

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/08/2011
FORM APPROVED
OMB NO. 0938-0381

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345411	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/28/2011
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH AND REHAB/WAYNESVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 516 WALL STREET WAYNESVILLE, NC 28786	
(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 281 SS=D	<p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to follow physician orders and failed to clarify a physician 's order for one (1) of ten (10) sampled residents (Resident #74).</p> <p>The findings are:</p> <p>Resident #74 was admitted on 7/3/08 with diagnoses that included congestive heart failure, hypertension, constipation and osteoporosis among others. The most recent Minimum Data Set (MDS) dated 06/17/11 specified the resident had moderately impaired cognition.</p> <p>Resident #74's monthly physician orders for 7/11 specified the resident was to receive Lasix 20mg (milligrams) by mouth every other day, hold if systolic blood pressure less than 100.</p> <p>a. Resident #74's monthly Medication Administration Records (MARs) dated 07/11 revealed the resident received 20 milligrams of Lasix every other day. There were no documented blood pressure readings on the MAR. Further review of the resident's medical record revealed the resident had her blood pressure recorded once weekly.</p> <p>An original physician's order dated 10/4/10 specified to decrease Resident #74's Lasix to</p>	F 281	<p>F-281</p> <p>Corrective action has been accomplished for the alleged deficient practice in regards to Resident #74 by contacting this resident's physician and obtaining a clarification order. As the facility recognizes this alleged deficient practice has the potential to affected other residents, the facility has implemented additional measures to ensure that the alleged deficient practice does not reoccur. To include mandatory re-education for nursing staff to ensure continued compliance. These system changes include Medical Records and Unit Coordinator auditing physician's orders daily for completeness and clarity. Additionally, all new orders are to be highlighted by the Unit Coordinator and Medical Records in orange to alert the nurse to the change. Additionally,</p> <p>"Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."</p>	8/25/2011

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

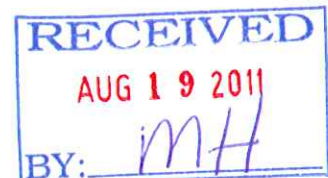
TITLE

(X5) DATE

Administrator

8/19/2011

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.



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F 281	<p>Continued From page 1 20mg by mouth every other day.</p> <p>On 07/26/11 at 2:35 p.m. licensed nurse (LN) #2, assigned to care for Resident #74, was interviewed and stated she wasn't aware of the order to check Resident #74's blood pressure prior to administering the Lasix. She reviewed the physician's order sheet and MAR and confirmed the order specified the Lasix was to be held if the resident's systolic blood pressure was less than 100. She added that she routinely gave the resident her Lasix and did not check the resident's blood pressure prior to giving the lasix. LN #2 reviewed the medical record and confirmed blood pressure readings were not documented in the medical record as having been taken prior to the medication being given.</p> <p>On 07/27/11 at 11:05 a.m. the South Wing Unit Manager was interviewed and confirmed that blood pressure readings should have been taken and documented on the MAR or in vitals section prior to administering Resident #74's Lasix medication.</p> <p>On 07/28/11 at 9:30 a.m. the Director of Nursing (DON) was interviewed and stated she would expect the licensed nurses to follow physician's orders as written or to call the physician to clarify an order if they had questions. She offered no explanation why the resident's Lasix order was not followed as written.</p> <p>b. Resident #74's medical record was reviewed and revealed an original physician's order dated 10/4/10 that specified to decrease Resident #74's Lasix to 20mg by mouth every other day.</p>	F 281	<p>all new orders will be brought daily to the Morning Meeting by Medical Records for additional review and corrective actions. The monitoring of this new system change will continue for six months, and may be extended, if required.</p> <p>The DON or her designee will review data obtained for patterns and trends. All data results will be presented to the QA&A Committee monthly for a period of 6 months. The QA&A Committee will evaluate the effectiveness of the plan based on the outcomes identified and adjust the plan as needed.</p> <p>"Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."</p>	8/25/2011	

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F 281	Continued From page 2 Further review of the medical record revealed the 07/11 monthly Medication Administration Record (MARs) specified the resident received Lasix 20mg (milligrams) by mouth every other day, hold if systolic blood pressure less than 100. On 07/26/11 at 2:35 p.m. licensed nurse (LN) #2, assigned to care for Resident #74, was interviewed and stated she wasn't aware of the order to check Resident #74's blood pressure prior to administering the Lasix. She reviewed the physician's order sheet and MAR and confirmed the order specified the Lasix was to be held if the resident's systolic blood pressure was less than 100. She stated she should have clarified the order by contacting the physician. On 07/27/11 at 3:30 p.m. the medical records director was interviewed and stated that the 10/04/10 physician's order was to decrease Resident #74's Lasix. She stated the blood pressure parameters (hold if systolic less than 100) were not to be continued. She specified the end of month physician's orders are reconciled for accuracy and added that the order had been overlooked for the past nine (9) months. On 07/28/11 at 9:30 a.m. the Director of Nursing (DON) was interviewed and stated she would expect the licensed nurses to follow physician's orders as written or to call the physician to clarify an order if they had questions. She offered no explanation why the resident's Lasix order was not clarified.	F 281			
F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309			

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F 309	<p>Continued From page 3</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interviews and record reviews the facility failed to manage and implement planned measures for adequate bowel elimination patterns for three(3) of thirteen (13) sampled residents (Resident #'s 9, 106 and 77).</p> <p>The findings are:</p> <p>The facility's "Bowel Program" revised 01/31/99 specified:</p> <p>-Bowel movements will be documented on the TAR (treatment administration record) each shift by the nurse. Results will be monitored each shift (by the nurse) and the following protocol will be initiated as needed and per MD (medical doctor) order on admission.</p> <p>-If resident has not had a bowel movement in 3 days (9 shifts):</p> <ol style="list-style-type: none"> Give Milk of Magnesia (laxative) 30cc (cubic centimeters) by mouth at night. If this is not effective by 6:00 a.m. give Dulcolax suppository 10mg (milligrams) per rectum. If this is not effective by 10:00 a.m. give Fleets enema 1 unit per rectum. 	F 309	<p>F-309</p> <p>Corrective action has been accomplished for the alleged deficient practice in regards to residents #9, #106 & #77 by educating the staff caring for these residents, and by educating the residents of the importance of communicating and documenting bowel movements. Residents #9, #106 & #77 were assessed to ensure that bowel movements were happening every three days. No further interventions were required as these residents communicated that they were having regular BM's, and they had no clinical signs or symptoms related to not having regular BM's. As the facility recognizes these alleged deficient practices have the potential to affect other residents, the facility has implemented these additional measures to ensure that the alleged deficient practice does not reoccur these include: mandatory re-education for nursing staff to</p> <p>"Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."</p>	8/25/2011

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F 309	<p>Continued From page 4</p> <p>d. If this is not effective notify medical doctor</p> <p>1. Resident #9 was admitted to the facility on 02/08/08 with diagnoses that included constipation, dementia and debility among others. The most recent Minimum Data Set (MDS) dated 07/22/11 specified the resident had short and long term memory impairment and severely impaired cognitive skills for daily decision making. The MDS also specified the resident required extensive assistance with Activities of Daily Living (ADLs) such as toileting, personal hygiene, locomotion off the unit and dressing; and the resident was frequently incontinent of bowel and bladder.</p> <p>Resident #9's bowel elimination care plan updated 07/27/11 specified the resident had a history of problems with constipation and was at increased risk for complications secondary to decreased mobility. The care plan goal revealed the resident would have adequate bowel elimination at least every three (3) days. The care plan interventions included:</p> <ul style="list-style-type: none"> -bowel protocol -observe for bowel pattern to ensure adequate bowel elimination -administer medications as ordered and observe for side effects and effectiveness <p>Resident #9's bowel elimination records were reviewed and revealed:</p> <ul style="list-style-type: none"> a. Starting on 08/06/11 and continuing for five (5) days no bowel movements were documented. b. Starting on 08/18/11 and continuing for 	F 309	<p>ensure continued compliance. These newly implemented systems changes include Unit Coordinator reviewing documentation every 3 days to ensure that all residents have had BM's in the last nine shifts. Additionally, Medical Records has relocated the nurse BM recording from the T.A.R. to the M.A.R., and placed the new bowel protocol on the M.A.R. The C.N.A.'s will record residents' BM's on their assignment sheets and turn their assignment sheets in to the nurse. The nurse will review the C.N.A. assignment sheets and document their findings. Then the nurse will assess and treat residents per the bowel protocol. The DON or Designee will monitor this documentation weekly for further intervention, if required. Monitoring for these new systems will continue for 6 months, however, monitor may be extended if required.</p> <p>"Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."</p>	

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F 309	<p>Continued From page 5</p> <p>twelve (12) days no bowel movements were documented.</p> <p>c. Starting on 07/01/11 and continuing for five (5) days no bowel movements were documented.</p> <p>A review of nursing notes for Resident #9 for the periods of 06/06/11 through 06/10/11, 06/18/11 through 06/29/11 and 07/01/11 through 07/05/11 revealed no documentation of assessment for constipation or implementation of the facility's bowel protocol for constipation.</p> <p>Review of the MAR and physician orders revealed no additional orders and/or interventions to address the three (3) episodes of constipation.</p> <p>Nurse aide (NA) #1 was interviewed on 07/27/11 at 1:45 p.m. and reported she documented residents' bowel movements on her daily assignment sheet that was turned in to the licensed nurse for review at the end of her shift.</p> <p>On 07/27/11 at 2:00 p.m. licensed nurse (LN) #1 was interviewed and reported that at the end of her shift she reviewed the nurse aide assignment sheets and transcribed episodes of bowel movements on to the residents' TARs. She added that at the beginning of her shift she reviewed the TARs to monitor for adequate bowel elimination of at least one documented bowel movement in the last nine (9) shifts (3 days). LN #1 reported that if a resident had not experienced a bowel movement in nine (9) shifts (3 days) she was to initiate the facility's bowel protocol.</p> <p>On 07/27/11 at 2:15 p.m. the South Wing Unit Manager was interviewed and reported that</p>	F 309	<p>The DON or her designee will review data obtained for patterns and trends. All data will be reported to the QA&A Committee monthly for a period of 6 months. The QA&A Committee will evaluate the effectiveness of the plan based on the outcomes identified and will adjust the plan as needed.</p> <p>"Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."</p>	8/25/2011	

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F 309	<p>Continued From page 6</p> <p>licensed nurses were responsible for documenting bowel movements in the resident's TAR and reviewing the TAR at the beginning of each shift to ensure the resident had experienced a bowel movement in the last nine (9) shifts (3 days). She added that she would expect the licensed nurse to initiate the bowel protocol if a resident had gone nine (9) shifts (3 days) without a bowel movement.</p> <p>On 07/28/11 at 9:20 a.m. the Director of Nursing (DON) was interviewed. She reviewed Resident #9's bowel elimination records and confirmed the resident had not experienced a bowel movement in greater than three days without documentation of the bowel protocol having been initiated. She stated she would expect the licensed nurses to monitor the TARs for bowel movements and initiate the bowel protocol when a resident went nine (9) shifts without a bowel movement. The DON offered no explanation why Resident #9 had no bowel protocol initiated for the three (3) episodes of constipation.</p> <p>2. Resident #106 was admitted to the facility on 06/28/10 and readmitted 09/07/10 with diagnoses that included constipation, hypertension, femur fracture and chronic obstructive asthma among others. The most recent Minimum Data Set (MDS) dated 06/10/11 specified the resident had short and long term memory impairment and severely impaired cognitive skills for daily decision making. The MDS also specified the resident required extensive assistance with Activities of Daily Living (ADLs) that included toileting, personal hygiene and transfers and specified the resident was frequently incontinent of bowel. The Care Area Assessment Review</p>	F 309			

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F 309	<p>Continued From page 7</p> <p>Report (CAAs) dated 06/13/11 specified the resident had no complications from incontinence and required assistance with all toileting needs.</p> <p>Resident #106's bowel elimination care plan updated 06/10/11 revealed the resident had an actual alteration in bowel function and episodes of constipation. Interventions to ensure the resident would have adequate bowel elimination at least every three days to include administer medications as ordered, observe for side effects and effectiveness, and notify the MD as indicated.</p> <p>Resident #106's bowel elimination records were reviewed and revealed:</p> <p>a. Starting on 03/06/11 and continuing for seven (7) days no bowel movements were documented.</p> <p>A review of nursing notes for Resident #106 for the periods of 03/06/11 through 03/12/11 revealed no documentation of assessment for constipation or implementation of the facility's bowel protocol for constipation.</p> <p>Review of the MAR and physician orders revealed no additional orders and/or interventions to address the episode of constipation.</p> <p>Nurse aide (NA) #1 was interviewed on 07/27/11 at 1:45 p.m. and reported she documented residents' bowel movements on her daily assignment sheet that was turned in to the licensed nurse for review at the end of her shift.</p> <p>On 07/27/11 at 2:00 p.m. licensed nurse (LN) #1 was interviewed and reported that at the end of</p>	F 309		

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F 309	<p>Continued From page 8</p> <p>her shift she reviewed the nurse aide assignment sheets and transcribed episodes of bowel movements on to the residents' TARs. She added that at the beginning of her shift she reviewed the TARs to monitor for adequate bowel elimination of at least one documented bowel movement in the last nine (9) shifts (3 days). LN #1 reported that if a resident had not experienced a bowel movement in nine (9) shifts (3 days) she was to initiate the facility's bowel protocol.</p> <p>On 07/27/11 at 2:15 p.m. the South Wing Unit Manager was interviewed and reported that licensed nurses were responsible for documenting bowel movements in the resident's TAR and reviewing the TAR at the beginning of each shift to ensure the resident had experienced a bowel movement in the last nine (9) shifts (3 days). She added that she would expect the licensed nurse to initiate the bowel protocol if a resident had gone nine (9) shifts (3 days) without a bowel movement.</p> <p>On 07/28/11 at 9:20 a.m. the Director of Nursing (DON) was interviewed. She reviewed Resident #106's bowel elimination records and confirmed the resident had not experienced a bowel movement in greater than three days without documentation of the bowel protocol having been initiated. She stated she would expect the licensed nurses to monitor the TARs for bowel movements and initiate the bowel protocol when a resident went nine (9) shifts without a bowel movement. The DON offered no explanation why Resident #106 had no bowel protocol initiated for the episode of constipation.</p> <p>3. Resident #77 was admitted to the facility on</p>	F 309			

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F 309	<p>Continued From page 9</p> <p>07/22/08 with diagnoses that included constipation, dementia and osteoporosis among others. The most recent Minimum Data Set (MDS) 07/08/11 specified the resident had no cognitive impairment, required limited assistance with Activities of Daily Living (ADLs) such as toileting, transfers, personal hygiene and dressing and was always continent.</p> <p>Record review revealed a care plan updated 07/13/11 that specified Resident #77 was at risk for constipation. The care plan specified interventions to ensure the resident would have adequate bowel elimination every three (3) days and included to observe for bowel patterns to ensure adequate elimination and administer medications as ordered.</p> <p>Resident #77's bowel elimination records revealed:</p> <ul style="list-style-type: none"> a. Starting on 06/09/11 and continuing for four (4) days no bowel movements were documented. b. Starting on 06/18/11 and continuing for five (5) days no bowel movements were documented. <p>A review of nursing notes for Resident #77 for the periods of 06/09/11 through 06/12/11 and 06/18/11 through 06/22/11 revealed no documentation of assessment for constipation or implementation of the facility's bowel protocol for constipation.</p> <p>The Medication Administration Record (MAR) and Treatment Administration Record (TAR) for 08/11 was reviewed and revealed an original physician</p>	F 309			

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(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 309	<p>Continued From page 10</p> <p>order dated 01/13/10 for Senna (laxative) two (2) tablets twice daily for constipation. Further review of the MAR and physician orders revealed no additional orders and/or interventions to address the two (2) episodes of constipation.</p> <p>Nurse aide (NA) #1 was interviewed on 07/27/11 at 1:45 p.m. and reported she documented residents' bowel movements on her daily assignment sheet that was turned in to the licensed nurse for review at the end of her shift.</p> <p>On 07/27/11 at 2:00 p.m. licensed nurse (LN) #1 was interviewed and reported that at the end of her shift she reviewed the nurse aide assignment sheets and transcribed episodes of bowel movements on to the residents' TARs. She added that at the beginning of her shift she reviewed the TARs to monitor for adequate bowel elimination of at least one documented bowel movement in the last nine (9) shifts (3 days). LN #1 reported that if a resident had not experienced a bowel movement in nine (9) shifts (3 days) she was to initiate the facility's bowel protocol.</p> <p>On 07/27/11 at 2:15 p.m. the South Wing Unit Manager was interviewed and reported that licensed nurses were responsible for documenting bowel movements in the resident's TAR and reviewing the TAR at the beginning of each shift to ensure the resident had experienced a bowel movement in the last nine (9) shifts (3 days). She added that she would expect the licensed nurse to initiate the bowel protocol if a resident had gone nine (9) shifts (3 days) without a bowel movement.</p> <p>On 07/28/11 at 9:20 a.m. the Director of Nursing</p>	F 309		

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F 309	Continued From page 11 (DON) was interviewed. She reviewed Resident #77's bowel elimination records and confirmed the resident had not experienced a bowel movement in greater than three days without documentation of the bowel protocol having been initiated. She stated she would expect the licensed nurses to monitor the TARs for bowel movements and initiate the bowel protocol when a resident went nine (9) shifts without a bowel movement. The DON offered no explanation why Resident #77 had no bowel protocol initiated for the two (2) episodes of constipation.	F 309			
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked,	F 431	F-431 Corrective action has been accomplished for the alleged deficit practice by the Unit Coordinators checking all medication storage areas and removing and disposing of all alleged expired medications and/or undated medications per facility policy. As the facility recognizes these alleged deficient practices have the potential to affected other residents, the facility has implemented these additional measures to ensure that the alleged deficient practice does not reoccur to include mandatory re-education for nursing staff to ensure continued compliance. These measures and systems changes include all nurses to check medication storage areas, including medication carts, medication refrigerators, medication rooms, and central supply room weekly for expired and/or undated medications. Additionally, on a designated day each week, a nurse will be "Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."	8/25/2011	

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F 431	<p>Continued From page 12</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to ensure that expired Tuberculin vaccine and insulin were removed from one (1) of (2) medication room refrigerators, and failed to ensure that expired insulin was removed from one (1) of four (4) medication carts.</p> <p>The findings are:</p> <p>1.) A facility policy entitled Recommended Minimum Medication Storage Parameters, dated 02/28/08, revealed that all insulin in vials, with the exception of insulin detemir, should be dated when opened and discarded twenty-eight days later.</p> <p>On 07/26/11 at 2:20 p.m. an observation of the North Wing Team One medication cart revealed an opened, partially used, and ready for use 10 ml vial of insulin glargine. The vial was hand dated as opened on 06/03/11.</p> <p>On 07/26/11 at 2:44 p.m. the North Wing Unit Manager was interviewed. She stated that insulin should be dated when opened and discarded</p>	F 431	<p>assigned to re-check all aforementioned locations and dispose of and re-order medications as needed. The nurse will report her findings to the Unit Coordinator. The Unit Coordinator will weekly spot-check all medication storage areas for expired or un-dated medications. Concurrently, a sign will be posted at each nurse's station by the Unit Coordinator to remind the nurses to check all medications for expiration dates and for dates opened. Additionally, monthly a pharmacy representative will check all medication storage areas for expired and undated medication. The Unit Coordinator and pharmacy representative will report their findings to the DON weekly and/or monthly. The DON will take additional corrective action as required. Monitoring of these new system changes will continue for 6 months. However, monitoring may be extended if required.</p> <p>"Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."</p>	8/25/2011

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F 431	<p>Continued From page 13</p> <p>twenty-eight days later. The Unit Manager discarded the vial of insulin.</p> <p>On 07/26/11 at 3:50 p.m. the Director of Nursing was interviewed. She stated she expected nursing staff to date all insulin vials when opened and to discard them twenty-eight days later per manufacturer's recommendations and facility policy.</p> <p>2.) A facility policy entitled Recommended Minimum Medication Storage Parameters, dated 02/28/08, revealed that Tuberculin vaccine should be refrigerated, dated when opened, and the unused portion discarded after thirty days.</p> <p>On 07/26/11 at 2:16 p.m. an observation of the North Wing medication room refrigerator revealed an opened, partially used, and ready for use 1 ml vial of Tuberculin vaccine. The vial was hand dated as opened on 06/16/11. The vial was in the manufacturer's box with instructions which read in part: "Once entered, vial should be discarded after 30 days."</p> <p>On 07/26/11 at 2:44 p.m. the North Wing Unit Manager was interviewed. She stated that Tuberculin vaccine should be dated when opened and discarded after thirty days. She discarded the Tuberculin vaccine vial.</p> <p>On 07/26/11 at 3:50 p.m. the Director of Nursing was interviewed. She stated she expected nursing staff to date Tuberculin vaccine when opened and to discard it thirty days later per manufacturer's recommendations and facility policy.</p>	F 431	<p>The DON or her designee will review data obtained for patterns and trends, and present the data to the QA&A Committee for a period of 6 months. The QA&A Committee will evaluate the effectiveness of the plan based on outcomes identified and will adjust the plan as needed.</p> <p>"Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."</p>	8/25/2011	

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F 431	<p>Continued From page 14</p> <p>3.) A facility policy entitled Recommended Minimum Medication Storage Parameters, dated 02/28/08, revealed that all insulin in vials, with the exception of insulin detemir, should be dated when opened and discarded twenty-eight days later.</p> <p>On 07/26/11 at 2:20 p.m. an observation of the North Wing medication room refrigerator revealed an opened, partially used, and ready for use 10 ml vial of insulin glulisine which had been dispensed by the pharmacy on 03/09/11. There was no date on the vial to indicate when it had been opened. The vial was in the manufacturer's box with instructions which read in part: "Use within 28 days after opening."</p> <p>On 07/26/11 at 2:44 p.m. the North Wing Unit Manager was interviewed. She stated that insulin should be dated when opened and discarded twenty-eight days later. She stated that because the insulin was undated, there was no way to know when it had expired. The Unit Manager discarded the vial of insulin.</p> <p>On 07/26/11 at 3:50 p.m. the Director of Nursing was interviewed. She stated she expected nursing staff to date all insulin vials when opened and to discard them twenty-eight days later per manufacturer's recommendations and facility policy.</p>	F 431			