 371		

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F 371	Continued From page 16 temperature readings for the 600 hall nourishment refrigerator. An interview was conducted with Administrative Staff #2 on 7/22/15 at 5:13 PM. He stated he was told of the elevated temperature reading in the 600 hall nourishment refrigerator on 7/20/15. He stated he was not made aware that the refrigerator had reached low temperatures in the months of June and July. He stated the temperature of the refrigerator was elevated due to the high number of foods items placed within the refrigerator. Administrative Staff #2 stated the 600 hall nourishment refrigerator was removed on 7/22/15 and a larger refrigerator would be placed on the 600 hall.	F 371		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature	F 431		8/19/15

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F 431	Continued From page 17 controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to discard expired medications and to date multi dose medications on 3 of 5 medication carts (400/500/600 halls) observed. Findings included: Facility's policy on Medication Expiration Dates dated 10/14 was reviewed. The policy indicated in part " all multi dose vials must be dated when opened. The multi dose vial should be discarded 28 days from the date the vial is opened. " 1a. On 7/22/15 at 2:00 PM, the medication cart on 400 hall was observed. There was an opened bottle of UTI stat (a supplement to prevent UTI) with no date of opening. The instruction on the bottle of UTI stat indicated " discard three months after opening. " On 7/22/15 at 2:20 PM, Nurse #2 was interviewed. She stated that the UTI stat should have been dated when opened but it was not. On 7/23/15 at 10:05 AM, administrative staff #1 was interviewed. She stated that her expectation	F 431	The medications that were noted expired or did not have open dates listed on vials from medication carts on 400/500/600 cart were removed from the cart and returned to the pharmacy on 7/22/2015. All carts were checked to ensure no out of date medication or open undated vials were present by the Director of Nursing on 7/23/2015. All licensed nursing staff, Full Time/ Part Time/PRN, have received in-service education from the Staff Development Coordinator, or Consultant Pharmacist on proper labeling of multi dose vials when opened and discarding of expired medications on 8/5, 8/6, and 8/10/2015 The following measures will be put in place as a systemic change to ensure proper discarding and labeling of open	

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F 431	Continued From page 18 was for the nurse to write the date on the bottle/vial when it was first open. 1b. On 7/22/15 at 200 PM, the medication cart on 400 hall was observed. There was an opened bottle of Regular insulin with date of opening of 6/8/15. On 7/22/15 at 2:20 PM, Nurse #2 was interviewed and stated that Regular insulin was good for 28 days after opening and acknowledged that the opened bottle of Regular insulin was already expired. On 7/23/15 at 10:05 AM, administrative staff #1 was interviewed. She stated that her expectation was for the nurse to check the expiration date on the vial before administering the insulin. She acknowledged that Regular insulin was good for 28 days after opening. 2a. On 7/22/15 at 2:30 PM, the 500 hall medication cart was observed. There was an opened bottle of UTI stat with no date of opening. The instruction on the bottle of the UTI stat read " discard three months after opening. " The pharmacy sticker on the bottle indicated that it was dispensed from the pharmacy on 2/4/15. On 7/22/15 at 2:45 PM, Nurse #1 was interviewed. She stated that the UTI stat should have been dated when opened but it was not. On 7/23/15 at 10:05 AM, administrative staff #1 was interviewed. She stated that her expectation was for the nurse to write the date on the bottle/vial when it was first open. 2b. On 7/22/15 at 2:30 PM, the 500 hall medication cart was observed. There were 2 opened bottles of lidocaine HCL (local anesthetic) injection with no date of opening. The sticker instruction on the bottle read " discard 28 days	F 431	vials on medication carts: The facility will have the Consultant Pharmacist,Director of Nursing, Assistant Director of Nursing or Staff Development Coordinator complete 1 cart audit a week X one month, then one cart audit every 2 weeks x one month, then one cart audit monthly until three months of compliance is sustained. The audit will occur on different days of the week, including weekends. The Director of Nursing, Assistant Director of Nursing or Consultant Pharmacist will review and discuss the audits at Quality Assurance meetings until three months of compliance is sustained for all audited medication cart reviews. The audit schedule will be as follows: The facility will have the Consultant Pharmacist, Director of Nursing, Assistant Director of Nursing or Staff Development Coordinator complete 1 cart audit a week X one month, then one cart audit every 2 weeks x one month, then one cart audit monthly until three months of compliance is sustained. The audit will occur on different days of the week, including weekends.	

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F 431	Continued From page 19 after opening. " There was also 1 opened bottle of lidocaine HCL injection in a small plastic bag with no date of opening. The bag indicated that the lidocaine was dispensed from the pharmacy on 5/25/15. On 7/22/15 at 2:45 AM, Nurse #1 was interviewed. Nurse #1 stated that the lidocaine should have been dated when opened and they were good for 28 days after opening. On 7/23/15 at 10:05 AM, administrative staff #1 was interviewed. She stated that her expectation was for the nurse to write the date on the bottle/vial when it was first open. 3a. On 7/22/15 at 3:04 PM, an observation of the 600 hall medication cart was conducted. An opened package of Budesonide (breathing medication) 0.25 milligrams (mg)/ two milliliters (ml) was observed in the medication cart. The label on the package stated to discard 14 days after opening. The date opened was documented as 7/5/15. On 7/22/15 at 3:04 PM, Nurse #1 stated she should have discarded the medication. On 7/22/15 at 3:37 PM, the pharmacy consultant stated the medication should have been discarded 14 days after opening the package on 7/5/15. 3b. On 7/22/15 at 3:04 PM, an observation of the 600 hall medication cart was conducted. An opened one ml vial of promethazine (nausea medication) 25mg/ ml was observed in the medication cart. This was a single dose vial. The date opened on the vial stated 9/16/14. On 7/22/15 at 3:04 PM, Nurse #1 stated she did not know the vial was in the medication cart. On 7/22/15 at 3:37 PM, the pharmacy consultant stated the promethazine was a single dose vial and any medication left in the vial after	F 431		

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F 431	Continued From page 20 administration should be have been discarded immediately.	F 431		