STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345195	A. BUILDING ______ B. WING ______	C 07/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - TARBORO	1000 WESTERN BOULEVARD TARBORO, NC 27886

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS IDR panel 9/14/15 deleted F 282, F 323 and F 325	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.	F 157		8/13/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 08/07/2015

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.

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F 157	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on record review and staff and family interview, the facility failed to notify the responsible party (RP) when psychotropic medications were started and stopped for 1 of 2 residents reviewed for notification of change (Resident #253). The findings included: Resident #253 was admitted to the facility on 6/12/14. Diagnoses included dementia without behaviors, urinary tract infection, gastroenteritis and dehydration. Admission physician orders for medications did not include any psychotropic drugs (drugs for anxiety, depression, psychosis, sleep). The admission Minimum Data Set dated 6/19/14 revealed the resident had severe cognitive impairment. A psychiatric evaluation on 7/7/15 revealed Resident #253 was seen due to recent onset of aggressive behavior and resistance to care. A diagnosis of dementia with behaviors was made. Physician orders dated 9/5/14 included Depakote (a drug used as a mood stabilizer) 250 mg twice a day. There was no documentation in the record that the RP was notified. Review of nurses' notes dated 9/11/14 revealed a family member visited and was given a progress report on the resident's behavior. The resident continued to be combative and resistant to care at times. Physician orders dated 9/12/14 included Seroquel (an antipsychotic) 12.5 mg twice a day. There	F 157	¿Preparation and/or execution of this Plan of Correction does not constitute admission of agreement by the provider of the truth of the facts alleged or conclusion set forth in the Statements of Deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provision of federal and state laws.¿ Corrective Action Affected Resident: Resident is no longer in facility. Discharged 2014. Corrective Action Potential Residents: Week day Clinical startup will be followed Monday through Friday. This Clinical Startup is a checklist to assist the facility in completing a comprehensive overview of care delivery every morning. This meeting reviews all nurses¿ notes and new physician orders for the previous day. So not only psychotropic meds but all new meds will be reviewed and we will make sure all Responsible Parties (RP¿s) are called. Attendance includes Nursing, Social, Activities, Dietary and Therapy Department Heads. As part of this meeting, an audit is done daily to ensure all Responsible Parties (RP) are called on any significant change. If RP not called, the Wing Manager/Charge Nurse will call the next morning, if identified, after Clinical Startup. RP notification is found	

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was no documentation in the record that the RP was notified.

On 9/18/14 a psychiatric progress note and physician order included to discontinue the Zoloft and Seroquel and start Ativan 0.5 mg daily. There was no documentation in the record that the RP was notified.

On 10/9/14 a psychiatric progress note and physician order included to restart the Zoloft 50 mg daily and Seroquel 12.5 mg twice a day. There was no documentation in the record that the RP was notified.

On 10/31/14 physician orders included to increase the Seroquel to 50 mg twice a day, stop the daily Ativan and reduce the Depakote to 250 mg daily for 1 week and then discontinue. There was no documentation in the record that the RP was notified.

On 7/16/15 at 9:00 AM, a telephone interview was conducted with Resident #253's RP. The RP stated she did not receive notification from the facility when the resident's medications were changed.

During an interview on 7/16/15 at 2:53 PM, Charge Nurse (CN) #1 on the 7-3 shift indicated when new orders were received, she would notify the agent (the term the facility used for RP) of the change and document it in the record.

During an interview on 7/16/15 at 3:22 PM, CN#2 on the 3-11 shift indicated she would notify the agent of new medication orders or treatments and document the notification in the record. If it was late in the evening, she would put a note in

F 157

in nurses¿ notes or on careplan reviews.

Weekend Clinical Startup Checklist will be done on Saturday and Sunday which is an abbreviated version of the daily checklist. This also includes notification of RP of any significant changes and does include a follow up section for any problems identified on the weekend.

An audit was done to ensure RP¿s were informed on recently started psychotropic meds for the last 30 days. This will completed by 8/13/15 and results will be on the form with follow up.

Measures:

Director of Clinical Education and Director of Nursing inserviced on 7/17/15, 7/23/15, 7/29/15, 7,31/15, 8/4/15, 8/5/15 and 8/12/15 nurses on importance of calling responsible parties with significant changes daily including Saturday and Sunday.

An audit form was initiated by ADNS for Wing Managers to audit new psychotropic meds to make sure RP¿s are informed. This will be done weekly for four weeks then monthly for 3 months. Results will be on form.

Monitoring:

The findings of the Clinical Startup Review will be documented on the Clinical Stand Down Form which lists any follow up identified from Clinical Startup. Clinical

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F 157	Continued From page 3 the shift report book for the day shift nurse to call. CN#2 reviewed the record and was unable to find documentation of notification. She also reviewed the shift report book and was unable to find documentation of a request for the day shift to notify the agent. On 7/16/15 at 4:30 PM, the DON was interviewed. She indicated she expected agents to be notified when there was a significant change in treatment.	F 157	Stand Down Form also includes staff member delegated and validation when complete. The results of the monitoring will be discussed monthly at Quality Assurance Performance Improvement (QAPI) meeting for 3 months with any recommendations and continued education. All Department Heads in facility attends QAPI and each department reports on their discipline. The Director of Nursing Services (DNS)/Assistant Director of Nursing Services (ADNS) will be responsible for overall compliance.	
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY 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 observations and staff interview the facility failed to provide an appropriate barrier between ready to eat food and the servers' bare hands for 7 Nursing Assistants (NAs) (NAs # 1, 2, 4, 5, 6, 7, 8) who touched food or straws with	F 371	Corrective Action Affected Resident: Director of Clinical Education (DCE) and Director of Nursing Services (DNS) inserviced Nurses/CNAs immediately on	8/13/15

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F 371	Continued From page 4 their bare hands while assisting residents with tray set up. The findings included: #1. A dining observation was conducted on 7/13/15 from 12:00 PM until 1:30 PM on the 300 hall. NA #7 was observed as she removed a piece of loaf bread with her bare fingers from the paper bag and placed it on the resident's plate. During an interview with NA #7 on 7/13/15 at 1:30PM NA #7 stated she did not realize she had touched the resident's bread with her bare hands. She stated she did not feel it was the correct but she did not have any gloves. On 7/16/2015 at 12:00 PM, an interview was conducted with the Staff Development Coordinator (SDC). The SDC stated she recently had an in-service with the NA's regarding passing meal trays. She stated they were instructed to limit touching resident's food as much as possible. She stated if the staff had to butter the bread, then they would have to touch it, and if they had to split the dinner roll in half, then they would have to touch it. She stated she didn't know that staff was not supposed to touch the food and she would let the Director of Nursing know. During an interview on 7/16/15 at 12:22 PM Nurse Manager #1 stated the food should not be touched with bare hands. She stated she assisted a resident the previous night and she stated she was able to "undo it (the bread) onto the plate without touching it." She stated the staff had received training but she did not remember when the training occurred. During an interview on 7/16/15 at 3:40 PM the DON stated the bread should not be touched with bare hands and the staff had been trained not to touch it with their hands. She added that their cooperation had a policy not to wear gloves for tray passing.	F 371	7/13/15 upon knowledge of CNA touching food and straw. Inservice included proper handling techniques on both. Inservice included staff cannot touch any ready to eat food with bare hands and must work bread out of the bag without touching. Also inserviced do not touch straws when removing them from wrapper. Remove bottom part of wrapper and use top to cover straw and transfer into resident¿s beverage. Corrective Action Potential Residents: A Meal Service Observation Form was initiated on 7/20/15 by the ADNS for Charge Nurses/Wing Managers to observe serving of all meals daily for 4 weeks then monthly for 3 months to monitor proper handling techniques of food and straw for breakfast, lunch, and dinner including Saturday and Sunday. If proper techniques are not followed we will re-educate one to one with staff. This will be documented on the Meal Service Observation form. Measures: Director of Clinical Education (DCE) and Director of Nursing Services (DNS) did overall inservice on 7/13/15, 7/14/15, 7/23/15, 7/29/15, 7/31/15, 8/4/15, 8/5/15 and 8/12/15 to Nurses/CNA¿s on proper handling of food and straw and techniques for delivery of food as stated above on 7/13/15 inservice.	

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F 371	Continued From page 5 #2. During a dining observation on 7/13/15 from 12:00 PM until 1:30 PM on the 300 hall NA #8 was observed while completing the tray set up for 3 residents. She touched the bread when she removed it from the paper bag while assisting each of the 3 residents. During an interview with NA #8 on 7/13/15 at 1:35 PM she stated she felt it was an infection control problem to touch bread with her bare hands. She stated she could have used the resident's utensils to hold or manipulate the bread if needed On 7/16/2015 at 12:00 PM, an interview was conducted with the Staff Development Coordinator (SDC). The SDC stated she recently had an in-service with the NA's regarding passing meal trays. She stated they were instructed to limit touching resident's food as much as possible. She stated if the staff had to butter the bread, then they would have to touch it, and if they had to split the dinner roll in half, then they would have to touch it. She stated she didn't know that staff was not supposed to touch the food and she would let the Director of Nursing know. During an interview on 7/16/15 at 12:22 PM the North Wing Unit Manager stated the food should not be touched with bare hands. She stated she assisted a resident the previous night and she stated she was able to "undo it (the bread) onto the plate without touching it." She stated the staff had received training but she did not remember when the training occurred. During an interview on 7/16/15 at 3:40 PM the DON stated the bread should not be touched with bare hands and the staff had been trained not to touch it with their hands. She added that their cooperation had a policy not to wear gloves for tray passing.	F 371	Monitoring: The results of the monitoring will be discussed monthly at Quality Assurance Performance Improvement (QAPI) meeting for 3 months with any recommendations and continued education. All Department Heads in facility attends QAPI and each department reports on their discipline. The Director of Nursing Services (DNS)/Assistant Director of Nursing Services (ADNS) will be responsible for overall compliance.	

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F 371	Continued From page 6 #3. On 7/13/2015 at 12:38 PM, the nursing assistant (NA #1) was observed to pass a tray to a resident in 509 B. The NA took the bread from the paper bag and placed it on the resident's tray with her bare hand. An interview was conducted with NA #1 on 7/16/2015 at 10:41 AM. The NA stated she was told not to touch the food. She usually used the fork to put the bread on the tray and hold it if she need to butter it. On 7/16/2015 at 12:00 PM, an interview was conducted with the Staff Development Coordinator (SDC). The SDC stated she recently had an in-service with the NA's regarding passing meal trays. She stated they were instructed to limit touching resident's food as much as possible. She stated if the staff had to butter the bread, then they would have to touch it, and if they had to split the dinner roll in half, then they would have to touch it. She stated she didn't know that staff was not supposed to touch the food and she would let the Director of Nursing know. During an interview on 7/16/15 at 3:40 PM the DON stated the bread should not be touched with bare hands and the staff had been trained not to touch it with their hands. She added that their cooperation had a policy not to wear gloves for tray passing. #4. On 7/13/2015 at 12: 43, PM, NA#1 sat down to feed the resident in 509 A, and touched the resident's pureed food with her index finger, and then wiped her finger on the napkin. An interview was conducted with NA #1 on 7/16/2015 at 10:41 AM. The NA stated she was told not to touch the food. She stated she must have been worried about the temperature of the food when she touched the food on the resident's tray.	F 371		

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F 371	Continued From page 7 On 7/16/2015 at 12:00 PM, an interview was conducted with the Staff Development Coordinator (SDC). The SDC stated she recently had an in-service with the NA's regarding passing meal trays. She stated they were instructed to limit touching resident's food as much as possible. She stated if the staff had to butter the bread, then they would have to touch it, and if they had to split the dinner roll in half, then they would have to touch it. She stated she didn't know that staff was not supposed to touch the food and she would let the Director of Nursing know. During an interview on 7/16/15 at 3:40 PM the DON stated the bread should not be touched with bare hands and the staff had been trained not to touch it with their hands. She added that their cooperation had a policy not to wear gloves for tray passing. #5. On 7/13/2015 at 12:44 PM, a nursing assistant (NA #2), passed a lunch tray to the resident in 508A. The NA took the bread out of the paper bag with her bare hand and placed it on the resident's tray. She then took the straw out of the wrapper and while bending the straw to place in the resident's cup, touched the straw at the drinking end with her thumb and index finger. NA #2 passed a lunch tray to a resident in room 507 A, and took the hush puppies out of the paper bag with her bare hand and placed them one by one on the resident's tray. NA #2 then passed a lunch tray to the resident in 508 B, and touched his hush puppies, taking them one at a time out of the bag and placing them on his tray. On 7/16/2015 at 8:50 AM, an interview was conducted with NA #2. The NA stated she was told not to touch the food. She stated she did touch the hush puppies, but she could have	F 371		

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opened the bag and shook it over the tray to dispense the food without touching it. She stated she does know how to open the straws without touching the drinking end.
On 7/16/2015 at 12:00 PM, an interview was conducted with the Staff Development Coordinator (SDC). The SDC stated she recently had an in-service with the NA's regarding passing meal trays. She stated they were instructed to limit touching resident's food as much as possible. She stated if the staff had to butter the bread, then they would have to touch it, and if they had to split the dinner roll in half, then they would have to touch it. She stated she didn't know that staff was not supposed to touch the food and she would let the Director of Nursing know.
During an interview on 7/16/15 at 3:40 PM the DON stated the bread should not be touched with bare hands and the staff had been trained not to touch it with their hands. She added that their cooperation had a policy not to wear gloves for tray passing.

#6. On 7/13/15 at 12:44 PM, NA#4 was observed opening a package of crackers for a resident in room 802. After opening the crackers, the NA gently pinched a corner of the crackers with her bare hand to remove them from the packaging.
During an interview on 7/13/15 at 1:55 PM, NA#4 indicated she tries to keep the wrapper between her bare hand and the food or straw to avoid direct touch. She added she meant to dump the crackers from the wrapper onto the resident's plate.
On 7/16/2015 at 12:00 PM, an interview was conducted with the Staff Development Coordinator (SDC). The SDC stated she recently

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had an in-service with the NA's regarding passing meal trays. She stated they were instructed to limit touching resident's food as much as possible. She stated if the staff had to butter the bread, then they would have to touch it, and if they had to split the dinner roll in half, then they would have to touch it. She stated she didn't know that staff was not supposed to touch the food and she would let the Director of Nursing know.
During an interview on 7/16/15 at 3:40 PM the DON stated the bread should not be touched with bare hands and the staff had been trained not to touch it with their hands. She added that their cooperation had a policy not to wear gloves for tray passing.

#7. On 7/13/15 at 1:24 PM, NA#5 was observed to pull bread out of its wrapper with his bare hand while setting up a tray in room 903.
During an interview on 7/13/15 at 1:52 PM, NA#5 indicated he should not have touched the bread with his bare hand. He explained that the bread was stuck in the wrapper but he could have used a fork to remove it.
On 7/16/2015 at 12:00 PM, an interview was conducted with the Staff Development Coordinator (SDC). The SDC stated she recently had an in-service with the NA's regarding passing meal trays. She stated they were instructed to limit touching resident's food as much as possible. She stated if the staff had to butter the bread, then they would have to touch it, and if they had to split the dinner roll in half, then they would have to touch it. She stated she didn't know that staff was not supposed to touch the food and she would let the Director of Nursing know.
During an interview on 7/16/15 at 3:40 PM the

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DON stated the bread should not be touched with bare hands and the staff had been trained not to touch it with their hands. She added that their cooperation had a policy not to wear gloves for tray passing.

#8. On 7/13/15 at 1:32 PM, NA#6 was observed to touch the bread with her bare hand while setting up a tray in room 907.
During an interview on 7/13/15 at 2:05 PN, NA#6 indicated it was ok to touch food with bare hands as long as hands had been washed.
On 7/16/2015 at 12:00 PM, an interview was conducted with the Staff Development Coordinator (SDC). The SDC stated she recently had an in-service with the NA's regarding passing meal trays. She stated they were instructed to limit touching resident's food as much as possible. She stated if the staff had to butter the bread, then they would have to touch it, and if they had to split the dinner roll in half, then they would have to touch it. She stated she didn't know that staff was not supposed to touch the food and she would let the Director of Nursing know.
During an interview on 7/16/15 at 3:40 PM the DON stated the bread should not be touched with bare hands and the staff had been trained not to touch it with their hands. She added that their cooperation had a policy not to wear gloves for tray passing.

#9. On 7/13/15 at 1:33 PM, NA#1 was observed to touch bread with her bare hand while setting up both trays in room 913.
During an interview on 7/13/15 at 1:57 PM, NA#1 stated if was ok to touch food with bare hands if hands are washed.
On 7/16/2015 at 12:00 PM, an interview was

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	345195	A. BUILDING ______ B. WING ______	C 07/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - TARBORO	1000 WESTERN BOULEVARD TARBORO, NC 27886

(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 371	Continued From page 11 conducted with the Staff Development Coordinator (SDC). The SDC stated she recently had an in-service with the NA's regarding passing meal trays. She stated they were instructed to limit touching resident's food as much as possible. She stated if the staff had to butter the bread, then they would have to touch it, and if they had to split the dinner roll in half, then they would have to touch it. She stated she didn't know that staff was not supposed to touch the food and she would let the Director of Nursing know. During an interview on 7/16/15 at 3:40 PM the DON stated the bread should not be touched with bare hands and the staff had been trained not to touch it with their hands. She added that their cooperation had a policy not to wear gloves for tray passing.	F 371		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the	F 431		8/13/15

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F 431	Continued From page 12 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. 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 discard expired medications in 4 of 5 medication carts, (the 100-400 hall cart, the 300 hall cart, the 500-700 hall cart, and the 500-900 hall cart) examined for medication storage. The findings included: #1. On 7/15/2015 at 4:46 PM, the stock drugs in the medication cart, called the 100-400 hall cart, was inspected. The top drawer contained a bottle of Refresh eye drops with the expiration date of 12/2014. A second bottle of Refresh eye drops was dated as opened on 7/24/2014, with the expiration date of 5/2015. The lower drawer contained a bottle of Pepto-Bismol liquid, with the expiration date of 12/2014. A second bottle of Pepto-Bismol liquid was also dated 12/2014. An interview was conducted on 7/15/2015 at 5:00 PM, with the medication nurse (Nurse #1). The	F 431	Corrective Action Affected Resident: All expired meds identified were discarded immediately on 7/16/15 upon knowledge of expiration dates by Med Nurse assigned to cart and Wing Manager. Corrective Action Potential Residents: All med carts were checked by Med Nurse assigned to each cart and Wing Manager for expired meds on 7/17/15. Measures: A monitoring form was initiated on 7/20/15 by ADNS for Wing Managers to audit carts weekly for 4 weeks then monthly with expired medications being discarded. Audits will be kept in the Wing Managers	

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F 431	Continued From page 13 nurse stated the cart is checked once per month for expired medications, and that is customary. On 7/15/2015 at 5:08 PM, an interview was conducted with the Director of Nursing (DON). The DON stated there was no facility policy concerning the expiration date of medications. She stated the carts were to be checked once per month by the floor nurses, and the nurse manager was responsible to see if the nurses were complying. On 7/15/2015 at 5:20 PM, an interview was conducted with the nurse manager (nurse manager #1). The nurse manager stated that the carts are usually checked at least once per month. The floor nurse assigned to the cart should check. She stated there was no system that would document who had checked the cart, as all the nurses were responsible. #2. On 7/16/2015 at 9:09 AM, the 300 hall medicine cart was inspected. The top drawer contained a bottle of Rena-vite tablets with the expiration date of 5/2015. The bottom drawer contained the following items: a container of natural fiber powder with the expiration date of 6/2014, a bottle of iron supplement liquid with the expiration date of 11/2014, a bottle of docusate sodium liquid with the date of expiration 12/2014, a bottle of vitamin and mineral supplement liquid with expiration date of 6/2015, and a multi vitamin supplement liquid with the expiration date of 12/2014. On 7/26/2015 at 9:14 AM, an interview with the nurse (nurse #2) was conducted. The nurse stated that each nurse is responsible to check the cart. She stated that the cart is checked maybe weekly. An interview was conducted with nurse manager #1 on 7/16/2015 at 9:22 AM. The nurse manager stated that the nurses are supposed to check	F 431	office. Director of Clinical Education (DCE) and Director of Nursing Services (DNS) inserviced on 7/17/15, 7/23/15, 7/29/15, 7/31/15, 8/4/15, 8/5/15 and 8/12/15 Nurses/CNA¿s on importance of checking dates of medicines and discard if expired. Monitoring: The results of the monitoring will be discussed monthly at Quality Assurance Performance Improvement (QAPI) meeting for 3 months with any recommendations and continued education. All Department Heads in facility attends QAPI and each department reports on their discipline. The Director of Nursing Services (DNS)/Assistant Director of Nursing Services (ADNS) will be responsible for overall compliance.	

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F 431	Continued From page 14 their carts weekly, but should do a deep check and clean monthly, and this cart was not checked. She stated that the bottles must have been covered up with stuff and couldn't be accessed easily. #3. On 7/16/2015 at 11:14 AM the medicine cart for half of the 500 and the 700 hall was inspected. An opened bottle of acetaminophen was dated as opened on 6/30/2015, and no expiration date was visible. The bottom drawer of the cart was very sticky from liquids. An interview was conducted with the nurse (nurse #3) on 7/16/2015 at 11:16 AM. The nurse stated she checks the medicine cart once per week, and the bottle of acetaminophen had an expiration date, but must have come off. #4. On 7/16/2015 at 11:24 AM, the medicine cart for half of the 500 and 900 hall was inspected. An opened bottle of acetaminophen had no expiration date. An interview was conducted with the nurse (nurse #4) on 7/16/2015 at 11:26 AM. The nurse stated she didn't know what happened to the date on the bottle, it must have rubbed off. Stated she checks the cart all time and the bottle did have a date on it at one time. On 7/16/2015 at 2:54 PM, an interview was conducted with the nurse manager (nurse manager #2). The nurse manager stated it was her expectation for the primary nurse who used the cart, to check the carts once per week.	F 431		