STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345332	A. BUILDING _____ B. WING _____	C 04/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH AND REHABILITATION/WILSON	2501 DOWNING STREET SW WILSON, NC 27895

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E 000	Initial Comments An unannounced recertification and complaint survey was conducted on 04/25/2022 - 04/28/2022. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID: Q1EE11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted 4/25/22 through 4/28/22. The following intakes were investigated: NC00185880, NC00175846, NC00184398, NC00186024, NC00178075. Event ID# Q1EE11. 1 of the 18 allegations was substantiated but did not result in a deficiency.	F 000		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;	F 692		5/20/22

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

Electronically Signed | 05/13/2022

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F 692	Continued From page 1 §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to address a weight loss issue for one of three residents (Resident #46). Findings included: A review of the medical record indicated Resident #46 was admitted 7/8/2021 with diagnoses including stroke, dementia, coronary artery disease and Peripheral Vascular Disease. The Quarterly Minimum Data Set (MDS) dated 3/25/22 noted Resident #46 was moderately impaired for cognition and needed extensive assistance for all daily care with the help of one person. The MDS noted Resident #46 could feed himself. The section of the MDS about weight loss indicated no or unknown weight loss. There was no care plan for Resident #46 for nutrition. A review of weights in the resident record revealed a weight of 154 lbs. on 10/6/21 with a gradual loss each month until 4/8/22 when the weight was listed as 136 lbs. This was a loss of 11.4 % in six months. There was no recorded weight for the month of March. In an interview on 4/27/22 at 7:46 AM, the Dietary Manager (DM) stated monthly weights are done by the first Wednesday of every month. The DM noted she meets with the RD when the RD comes to the facility. The DM noted the person who records the weights for the Director of Nursing gives them to her (the DM), and the DM	F 692	1. Resident #46 suffered no ill effects related to this incident secondary the facility failing to address a weight loss issue. 2. All Facility residents have the potential to be affected by this deficient practice in relation to having timely, and accurately recorded monthly weights in the electronic medical record that are reviewed and interventions implemented by the RD per policy. 100% audit was completed by the DON/RD to ensure all monthly weights were obtained and recorded in EHR and interventions if indicated are put into place by the RD. Completed on 5/2/22. 3. All Nursing staff will be in-serviced educated on proper policy and procedures to properly obtaining and documenting monthly weights in the EHR, and communicating with the RD/DM regarding weight changes and if interventions are indicated by the DON/ designee. DON/designee will ensure all monthly weights are completed by the 5th of each month and that the RD addresses any weight loss/gain timely and accurately. Education will be completed on 5/20/22. 4. The DON/ designee will audit all monthly weights and ensure accurate and timely completion with documentation in the EHR, and RD notification and assessment with interventions if indicated are in place. DON/designee will complete a weekly audit x 6 weeks. All results of the	

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F 692	Continued From page 2 makes a list or texts the RD and lets the RD know which residents need to be seen by the RD. The DM also said the Director of Nursing may let her know a resident that the RD needs to see. The DM stated she puts the weights into a program called Mealtracker when she gets them. A dietary note written on 3/25/22 included information from the Dietary Manager on Resident #46 and his weight loss and that Resident #46 would be referred to the Registered Dietician (RD). On 4/26/22 at 4:00 PM, an interview was conducted with the RD who stated she comes to the facility weekly. The RD stated she did not know why there was no weight for Resident #46 for March, she did not do weights, the nurses did weights. In a telephone interview of 4/27/22 at 11:11 AM, the RD stated she usually runs a report on Tuesdays. The RD stated she did not know why she did not see that Resident #46 had been indicated for weight loss after the DM wrote the note on 3/25/22. The RD stated she did not see it until Friday April 22, called and talked to the nurses on Monday April 25, and was told he was eating, the RD wrote a note and ordered fortified foods. "I guess I just didn ' t see it" the RD stated about the weight loss.	F 692	audits and any concerns identified will be reported/ trended to our Quality Assurance committee monthly times three. 5. Date of compliance 05/20/2022	
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must	F 693		5/20/22

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F 693	Continued From page 3 ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to ensure a bottle of tube feeding formula was discarded within twenty-four hours when opened for use. The facility also failed to label the storage package for tube feeding syringe when opened for use and failed to label the water bag for flushes with a date when opened for use for 1 of 1 resident reviewed for tube feedings (Resident #40). This practice had the potential for causing contamination. Findings included: Manufacturer guidelines for the tube feeding formula stated tube feeding formula containers must be discarded at twenty-four hours after opening. Resident #40 was admitted to the facility 4/3/2020. His diagnoses included cerebral	F 693	1. Resident #40 suffered no ill effects related to the facility failing to ensure a bottle of tube feeding formula was discarded within 24 hours after opened for use. Resident #40 was also noted that the facility failed to label the storage package for tube feeding syringe while open for use and failed to label the water bag for flushes. Thus, potential for causing a contamination. 2. All Facility residents that are receiving tube feedings have the potential to be affected by this deficient practice. Residents who require tube feeding must be assessed for formula being discarded after 24 hours in use and efficiently labeling and dating all tube feeding related materials. DON/designee will review all residents that receive tube feeding and ensure that all items are labeled, dated and discarded per MD orders. Initial	

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F 693	Continued From page 4 infarction (stroke) and dysphagia (difficulty swallowing). Resident #40's initial care plan dated 4/3/2020 revealed he required a tube feeding due to dysphagia. Interventions included checking for tube placement and gastric contents and checking physician orders for current tube feeding orders. Interventions also stated Resident #40 was dependent on tube feedings and water flushes. A review of the physician orders revealed on 4/23/2021 to change tube feeding syringe every twenty-four hours every night shift. A review of the physician orders revealed on 12/2/2021 to flush GT with 250 milliliters of water every four hours per pump for GT flush. A review of the physician orders revealed on 2/23/2022 to administer tube feeding formula controlled at 40 milliliters per hour continuous via GT and document amount given each shift. The Quarterly Minimum Data Set (MDS) assessment dated 3/20/2022 indicated Resident #40 was severely cognitively impaired and required total assistance with eating by receiving tube feedings and fluids through a gastrostomy tube (GT). Resident #40's tube feeding formula was observed on 4/25/2022 at 10:39 a.m. infusing at 40 milliliters per hour via pump, and the tube feeding formula bottle was labeled 4/23/2022 with a black sharpie. The opened tube feeding syringe storage packet and a thousand milliliter bag of water connected to infuse flushes every four	F 693	assessment was completed on 4/26/22. 3. Facility staff will be in service educated on the proper policy and procedure for the Resident Tube Feeding policy and expectations of discarding, labeling and proper dating. This will be completed by the DON/ designee by 5/20/22. 4. The DON/ designee will audit all Tube Fed residents weekly x 6 weeks to ensure tube feeding is properly labeled, dated and discarding per MD orders per policy. Results of the audits and any concerns identified will be reported/ trended to our Quality Assurance committee monthly times three. 5. Compliance date: 05/20/22	

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F 693	Continued From page 5	F 693		

hours were observed hanging beside the tube feeding formula with no date or label indicating when they were opened for use.

The unit coordinator stated on 4/25/2022 at 10:45 a.m. in an interview, 4/23/2022 labeled on the tube feeding formula bottle indicated when the tube feeding formula was started. She stated tube feeding formula was changed every twenty-four hours on the night shift and should had been changed by the assigned night shift nurse and dated 4/25/2022.

On 4/26/2022 at 8:30 a.m. in an interview with the unit coordinator, she stated the bag for water flushes and the tube feeding syringe were to be changed and dated also daily on the night shift.

On 4/27/2022 at 4:57 p.m. in an interview with Nurse #1, she stated she worked night shift the weekend of 4/23/2022 and 4/24/2022 and was assigned Resident #40. She stated the tube feeding formula bottle, administration tubing, and water bag was changed nightly every twenty-four hours and it was scheduled on the Medication Administration Record (MAR) and recorded in the computer. She stated she could not recall changing Resident #40's tube feeding formula, bag for water and tube feeding syringe on 4/24/2022 on the night shift and sometimes the 3p.m. to 11p.m. staff member changed the tube feeding formula.

A review of the daily staffing assignment sheets revealed Nurse #1 worked a twelve-hour night shift both 4/23/2022 and 4/24/2022.

Review of the March 2022 and April 2022 MAR revealed staff documented changing the tube

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F 693	Continued From page 6 feeding syringe, water flushes at 250 milliliters every four hours, and tube feeding formula at forty milliliters per hour and three hundred and twenty milliliters of formula infused every shift. There was no documentation of changing the tube feeding formula bottle every night shift. The Director of Nursing (DON) stated in an interview on 4/28/2022 at 4:15 p.m. tube feeding formulas were changed out every twenty-four hours, and nursing staff were to write date and time when formula was started on the bottle. She stated tube feeding syringe and bag of water was also changed every twenty-four hours and was to be dated or labeled with date when started. She stated a set of tube feeding orders populated in the computer, and nurses were to check tube feeding orders based on needs of the resident. She stated she thought the nurse placed the wrong date on the tube feeding formula because the formula would have run out if started on 4/23/2022 as the formula bottle was marked.	F 693		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law).	F 732		5/20/22

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F 732	Continued From page 7 (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to post complete and accurate nurse staffing data summaries for 11 of 118 days reviewed for nurse staffing data. (1/3/2022, 2/12/2022, 2/18/2022, 2/20/2022, 2/25/2022, 3/19/2022, 3/20/2022, 4/2/2022, 4/25/2022. 4/26/2022, and 4/27/2022) Findings included: On 4/25/2022 at 9:30 a.m., a nurse staffing data summary for 4/25/2022 was observed in a clear plastic folder hanging on the bulletin board at the beginning of the 300-hall behind the nursing	F 732	1. No Residents or staff suffered any ill effects related to the facility failing to post complete and accurate nurse staffing data summaries for 11 of 118 days reviewed. 2. All Facility staff and residents have the potential to be affected by this deficient practice if the nursing staffing data summaries are inaccurate and not updated with changes to the daily nursing schedule. Daily nursing staffing data summaries need RN coverage verified by 8 hours in a 24-hour period. Initial audit completed by 04/28/2022 DON/ADON/HR-SCHEDULER.	

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F 732	Continued From page 8 station. Nurse staffing data summaries dated 4/25/2022 to 4/29/2022 were observed located in the plastic folder, and each one was dated printed on 3/25/2022. Nurse staffing data summary dated 4/25/2022 revealed 1-certified medication aide (CMA), 5- nurse aides (NA), 3- licensed practical nurse (LPN), 1- restorative aide, 1- unit coordinator and 1-wound nurse for the 7a.m. to 3p.m. shift. The 3p.m. to 11p.m. shift indicated 1-CMA, 2- NA and 2-LPN, and the 11p.m. to 7a.m. shift indicated 5-NA and 1-LPN. There was no registered nurse (RN) coverage indicated on the nurse staffing data summary dated 4/25/2022. The daily nursing assignment sheet dated 4/25/2022 revealed the following were scheduled: 7a.m. to 3p.m. shift indicated 2-CMA, 7-NA, 2-LPN, 1-restorative aide, 1- unit coordinator and 2- treatment nurses (LPN); 3p.m. to 11p.m. shift indicated 1-CMA, 6-NA and 3-LPN; 11p.m. to 7a.m. shift indicated 5-NA and 1-LPN and 2-RN. Based on the daily nursing assignment sheet, the posted staffing data summary dated 4/25/2022 did not include one CMA, two nurse aides for the 7a.m. to 3p.m. shift, did not included four nurse aides and one LPN for the 3p.m. to 11p.m. shift and did not include two registered nurses (RN) for the 11p.m. to 7a.m. shift. On 4/26/2022 at 8:30 a.m., nursing staffing data summary dated 4/26/2022 was observed posted. Census was listed as 76, and the 7a.m. to 3p.m. shift included 1-CMA, 4-NA, 4-LPN, 1- restorative aide and 1-unit coordinator. The 3p.m. to 11p.m. shift indicated 1-CMA, 3-NA and 2-LPN, and the 11p.m. to 7a.m. shift indicated 5-NA and 1-LPN. There was no RN coverage noted on the posted nurse staffing summary dated 4/26/2022.	F 732	3. All Nursing Scheduling staff will be in-service educated on proper policy and procedures on posting nursing data summary staffing sheets that must be accurate, and corrected daily with any changes to the nursing schedule by 5/20/22. 4. The Nursing Scheduler/Administrator or/ designee will audit all daily nursing staffing data sheets for accuracy for scheduling purposes. This will be audited using the audit tool 3x weekly x 6 weeks by the Nurse scheduler/ADM or designee x 6 weeks. All Results of the audits and any concerns identified will be reported/ trended to our Quality Assurance committee monthly times three. 5. Date of compliance 05/20/22	

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F 732	Continued From page 9	F 732		

The daily nursing assignment sheet dated 4/26/2022 revealed the following were scheduled: 7a.m. to 3p.m. shift indicated 1-CMA, 8-NA, 3-LPN, 1- restorative aide, 1-unit coordinator, 1-treatment nurse (LPN) and 1-Assistant Director of Nursing (House-RN); 3p.m. to 11p.m. indicated 1-CMA, 7-NA and 3-LPN; 11p.m.to 7a.m. shift indicated 5-NA, 1-LPN and 2-RN. Based on the daily nursing assignment sheet, the posted staffing data summary dated 4/26/2022 did not include four nurse aides and one RN for the 7a.m. to 3p.m. shift, did not include four nurse aides and one LPN for the 3p.m. to 11p.m. shift and did not included two RNs for the 11p.m. to 7a.m. shift.

On 4/27/2022 at 9:00 a.m. nursing staffing data summary dated 4/27/2022 was observed posted. Census was recorded as 76, and the 7a.m. to 3p.m. shift included 1-CMA, 4-NA, 4-LPN, 1-restorative aide and 1 unit coordinator. The 3p.m. to 11p.m. shift indicated 1-CMA, 1-NA and 2-LPN, and the 11p.m to 7a.m. shift indicated 5-NA and 1-LPN. There was no RN coverage recorded on the nursing staffing data summary dated 4/27/2022.

The daily nursing assignment sheet dated 7/27/2022 revealed the following were scheduled: 7a.m. to 3p.m. shift indicated 1-CMA, 7-NA, 2-LPN, 1-restorative aide, 1 unit coordinator, 1 treatment nurse(LPN) and 1-staff development coordinator (House-RN); 3p.m. to 11p.m. shift indicated 1-CMA, 8-NA and 3-LPN; 11p.m. to 7a.m. shift indicated 4-NA, 1-LPN and 2-RN. Based on the daily nursing assignment sheet, the posted staffing data summary dated 4/27/2022 did not include three nurse aides and one RN and listed an additional LPN for the 7a.m. to 3p.m.

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F 732	Continued From page 10	F 732		

shift, did not include seven nurse aides and one LPN for the 3p.m. to 11p.m. shift and did not included two RNs and listed an additional nurse aide for the 11p.m. to 7a.m. shift.

On 4/27/2022, a review of posted nurse staffing data summaries and daily nursing assignment sheets dated January 2022 to April 24, 2022 revealed inaccurate completion of the posted nurse staffing data summaries for RN coverage for the following dates: 1/3/2022, 2/12/2022, 2/18/2022, 2/20/2022, 2/25/2022, 3/19/2022, 3/20/2022, 4/2/2022.

On 4/27/2022 at 9:04 am updated posted nurse staffing data summary dated 4/25/2022 and 4/26/2022 revealed hand-written corrections with a black ink pen. Corrections included circling the number printed, marking through the number printed and writing a different number and circling, and writing RN as a category and marking the hours the RN worked.

On 4/27/2022 at 9:04 a.m. in an interview with the Director of Nursing (DON), she stated she printed posted nurse staffing data summaries two to three weeks in advance, and the scheduler printed daily nursing assignment sheets on the evening prior to the next day and recorded the census. She stated nursing schedules changed daily and posted nurse staffing data summaries dated 4/25/2022, 4/26/2022 and 4/27/2022 did not reflect accurate nurse staffing data because the posted nurse staffing data summary was not updated to reflect changes in the daily nursing assignments sheets until the day after posted. She stated posted nurse staffing data summaries dated 1/3/2022, 2/12/2022, 2/18/2022, 2/20/2022, 2/25/2022, 3/19/2022, 3/20/2022, 4/2/2022 were

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345332	A. BUILDING _____ B. WING _____	C 04/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH AND REHABILITATION/WILSON	2501 DOWNING STREET SW WILSON, NC 27895

(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 732	Continued From page 11 inaccurate because a computerized scheduling program did not recognize and list office personnel staffing as registered nurses on the daily nursing assignment sheets. On 4/28/2022 at 8:53 a.m. during an interview with the scheduler, she stated she or the DON posted the nurse staffing data summaries ahead of time. She stated she printed the posted nurse staffing data summaries about one week before and placed in the designated area. She stated she printed the daily staff assignment sheets at five o ' clock daily and left at the nurse's station for the next day, and the census was completed every twenty-four hours at midnight. She stated when MDS nurses (both RN) and ADON worked as a staff nurse, the computerized scheduling program did not generate a posted nurse staffing data summary that reflected RN coverage. She stated posted nurse staffing data summaries were updated by the DON. On 4/28/2022 at 4:24 p.m. during an interview with the Administrator, she stated posted nurse staffing data summary was to be complete and accurate when posted.	F 732		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §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	F 761		5/20/22

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F 761	Continued From page 12 §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 interviews the facility failed to date insulin pens when opened and failed to dispose of expired insulin pens in 1 of 4 medication carts inspected (300 hall back cart). Findings included: On 4/28/22 at 2:00 PM the 300 hall back medication cart was inspected with the Unit Coordinator. One Novalog FlexPen (a diabetic medication) was observed opened with no open date documented. One Insulin Aspart FlexPen (a diabetic medication) was observed with an expiration date of 4/27/22. The Unit Coordinator stated the insulin pens should not be in the medication cart. A review of the manufacturer's recommendations for the use of Novalog FlexPen and Insulin Aspart FlexPen revealed they can be used up to 28 days	F 761	1. No Resident suffered any ill effects related to this incident. The facility failed to dispose of expired insulin pens in 1 of 4 medication carts inspected. 2. All Facility residents have the potential to be affected that have an MD order for insulin pens. 3. On 04/28/22, a 100% audit of all medication carts to ensure no expired medications/labeled and dated properly, no open, non dated or expired insulin pens were inside the medication carts by the SDC/IP and DON. The audit was to ensure all medication carts had no expired medications, no expired insulin pens in the medication cart. The DON and SDC/IP corrected all concerns identified during the audit. 4. An education Inservice was initiated by the Staff Development	

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F 761	Continued From page 13 after the initial opening. The Unit Coordinator was interviewed on 4/28/22 at 2:40 PM and stated it was the morning nurse's responsibility to discard the expired insulin. She stated the morning nurses should have filled out the Insulin Cart Audit Tool which included writing down the insulins in the cart with open and expiration dates and the expired insulin should have been thrown out. On 4/28/22 at 2:50 PM an interview was conducted with Medication Aid #1 who was working with the 300 hall back cart and stated she was responsible for filling out the Insulin Cart Audit Tool. She stated she had forgotten to do it this morning.	F 761	Coordinator/IP/DON on 04/28/22 with all Nursing staff related to ensuring all expired medications, proper labeling and dating properly, to include insulin pens that are in the medication carts. All newly hired employees and any nurse agency staff will also receive this education. Education will be completed by 5/20/22. 5. The DON/ designee will audit all 4 medication carts weekly x 6 weeks to ensure no expired or non-labeled insulin pens are present in the medication carts. Results of the audits and any concerns identified will be reported/ trended to our Quality Assurance committee monthly times three. 6. Compliance date: 05/20/22	