Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH0068	A. BUILDING: _____ B. WING _____	C 08/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY VILLAGE	1265 21 STREET NE HICKORY, NC 28601

(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) COMPLETE DATE
L 000	INITIAL COMMENTS A complaint investigation was conducted on 07/29/19 through 08/01/19. There was one allegation and it was unsubstantiated. No deficiencies were cited as a result of this investigation. Event ID G0M611.	L 000		

Division of Health Service Regulation

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

Electronically Signed | 08/16/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345152	A. BUILDING _____ B. WING _____	C 08/01/2019

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E 000	Initial Comments A recertification and complaint survey was conducted from 07/29/19 through 08/01/19. The faciltiy was in compliance with the requirements 483.73 Emergency Preparedness, Event ID HQ1E11.	E 000		
F 000	INITIAL COMMENTS A recertification survey and complaint investigation survey was conducted from 07/29/19 through 8/1/19. There was a total of four allegations investigated and one was substantiated and cited. Event ID# HQ1E11.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to accurately code the discharge status of a resident for 1 of 3 closed records sampled (Resident #92). The findings included: Resident #92 was admitted to the facility on 05/07/19 with diagnoses that included diabetes mellitus, dementia, atrial fibrillation, Parkinson's disease, and others. Resident #92 was discharged on 05/23/19. Review of the Minimum Data Set (MDS) assessment dated 05/23/19 revealed that Resident #92 was severely cognitively impaired for daily decision making and required limited	F 641	1. Resident #92 was not affected due to the deficient practice. MDS nurse immediately corrected the mistake when it was reported on 7/31/19 and resubmitted the MDS. 2. All resident assessments have the potential to be entered incorrectly into the MDS as human errors do occur. All residents who were discharged in the last 30 days were audited for accuracy by The Director of Quality Life & Care on 8/1/19 and no other submission errors were found. 3. The MDS nurses were re-educated on the importance of accurate MDS entries	8/24/19

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

Electronically Signed | 08/21/2019

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F 641	Continued From page 1 assistance with activities of daily living. The MDS further indicated that Resident #92 was discharged to the hospital. The MDS was completed by MDS Nurse #1. Review of a nurses note dated 05/23/19 read, Resident #92 was discharged to the dogwood assisted living. Family and medical provider notified. An interview was conducted with MDS Nurse #2 on 08/01/19 at 11:48 AM. MDS Nurse #2 confirmed that Resident #92 had discharged to assisted living and had not gone to the hospital on 05/23/19. She added that MDS Nurse #1 was not longer working at the facility. MDS Nurse #2 stated that it was just a data entry error and she would correct the error immediately. An interview was conducted with the Administrator on 08/01/19 at 12:25 PM. The Administrator stated that MDS Nurse #1 was the one of the best MDS nurses in the entire company and it was just a data entry error. The Administrator further stated she expected the MDS assessments to be coded accurately. An interview was conducted with the Director of Clinical Services (DCS) on 08/01/19 at 2:45 PM. The DCS indicated that it was a data entry error and the staff would correct the error.	F 641	by Marcheta Campbell, Administrator on 8/7/19. They have been instructed to double check all information for accuracy before submitting the MDS. 4. The Director of Quality Life & Care will conduct random audits of discharged residents' MDS (1) x weekly for (4) weeks and (1) x monthly for (6) months. All incorrect entries will be corrected immediately and resubmitted. Audit results will be reported to the QAPI committee for (6) months for trending and tracking purposes. All corrective action will be completed by 8/24/19.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the	F 656		8/24/19

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F 656	Continued From page 2 resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, record reviews and	F 656	1. Resident #13 no longer has pain	

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F 656	Continued From page 3 interviews the facility failed implement a care plan intervention that required a dependent resident to be transferred via two-person assistance for 1 of 3 residents reviewed for supervision to prevent accidents (Resident #13). The finding included: Resident #13 was admitted to the facility on 11/29/18 with diagnoses which included diabetes and left sided weakness. Review of Resident #13's quarterly Minimum Data Set (MDS) dated 02/27/19 revealed, her cognition was intact, and she required extensive assistance via two persons for transfers. The MDS also indicated, Resident #13 was only steady with assistance and was coded as having a limitation in functional range of motion to one side of her body in both upper and lower extremities. Review of Resident #13's Care Plan initiated 12/07/18 revealed, a potential for falls related to left sided weakness which required interventions that included two persons assistance with transfers. Review of an Incident Report (IR) dated 03/19/19 and completed by Nurse #3 indicated, Resident #13 self-reported a fall that occurred on 03/19/19 at approximately 6:30 AM when she was being transferred from her wheelchair by Nurse Aide (NA) #1. The immediate action taken post incident was that the Resident was offered an ice pack for her right knee but was declined and pain medication was offered and administered for pain in the right knee. The IR also indicated, the Physician and Responsible Party were notified.	F 656	associated with the incident which took place on 3/19/19. No futher incidents have occurred and her care plan remains accurate. 2. All residents have the potential to be affected if the care plan is not followed. All nurses and CNAs were in-serviced by the DON on 8/13/19 reiterating the expectation of following and reading the care plan for each resident. New staff will also be educated on the expectation during orientation by the SDC. 3. The DON in-serviced all CNAs on 8/13/19 regarding the protocol for following care plans. Changes to the care plan, including transfer status, are automatically transferred to the CNA flow sheets. The shift supervisor will then ensure that any changes to the care plan are communicated to the interdisciplinary team so the care plan can be updated. 4. Staff Development Coordinator will observe (2) CNAs weekly for (4) weeks, then monthly for (2) months, and quarterly for (9) months. If during the random observations, CNAs fail to properly follow the care plan, they will receive additional training and disciplinary action, as appropriate. Written results from the audits will be reported to the QAPI committee quarterly for (12) months. All corrective action will be implemented by 8/24/19.	

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F 656	Continued From page 4	F 656		

Review of a Progress Note (PN) dated 03/19/19 at 4:54 PM written by Nurse #3 revealed, as she assessed Resident #13 for a complaint of right knee pain the Resident reported that while she was being transferred to the bed from her wheelchair that morning around 6:30 AM, NA #1 did not lock her wheelchair and the wheelchair rolled backwards which caused the NA to sit her down on the Resident's right leg as it bent underneath her. The PN indicated, upon assessment Resident #13's right knee was slightly larger than her left knee and that no bruising or redness was visible. The PN also indicated, Resident #13 initially refused pain medication but later agreed to take pain medication which she already had an order for.

Review of a written statement by Nurse #3 dated 03/19/19 revealed, Resident #13 had complained of right knee pain and upon assessment of her right knee the resident reported that when NA#1 was helping her back into bed after taking her to the bathroom the wheelchair was not locked and it rolled backwards which caused the NA to sit the Resident down on the Resident's right leg which had bent backwards underneath her. Resident #13 continued to explain, that she asked the NA to go get help but she didn't, and the NA got behind her and lifted the Resident up off the floor and into the bed.

Nurse #3 was not available for interview.

Review of Resident #13's Physician Orders dated 03/20/19 revealed, an order for x-ray of the right knee.

Review of Resident #13's x-ray report dated

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F 656	Continued From page 5	F 656		

03/20/19 indicated, no acute fracture.

Review of Resident #13's Physician Orders dated 03/21/19 revealed, an order for ice to be applied to the right knee for 20 minutes three times a day for edema.

During an interview with Resident #13 on 07/29/19 at 3:29 PM she indicated that on the morning of the incident (03/19/19) NA #1 had taken her to the bathroom and when the NA stood her up to transfer her back to bed, the NA realized that she had not locked the brakes on her wheelchair. Resident #13 continued to explain, the wheelchair started to roll backwards, and the Resident's right knee started to bend which caused the NA to have to sit her down on the Resident's right leg. The Resident stated she asked the NA to get some help, but the NA wouldn't and then got behind her and lifted her up into the bed. The Resident stated she did not report the incident until her right knee started to hurt later that day because she did not want to get anyone into trouble but that she had not seen NA #1 since the incident happened. Resident #13 also stated, that after the fall her right knee became swollen and painful and was treated with pain medication and ice packs. The Resident also stated, her right knee was x-rayed but not fractured.

An interview was conducted on 07/31/19 at 11:15 AM with NA #2 who explained, the facility provided the NAs with Resident Care Guides (RCG) that included specific interventions necessary to provide care to the residents and the RCG were updated as needed with new interventions. NA #2 stated, that in order to provide a safe transfer for Resident #13, she

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F 656	Continued From page 6 required a two person assist for transfers. An interview with the Administrator on 08/01/19 at 1:05 PM revealed, the Director of Nursing (DON) (who was currently on vacation) investigated the incident with Resident #13 on 03/19/19 and discovered that the NA involved in the incident was NA #1. The DON found that NA #1 had not followed the appropriate care planned intervention of a two person transfer for Resident #13 and also NA #1 also did not report the incident until Resident #13 reported the incident later that day on 03/19/19. NA #1 was given a written reprimand on 03/20/19 and subsequently terminated. NA #1 was not available for interview. The Director of Nursing was not available for interview. During a follow up interview with the Administrator on 08/01/19 at 4:34 PM she indicated, that the residents' safety was her utmost concern and she expected the staff to follow the Resident's care plan to assure the appropriate lift status was utilized.	F 656		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.	F 689		8/24/19

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F 689	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews the facility failed to safely transfer a dependent resident who needed the assistance of two persons for one of three residents reviewed for accidents (Resident #13). One staff member assisted Resident #13 alone and did not lock the wheelchair during the transfer resulting in the wheelchair rolling backwards and causing the staff to sit the resident on the Resident's leg as it bent underneath her. Resident #13 experienced pain and swelling requiring pain medication and ice pack but without fracture in her right knee. The findings included: Resident #13 was admitted to the facility on 11/29/18 with diagnoses which included diabetes and left sided weakness. Review of Resident #13's quarterly Minimum Data Set (MDS) dated 02/27/19 revealed, her cognition was intact, and she required extensive assistance of two persons for transfers. The MDS also indicated, Resident #13 was only steady with assistance and was coded as having a limitation in functional range of motion to one side of her body in both upper and lower extremities. Review of Resident #13's Care Plan initiated 12/07/18 revealed, a potential for falls related to left sided weakness which required interventions that included two persons assistance with transfers. Review of an Incident Report (IR) dated 03/19/19 and completed by Nurse #3 indicated, Resident #13 self-reported a fall that occurred on 03/19/19	F 689	1. Resident #13 no longer has pain associated with the incident which took place on 3/19/19 from the deficient practice related to the transfer. There have been no further incidents with transferring resident #13 since 3/19/19. 2. All residents have the potential to be affected if the care plan is not followed. All CNAs were in-serviced by the DON on 8/13/19 reiterating the expectation of following the CNA flow sheet which references the transfer status for each resident. New staff will also be educated on the expectation during orientation by the SDC. 3. The DON in-serviced all CNAs on 8/13/19 regarding the policy for transferring residents. Effective immediately, any CNA who transfers a resident incorrectly by not following the care plan will receive additional training and disciplinary action as appropriate. Also, during the audits listed below in #4, the SDC will check to make sure staff have the proper equipment/devices identified and are following the care plan. 4. Staff Development Coordinator will observe (2)random transfers by CNAs weekly for (4) weeks, then monthly for (2) months, and quarterly for (9) months. Written results from the audits will be reported to the QAPI committee quarterly for (12) months.	

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F 689	Continued From page 8 at approximately 6:30 AM when she was being transferred from her wheelchair by Nurse Aide (NA) #1. The immediate action taken post incident was that the Resident was offered but declined an ice pack for her knee and pain medication was offered and administered for pain in the right knee. The IR also indicated, the Physician and Responsible Party were notified. Review of a Progress Note (PN) dated 03/19/19 at 4:54 PM written by Nurse #3 revealed, as she assessed Resident #13 for a complaint of right knee pain, the resident reported that while she was being transferred to the bed from her wheelchair that morning around 6:30 AM, NA #1 did not lock her wheelchair and the wheelchair rolled backwards which caused the NA to sit her down on the Resident's right leg as it bent underneath her. The PN indicated, upon assessment Resident #13's right knee was slightly larger than her left knee and that no bruising or redness was visible. The PN also indicated, Resident #13 initially refused pain medication but later agreed to take pain medication which she already had an order for. Review of a written statement by Nurse #3 dated 03/19/19 revealed, Resident #13 had complained of right knee pain and upon assessment of her right knee, the resident reported that when NA#1 was helping her back into bed after taking her to the bathroom the wheelchair was not locked and it rolled backwards which caused the NA to sit the Resident down on the Resident's right leg which had bent backwards underneath her. Resident #13 continued to explain, that she asked the NA to go get help but she didn't, and the NA got behind her and lifted the Resident up off the floor and into the bed.	F 689	All corrective action will be completed by 8/24/19.	

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F 689	Continued From page 9	F 689		

Nurse #3 was not available for interview.

Review of Resident #13's Physician Orders dated 03/20/19 revealed, an order for x-ray of the right knee.

Review of Resident #13's x-ray report dated 03/20/19 indicated, no acute fracture.

Review of Resident #13's Physician Orders dated 03/21/19 revealed, an order for ice to be applied to the right knee for 20 minutes three times a day for edema.

During an interview with Resident #13 on 07/29/19 at 3:29 PM she reported that she required two persons to assist her for transfers, but on the morning of the incident (03/19/19) NA #1 had taken her to the bathroom and when the NA stood her up to transfer her back to bed, the NA realized that she had not locked the brakes on her wheelchair. Resident #13 continued to explain, the wheelchair started to roll backwards, and the Resident's right knee started to bend which caused the NA to have to sit her down on the Resident's right leg. The Resident stated she asked the NA to get some help, but the NA wouldn't, then she got behind the Resident and lifted her up into the bed. The Resident stated she did not report the incident until her right knee started to hurt later that day because she did not want to get anyone in trouble but that she had not seen NA #1 since the incident happened. Resident #13 also stated, that after the fall her right knee became swollen and painful and was treated with pain medication and ice packs. The Resident also stated, her right knee had an x-ray but was not fractured.

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F 689	Continued From page 10 An interview was conducted on 07/31/19 at 11:15 AM with NA #2 who explained, the facility provided the NAs with Resident Care Guides (RCG)s that included specific interventions necessary to provide care to the residents and the RCGs were updated as needed with new interventions. NA #2 stated, that in order to provide a safe transfer for Resident #13, she required the assistance of two persons for transfers. An interview with the Administrator on 08/01/19 at 1:05 PM revealed, the Director of Nursing (DON) (who was currently on vacation) investigated the incident with Resident #13 on 03/19/19 and discovered that the NA involved in the incident was NA #1. The DON found that along with not having followed the appropriate lift status for a two person transfer for Resident #13, NA #1 also did not report the incident until Resident #13 reported the incident later that day on 03/19/19. NA #1 was given a written reprimand on 03/20/19 and subsequently was terminated. NA #1 was not available for interview. The Director of Nursing was not available for interview. During a follow up interview with the Administrator on 08/01/19 at 4:34 PM she indicated, that the residents' safety was her utmost concern and she expected the staff to follow the appropriate lift status to ensure the residents' safety.	F 689		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2)	F 761		8/24/19

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F 761	Continued From page 11 §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interview the facility failed to remove expired medications from 2 of 3 medication carts (300 and 600 hall carts) and 1 of 3 medication rooms (central supply) reviewed during medication storage. The findings included: 1. Resident #254 was readmitted to the facility on 07/31/19 from an assisted living facility with diagnoses that included heart disease,	F 761	1. No resident was directly affected due to the deficient practice. 2. All residents have the potential to be affected. All licensed nurses and medication aides were in-serviced on 8/13/19 by the DON regarding expired medications. All expired medications identified by surveyors were immediately removed from the carts and medication storage rooms on 8/1/19. All medication rooms, medication carts and treatment	

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gastroesophageal reflux disorder, hyperlipidemia, and hypertension.

Review of a physician order dated 08/01/19 read, Meloxicam 7.5 milligrams (mg) by mouth twice a day as needed for osteoarthritis.

An observation of the 300-hall medication cart was made on 08/01/19 at 10:52 AM along with Nurse #2. In the top drawer of the medication cart and available for use was a bottle of medication prescribed for Resident #254 of Meloxicam 7.5 mg 30 tablets. The bottle of Meloxicam 7.5 mg contained a use before date of 07/25/19.

An interview was conducted with Nurse #2 on 08/01/19 at 10:55 AM. Nurse #2 stated that Resident #254 admitted to the 300-hall on 07/31/19 from an assisted living and the bottle of Meloxicam came with her. Nurse #2 stated that she did not notice the expiration date of the Meloxicam when she was moving it from the assisted living to the 300-hall within the facility. Nurse #2 stated that each nurse was responsible for making sure that there was no expired medication on their cart and the night shift staff also went through the medication carts and discarded any expired medication. Nurse #2 stated that she would dispose of the Meloxicam 7.5 that expired on 07/25/19.

An interview was conducted with the Day Supervisor (DS) on 08/01/19 at 11:14 AM. The DS stated that the night shift nursing staff were responsible for going through the medication rooms and medication carts and were to remove any expired medication they found and return them to the pharmacy. The DS stated that the Meloxicam 7.5 mg that expired on 07/25/19

carts were audited for expired medications by the SDC. One expired medication was found and discarded.

3. A new audit tracking tool was created and implemented on 8/7/19. All medication and treatment carts and the medication storage room will be audited weekly on 3rd shift by the facility supervisor using the newly created audit tool. This practice will be ongoing. In addition, a representative from the organization's pharmacy will educate the nurses and medication aides on 8/23/19 on the importance of identifying and removing expired drugs.

4. Each week, starting 8/8/19, the SDC will randomly audit two carts and the medication storage room (1) x weekly for (4) weeks, then (1) x monthly for (2) months and quarterly for (12) months to identify trends requiring follow up and re-education. Written results from the audits will be reported to the QAPI committee quarterly for (12) months.

All corrective action will be completed by 8/24/19.

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should not have been on the medication cart and should have been removed and returned to the pharmacy.

An interview was conducted with the Director of Clinical Services (DCS) on 08/01/19 at 11:42 AM. The DCS stated that the facility followed manufacture guidelines for expired medication. She stated that the night shift nursing staff went through the medication carts and medication rooms and were to remove any expired medication they found. The DCS added that the pharmacy visited the facility every 3 months and assisted with medication storage during those times as well. The DCS stated that she knew the night shift staff went through the medication carts and they must have overlooked the Meloxicam 7.5 mg that expired on 07/25/19.

An interview was conducted with the Administrator on 08/01/19 at 12:25 PM. The Administrator stated that she expected the staff to follow the protocol and discard any expired medication. She added that the Meloxicam 7.5 mg that expired 07/25/19 should not have been on the medication cart available for use, it should have been removed and returned to the pharmacy.

2. Resident #80 was readmitted to the facility on 09/09/17 with diagnoses that included atrial fibrillation, depression, gastroesophageal reflux disease, osteoarthritis, and others.

Review of a physician order dated 01/30/18 read, Zofran 4 milligrams (mg) by mouth (po) every 6 hours as needed.

An observation of the 600-hall medication cart

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was made on 08/01/19 at 10:39 AM along with Nurse #1. In the second large drawer of the medication cart and available for use was a card of Zofran 4 mg that contained 19 tablets and had an expiration date of 01/12/19 and was prescribed for Resident #80.

An interview was conducted with Nurse #1 on 08/01/19 at 10:42 AM. Nurse #1 took the card of Zofran 4 mg that expired 01/12/19 and threw in the trash can, she stated Resident #80 "was not on the Zofran" anymore.

An interview was conducted with the Day Supervisor (DS) on 08/01/19 at 11:14 AM. The DS stated that the night shift nursing staff were responsible for going through the medication rooms and medication carts and were to remove any expired medication they found and return them to the pharmacy. The DS stated that the 19 tablets of Zofran 4 mg that expired 01/12/19 should not have been on the medication cart and should have been removed and returned to the pharmacy.

An interview was conducted with the Director of Clinical Services (DCS) on 08/01/19 at 11:42 AM. The DCS stated that the facility followed manufacture guidelines for expired medication. She stated that the night shift nursing staff went through the medication carts and medication rooms and were to remove any expired medication they found. The DCS added that the pharmacy visited the facility every 3 months and assisted with medication storage during those times as well. The DCS stated that she knew the night shift staff went through the medication carts and they must have overlooked the Zofran that expired 01/12/19.

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An interview was conducted with the Administrator on 08/01/19 at 12:25 PM. The Administrator stated that she expected the staff to follow the protocol and discard any expired medication. She added that the Zofran 4 mg that expired on 01/12/19 should not have been on the medication cart available for use, it should have been removed and returned to the pharmacy.

3. Resident #81 was readmitted to the facility on 06/03/18 with diagnoses that included heart disease and hypertension.

Review of a physician order dated 05/22/17 read, DuoNeb 0.5 milligrams (mg)/3 milliliters (ml) inhalation every 6 hours as needed for wheezing and cough.

An observation of the Central Supply room on 08/01/19 at 11:14 AM along with the Day Supervisor (DS) was made. There were 10 vials of DuoNeb 0.5 mg/3 ml prescribed for Resident #81 that expired December 2018.

An interview was conducted with the DS on 08/01/19 at 11:14 AM. The DS stated that the night shift nursing staff were responsible for going through the medication rooms and medication carts and were to remove any expired medication they found and return them to the pharmacy. The DS stated that the DuoNeb 0.5 mg/3 ml should not have been in the central supple and should have been removed and returned to the pharmacy.

An interview was conducted with the Director of Clinical Services (DCS) on 08/01/19 at 11:42 AM. The DCS stated that the facility followed

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manufacture guidelines for expired medication. She stated that the night shift nursing staff went through the medication carts and medication rooms and were to remove any expired medication they found. The DCS added that the pharmacy visited the facility every 3 months and assisted with medication storage during those times as well. The DCS stated that she knew the night shift staff went through the medication rooms and they must have overlooked the 10 vials of DuoNeb 0.5 mg/3 ml that expired December 2018.

An interview was conducted with the Administrator on 08/01/19 at 12:25 PM. The Administrator stated that she expected the staff to follow the protocol and discard any expired medication. She added that the DuoNeb 0.5 mg/3 ml that expired December 2018 should not have been in the central supply room available for use, it should have been removed and returned to the pharmacy.

4. Resident #91 was readmitted to the facility on 07/18/18 with diagnoses that included anxiety, diabetes mellitus, and decreased appetite.

Review of a physician order dated 08/15/18 read, Remeron 15 milligrams (mg) by mouth every night at bedtime for decreased appetite.

Review of a physician order dated 08/28/18 read, discontinue Remeron.

An observation of the Central Supply room was made on 08/01/19 at 11:14 AM. There was a card of Remeron 7.5 mg 15 tablets that expired on 07/31/19 in the extra medication bin and available for use that was prescribed for Resident #91.

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An interview was conducted with the DS on 08/01/19 at 11:14 AM. The DS stated that the night shift nursing staff were responsible for going through the medication rooms and medication carts and were to remove any expired medication they found and return them to the pharmacy. The DS stated that the Remeron 7.5 mg that expired on 07/31/19 should not have been in the central supply room and should have been removed and returned to the pharmacy.

An interview was conducted with the Director of Clinical Services (DCS) on 08/01/19 at 11:42 AM. The DCS stated that the facility followed manufacture guidelines for expired medication. She stated that the night shift nursing staff went through the medication carts and medication rooms and were to remove any expired medication they found. The DCS added that the pharmacy visited the facility every 3 months and assisted with medication storage during those times as well. The DCS stated that she knew the night shift staff went through the medication rooms and they must have overlooked the Remeron 7.5 mg that expired on 07/31/19.

An interview was conducted with the Administrator on 08/01/19 at 12:25 PM. The Administrator stated that she expected the staff to follow the protocol and discard any expired medication. She added that the Remeron 7.5 mg that expired on 07/31/19 should not have been in the central supply room available for use, it should have been removed and returned to the pharmacy.