STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345128	A. BUILDING _____ B. WING _____	R-C 05/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & REHABILITATION/STATESVILLE	520 VALLEY STREET STATESVILLE, NC 28677

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F 000	INITIAL COMMENTS On 05/26/16 the facility was provided an amended Statement of Deficiencies because information in tag F-323 was amended by the State Agency. Event ID# SMY712.	F 000		
F 279 SS=G	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to develop a care plan that reflected individualized approaches for a resident with a history of falls for 1 of 3 sampled residents (Resident #154).	F 279	1. The Care Plan for Resident #154 was reviewed and revised to include individualized interventions and goals for ongoing management of falls. This was completed by the Director of Nursing and the Resident Care Management Director	6/6/16

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

Electronically Signed

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F 279	Continued From page 1 The findings included: Resident #154 was admitted to the facility on 01/06/15 with diagnoses that included dementia, psychosis and a history of falls. A fall risk care plan was created on 04/23/15 because the resident had fallen and remained at risks for falls due to unsteady gait, poor balance and poor communication and comprehension. Interventions to prevent further incidents included: - Encourage resident to ask for assistance - Low bed with slide mats on either side of bed if the bed is away from the wall and one slide mat if the bed is against the wall. - Place frequently used items in reach The care plan did not specify the resident required frequent monitoring and had a personal alarm to her bed and wheelchair. Resident #154's "care card" not dated (a reference sheet used by nurse aides for providing care for residents) specified Resident #154 was a fall risk, required a bed and chair alarm and to encourage resident to call/wait for assistance with transfers and ambulation. Review of the nurses' notes specified Resident #154 fell on 01/12/16 but was not injured. The most recent Minimum Data Set (MDS) dated 03/15/16 specified the resident had severely impaired cognition, required extensive assistance with activities of daily living including transfers and was not steady on her feet but had not fallen since the last assessment. On 05/02/16 at 12:45 AM Nurse #1 documented	F 279	on 6/1/2016. 2. All residents with a history of falls have the potential to be affected by this alleged deficient practice. The RCMD and MDS coordinator conducted an audit of care plans for current residents with a history of falls occurring during the last 30 days to validate these residents have a care plan in place that reflects individualized interventions and goals for ongoing management of falls. This audit was completed by 6/6/2016. 3. The Area Staff Development Coordinator has re-educated the Administrative Nursing Staff regarding developing care plans to address and implement individualized interventions and goals for residents with falls. This education was completed by 6/6/2016. The RCMD or MDS Coordinator will randomly audit 5 care plans weekly for twelve weeks of residents with a history of falls to validate these residents have a care plan that includes individualized interventions and goals for ongoing management of falls. Opportunities will be corrected as identified. 4. Measures to ensure that corrections are achieved and sustained include: The results of these audits and monitors will be submitted to the QAPI Committee by the RCMD for review by IDT members each month. The QAPI Committee will evaluate the effectiveness and amend as needed. Date of compliance is 6/6/2016.	

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F 279	Continued From page 2	F 279		

that Resident #154 had a change in condition from a fall. The nurse documented the resident appeared to have attempted to get out of bed, fell and "appears to have broken her left wrist, the wrist is visibly deformed." The Resident complained of pain and Nurse #1 called 911.

The Emergency Department summary dated 05/02/16 specified Resident #154 was diagnosed with a "traumatic closed displaced Colles' fracture of left radius." Resident #154 received Morphine to control her pain and returned to the facility on 05/02/16 with a splint to her left arm.

A documented titled "Incident/Accident Report" dated 05/02/16 read in part that Resident #154 fell on 05/02/16 at 12:15 AM in her room. Resident #154 was unable to explain what happened but complained of pain. The incident report also specified that previous interventions included a bed and chair alarm.

On 05/17/16 at 9:23 AM observations were made of Resident #154 sitting in her wheelchair at a table looking at a newspaper. The Resident was noted to have a white cast to her left arm. Resident #154 was unable to explain what happened to her arm.

On 05/17/16 at 12:03 PM Nurse Aide (NA) #1 was interviewed on the telephone and explained she routinely was assigned to Resident #154. The NA reported that Resident #154 was impulsive at times and at risk for falls. She stated interventions to prevent the resident from falling included a personal alarm to her bed and wheelchair, a mat bedside her low bed and staff were supposed to make frequent checks on the resident. NA #1 added Resident #154 had very

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F 279	Continued From page 3	F 279		

poor cognition and poor balance. The NA stated Resident #154 did not attempt to remove her personal alarm and that she did not have the cognition to know how to turn it off. NA #1 explained she worked on 05/01/16 from 7:00 PM to 7:00 AM the following day. The NA stated that from 7:00 PM to 11:00 PM she worked an assignment on the 200 Hall but at 11:00 PM her assignment changed to the 300 Hall caring for Resident #154. NA #1 reported she arrived to the 300 Hall ten minutes late and did not get report from the previous NA. NA #1 was unaware of who the previous NA had been. NA #1 started her first round on the hall and sometime between 11:30 PM and 11:45 PM and noticed that Resident #154's door was closed, stating "That's a no-no and I knew to go in and check." NA #1 stated when she opened the door Resident #154 was laying in the floor and unable to state what happened and the personal alarm was not sounding. NA #1 stated the alarm had been turned off. NA #1 explained she called for help and went to find Nurse #1.

On 05/17/16 at 2:24 PM Unit Manager #1 was interviewed and explained she was new in her role but had worked in the facility for 3 years and was familiar with Resident #154. The Unit Manager reported that Resident #154 was very impulsive and required various interventions to keep her safe from falling due to her poor cognition and lack of safety awareness. The Unit Manager stated that it was reported that Resident #154 was found in her room with the door closed and personal alarm turned off. The Unit Manager added it was "highly unlikely" the resident had closed the door and turned off the alarm but no one knew who had closed the door. The Unit Manager also stated that she didn't know how

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F 279	Continued From page 4 long the resident had been on the floor. On 05/17/16 at 4:18 PM the DON was interviewed and reported that she expected the care plan and "care card" to accurately reflect the needs of the residents so the NAs and nurses could provide the appropriate assistance.	F 279		
{F 312} SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and resident and staff interviews the facility failed to provide nail care for 1 of 3 dependent residents reviewed for activities of daily living (ADL) (Resident #68). The findings included: Resident #68 was readmitted to the facility on 03/02/16 with diagnoses diabetes mellitus, partial amputation of foot, cellulitis of leg, and osteomyelitis. Resident #68 most recent minimum data set (MDS) dated 04/25/16 indicated that he was cognitively intact and required extensive assistance of one staff member for personal hygiene. No rejection of care was identified. Observation of Resident #68 on 05/17/16 at 11:29	{F 312}	1. Nail care was provided to Resident #68 by NA#3 on 5/17/16 and validated by the Director of Nursing on 5/17/16. 2. Residents requiring assistance with Activities of Daily Living (ADLs) have the potential to be affected by this alleged deficient practice. An audit of Residents requiring assistance with ADLs was completed by the DON, SDC and Unit Managers by 6/6/2016 to validate Nail Care. Trimming, cleaning and filing were provided as need was identified. 3. Nursing Staff were re-educated by the Administrator, DON, and Area Staff Development Coordinator on providing assistance with ADLs with a focus on Nail Care to include cleaning, trimming, and	6/6/16

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{F 312}	Continued From page 5 AM revealed all 10 fingernails were approximately a ¼ inch long and had brown dried substance under them. Interview with Resident #68 on 05/17/16 at 11:29 AM revealed he could not remember when the staff had last cleaned or trimmed his nails. Resident #68 looked at his fingernails and stated "yes, they definitely need to be trimmed and gosh they are dirty." An observation of Resident #68 on 05/17/16 at 11:35 AM with the Director of Nursing (DON) revealed she looked at Resident #68's fingernails and stated "they have not been taken care of." The DON further stated she would check and see when they were last trimmed. Nurse Aide (NA) #3 was also in Resident #68's room and stated she would take care of them because she was getting ready to give him a bed bath for the day. Interview with NA #3 on 05/17/16 at 1:16 PM revealed that she was responsible for taking care of Resident #68 today and that she had provided morning care at 11:29 AM that included a bed bath, putting deodorant on the resident, placing a new brief on resident, getting him dressed and up to his wheelchair. NA #3 also stated she had cleaned and trimmed Resident #68 fingernails because the DON had asked her to. NA #3 further stated that she usually performed nail care during the residents shower and this was the first time she had taken care of Resident #68 in a while. During a follow up interview on 05/17/16 at 2:09 PM the DON stated when she saw Resident #68's fingernails her first impression was that they were "very dirty and very long" and should	{F 312}	filing as needed. This re-education was completed by 6/6/2016. The DON or Unit Managers will audit at least 10 residents weekly for 12 weeks to validate the completion of nail care by observing residents' fingernails. Opportunities will be corrected as identified by the DON, SDC and Unit Managers. 4. The DON will report the results of the audits to the QAPI committee monthly for 3 months. The committee will make changes or recommendations as indicated. Date of Compliance is 6/6/2016.	

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{F 312}	Continued From page 6 not be like that. The DON stated that on 04/28/16 Resident #68's nails were fine but could not provide any information that nail care had been provided since that day. Interview with the Administrator on 05/17/16 at 5:28 PM revealed that she expected all residents to have their ADL completed in a timely manner and this included nail care. The Administrator further stated that the NAs were reeducated on nail care recently and they were aware that nail care was expected to be completed as needed.	{F 312}		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to monitor a resident that was high risk for falls, the resident sustained a fractured wrist after a fall from her bed for 1 of 3 sampled residents (Resident #154). The findings included: Resident #154 was admitted to the facility on 01/06/15 with diagnoses that included dementia, psychosis and a history of falls.	F 323	1. The Care Plan for Resident #154 was reviewed and revised to include individualized interventions and goals for ongoing management of falls. This was completed by the Director of Nursing and the Resident Care Management Director on 6/1/2016. The DON observed Resident #154 and validated implementation of care planned interventions on 6/1/2016. 2. All residents with a history of falls have the potential to be affected by this alleged	6/6/16

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F 323	Continued From page 7 A fall risk care plan was created on 04/23/15 because the resident had fallen and remained at risks for falls due to unsteady gait, poor balance and poor communication and comprehension. Interventions to prevent further incidents included: - Encourage resident to ask for assistance - Low bed with slide mats on either side of bed if the bed is away from the wall and one slide mat if the bed is against the wall. - Place frequently used items in reach Review of the nurses' notes specified Resident #154 fell on 01/12/16 but was not injured. The most recent Minimum Data Set (MDS) dated 03/15/16 specified the resident had severely impaired cognition, required extensive assistance with activities of daily living, was not steady but had not fallen since the last assessment. On 05/02/16 at 12:45 AM Nurse #1 documented that Resident #154 had a change in condition from a fall. The nurse documented the resident appeared to have attempted to get out of bed, fell and "appears to have broken her left wrist, the wrist is visibly deformed." The Resident complained of pain and Nurse #1 called 911. The Emergency Department summary dated 05/02/16 specified Resident #154 was diagnosed with a "traumatic closed displaced Colles' fracture of left radius." Resident #154 received Morphine to control her pain and returned to the facility on 05/02/16 with a splint to her left arm. A documented titled "Incident/Accident Report" dated 05/02/16 read in part that Resident #154 fell on 05/02/16 at 12:15 AM in her room.	F 323	deficient practice. The RCMD and MDS Coordinator conducted an audit of care plans for current residents with a history of falls occurring during the last 30 days to validate these residents have a care plan in place that reflects individualized interventions and goals for ongoing management of falls. This audit was completed by 6/6/16. The DON and Unit Managers completed observations of residents with a history of falls occurring during the last 30 days to validate implementation of care planned interventions. These observations were completed by 6/6/2016. Opportunities were corrected as identified. 3. The Area Staff Development Coordinator re-educated the Nursing Staff regarding the implementation of individualized interventions according to the care plan for residents with a history of falls. This education was completed by 6/6/2016. The DON and Unit Managers will randomly observe 5 residents with a history of falls weekly for 12 weeks to validate these residents have interventions in place for falls management according to the care plan. Opportunities will be corrected as identified. 4. The results of these audits will be presented by the DON monthly for 3 months at QAPI Committee meetings. The committee will make changes or recommendations as indicated. Date of Compliance is 6/6/2016.	

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Resident #154 was unable to explain what happened but complained of pain.

On 05/17/16 at 9:23 AM observations were made of Resident #154 sitting in her wheelchair at a table looking at a newspaper. The Resident was noted to have a white cast to her left arm. Resident #154 was unable to explain what happened to her arm.

On 05/17/16 at 12:03 PM Nurse Aide (NA) #1 was interviewed on the telephone and explained that she was routinely assigned to Resident #154. The NA reported that Resident #154 was impulsive at times and at risk for falls. She stated that interventions to prevent the resident from falling included a personal alarm to her bed and wheelchair, a mat bedside her low bed and staff were supposed to make frequent checks on the resident. NA #1 added that Resident #154 had very poor cognition and poor balance. The NA stated that Resident #154 did not attempt to remove her personal alarm and that she did not have the cognition to know how to turn it off. NA #1 explained that she worked on 05/01/16 from 7:00 PM to 7:00 AM the following day. The NA stated that from 7:00 PM to 11:00 PM she worked an assignment on the 200 Hall but at 11:00 PM her assignment changed to the 300 Hall caring for Resident #154. NA #1 reported that she arrived to the 300 Hall ten minutes late and did not get report from the previous NA. NA #1 was unaware of who the previous NA had been. NA #1 started her first round on the hall and sometime between 11:30 PM and 11:45 PM noticed that Resident #154's door was closed, stating "That's a no-no and I knew to go in and check." NA #1 stated that when she opened the door Resident #154 was laying in the floor and

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unable to state what happened and the personal alarm was not sounding. NA #1 stated the alarm had been turned off. NA #1 explained that she called for help and went to find Nurse #1.

On 05/17/16 the Director of Nursing (DON) was interviewed and explained that room doors could be closed but if a resident required frequent monitoring then staff should not leave the door closed. The DON stated that she wasn't very familiar with Resident #154 and didn't know if she had a history of falls because she was new in her role. The DON didn't know if it was acceptable for Resident #154's door to be closed.

The facility provided the assignment schedule for 05/01/16 that specified NA #2 was assigned to care for Resident #154 on 05/01/16 from 3:00 PM to 11:00 PM.

On 05/17/16 at 2:12 PM NA #2 was interviewed on the telephone and stated she was not Resident #154's NA on 05/01/16 from 3:00 PM to 11:00 PM. The NA reported that Resident #154 was at risk for falls and often tried to get out of bed and the resident's bed was to be in a low position and alarms were to be attached to the bed and wheelchair. NA #2 added that Resident #154's door should only be closed if providing care.

On 05/17/16 at 2:24 PM Unit Manager #1 was interviewed and explained that she was new in her role but had worked in the facility for 3 years and was familiar with Resident #154. The Unit Manager reported that Resident #154 was very impulsive and required various interventions to keep her safe from falling due to her poor cognition and lack of safety awareness. The Unit

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F 323	Continued From page 10 Manager stated that it was reported that the Resident was found in her room with the door closed and personal alarm turned off. The Unit Manager added that it was "highly unlikely" the resident had closed the door and turned off the alarm but no one knew who had closed the door. The Unit Manager also stated that she didn't know how long the resident had been in the floor. On 05/17/16 at 3:35 PM Nurse #1 was interviewed on the telephone and reported that around midnight NA #1 notified her that Resident #154 was on the floor and injured. She stated that she assessed the resident and contacted 911 because the resident's wrist was "deformed" and she complained of hip pain. Nurse #1 nurse stated that she was also told the alarm was not sounding at the time of the fall but did not proceed to investigate because her concern was the injured resident. Nurse #1 could not recall if she had seen Resident #154 prior to the fall that night. She explained that she did not get any concerns about the resident in report at 11:00 PM, made a "quick walk through" and then left the hall to assist with an incident on another hall and was notified around midnight Resident #154 had fallen. On 05/17/16 at 4:18 PM the DON was interviewed and reported that she was unable to determine who had been assigned to Resident #154 on 05/01/16 from 3:00 PM to 11:00 PM.	F 323		
{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	{F 431}		6/6/16

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{F 431}	Continued From page 11 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 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, record review, and staff interviews the facility failed to remove expired medications from 1 of 1 central supply closets and failed to remove expired insulin from 1 of 4 medication carts.	{F 431}	1. The Director of Nursing discarded all identified expired drugs on 5/17/2016. 2. All residents have the potential to be affected by this alleged deficient practice. An audit of all medication storage rooms,	

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	345128	A. BUILDING _____ B. WING _____	R-C 05/17/2016

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{F 431}	Continued From page 12 The findings included: The facility's undated policy for "Medication Storage in the Facility" read in part: outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal and reordered from the pharmacy, if a current order exists. 1. a. Observation of the Central supply closet on 05/17/16 at 10:45 AM revealed 5 Curad ready to use enema that had an expiration date of February 2016 and also revealed a box of equate hemorrhoid ointment that had an expiration date of 03/16. 1. b. Observation of the Courtyard Cart #2 on 05/17/16 at 11:00 AM revealed a bottle of Humalog that contained an open date of 04/18/16 and an expiration date of 05/16/16. Interview with the Central Supply Clerk on 05/17/16 at 10:45 AM revealed that she had pulled all the items in central supply and made sure that they were all in date and stated she could not believe that they were in the central supply closet. The Central Supply clerk also stated that maybe someone pulled them off a medication cart and put them in there. The Central Supply clerk then threw the expired enemas and hemorrhoid cream away. Interview with Nurse #1 on 05/17/16 at 11:00 AM revealed that he was responsible for the Courtyard Cart #2 and confirmed that the insulin should have been thrown away yesterday and a new vial obtained. Nurse #1 stated he would take	{F 431}	refrigerators, and medication carts was conducted and completed on 6/6/2016 by the DON, Area Staff Development Coordinator, and Unit Managers. All expired and unlabeled items were discarded immediately. 3. The DON re-educated the Central Supply Clerk and Licensed Nurses regarding storage and labeling of medications to include labeling and dating insulins and discarding any resident specific items that are expired. This education was completed by 6/6/2016. The DON, SDC, or Unit Managers will audit all medication storage rooms, refrigerators and medication carts 3 times/week for 12 weeks to verify medication storage per policy. Opportunities will be corrected as identified. 4. Results of audits and inventories will be presented to the QAPI Committee monthly for 3 months by the DON. The committee will make changes or recommendations as indicated. Date of Compliance is 6/6/2016.	

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{F 431}	Continued From page 13 care of it. Interview with the Director of Nursing (DON) on 05/17/16 at 2:17 PM revealed that she could not believe that there were any expired medications in the building. The DON stated that the Central Supply Clerk had completed an audit on 04/18/16 and those items were not there. The DON also stated that she expected the night shift nurses to go through the medication carts and discard any expired medications and if the vial was dated as being expired on 05/16/16 then it should have been discarded. Interview with the Administrator on 05/17/16 at 5:28 PM revealed that she had no clue how the expired items got in the central supply closet, she stated that they had completed an audit and those items were not there. The Administrator stated that there was a lot of oversight for the medication carts and central supply closets and just could not explain how or why the expired medications were found.	{F 431}		
{F 520} SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and	{F 520}		6/6/16

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{F 520}	Continued From page 14 develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor the interventions the committee put into place in April 2016. This was for two recited deficiencies that were originally cited in April 2016 and subsequently cited in May 2016 on the onsite follow up to the recertification survey. The repeated deficiencies were in the areas quality of care and pharmacy services. The continued failure of the facility during two federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program. The findings included: The tags were cross referred to: F 312: Based on observations, record review, and	{F 520}	1. Corrective action was accomplished for the alleged deficient practice by the Administrator holding an Ad Hoc QAPI meeting on 6/1/2016 to discuss the outcomes of the revisit and complaint survey and repeat citations of F312 related to Residents receiving assistance with ADLs and F431 related to storage of medications. The Interdisciplinary Department Head Team reviewed the previous plans of correction related to F312 and F431 and the failure in effective monitoring. 2. F312 - Residents requiring assistance with ADLs have the potential to be affected by this alleged deficient practice. An audit was provided of residents requiring assistance with ADLs was completed by the DON, SDC, and Unit Managers by 6/6/2016 to validate Nail Care including trimming, cleaning, and filing as needed. Opportunities corrected	

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{F 520}	Continued From page 15 resident and staff interviews the facility failed to provide nail care for 1 of 3 dependent residents that were sampled for activities of daily living (ADL) (Resident #68). The facility was recited for F 312 for failing to provide nail care to Resident #68. F 312 was originally cited during the April 2016 recertification survey for failing to provide oral care and nail care for 3 of 6 dependent residents reviewed for activities of daily living including Resident #68. F 431: Based on observations, record review, and staff interviews the facility failed to remove expired medications from 1 of 1 central supply closets and failed to remove expired insulin from 1 of 4 medication carts. The facility was recited for F 431 for failing to remove expired enemas and hemorrhoidal ointment from the central supply closet and remove an expired insulin vial from a medication cart. F 431 was originally cited during the April 2016 recertification survey for failing to remove expired insulin vials and an expired bottle of ibuprofen from a medication cart and remove two expired bottles of iron elixir and a bottle of milk of magnesia the central supply closet. An interview was conducted with the Administrator on 05/17/16 at 5:30 PM. The Administrator stated the facility's Quality Assurance (QA) Committee had met weekly since the recertification survey to discuss the monitoring completed for all of the citations. All residents were audited for nail care and oral care after the recertification survey and the staff were inserviced. The Administrator further stated if	{F 520}	by the DON and Unit Managers were identified. F431 - All residents have the potential to be affected by this alleged deficient practice. An audit of all medication storage rooms, refrigerators, and medication carts was conducted and completed by 6/6/16 by the DON, ASDC, and Unit Managers. All expired and unlabeled items were discarded immediately. 3. The Interdisciplinary Department Head Team were re-educated by the DON and the Administrator regarding the regulatory requirement for F312 and F431. The education was completed by 6/6/2016. The Administrator will hold a weekly Ad Hoc QAPI meeting to review F312 and F431 audits results. 4. Measures to ensure that corrections are achieved and sustained include: The results of these weekly meetings will be submitted to the QAPI Committee by the Administrator for review by IDT members each month. The QAPI committee will evaluate the effectiveness and amend as needed. Date of Compliance is 6/6/2016.	

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{F 520}	Continued From page 16 they knew Resident #68 had a problem with nail care he should have been put on the list of residents that were monitored for compliance. In regards to the expired medications, the Administrator stated she was not sure what they could have done differently. The night shift nurses were supposed to be checking the medication carts every night and the unit mangers were checking the medication carts and the medication rooms weekly. The Administrator noted the central supply room was checked for expired medications after the recertification survey and the central supply staff member was to check monthly thereafter. The Administrator indicated no one could figure out where the expired enemas and ointment had come from or who put them in the central supply closet.	{F 520}		