

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

PRINTED: 12/19/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345438	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/08/2011
NAME OF PROVIDER OR SUPPLIER THE LAURELS OF SUMMIT RIDGE			STREET ADDRESS, CITY, STATE, ZIP CODE 100 RICEVILLE ROAD ASHEVILLE, NC 28805	
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F 000	INITIAL COMMENTS	F 000	The Laurels of Summit Ridge wishes to have this submitted plan of correction stand as its allegation of compliance. Our date of alleged compliance is 1/5/12.	
F 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on resident, family, and staff interviews, and medical record review, the facility failed to follow up on a grievance of lost glasses for one (1) of two (2) residents (Resident #115). The findings are: Resident #115 was admitted to the facility with a diagnosis of fractured hip. The admission Minimum Data Set, dated 08/23/11, revealed the resident was cognitively intact. On 12/05/11 at 2:24 PM Resident #115 and a family member were interviewed together. They reported that the resident had come to the facility with a new pair of glasses. They reported the glasses and \$10 were in the glasses case on the resident's over-bed table when they disappeared one day. The resident and family member were unsure of the date but stated they reported it to the Admissions Coordinator who said she would initiate an investigation. The family member stated they had never heard anything back from	F 166	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. F166 Resident #115's report of missing glasses has been investigated. The Admissions Coordinator has been reeducated regarding prompt reporting of resident concerns and completion of the guest satisfaction form. The Director of Social Services will interview oriented residents to determine if there are any unreported or unresolved concerns. Any concerns identified will be entered into the	1/5/12

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

Judi Boyer

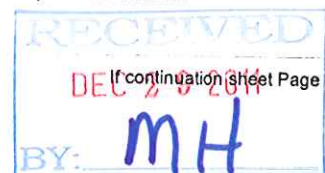
TITLE

Administrator

(X6) DATE

12/29/11

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 166	Continued From page 1 the facility. The family member also stated her husband had asked the Admissions Coordinator about the investigation last week as the resident was preparing to discharge soon, and he had been told it was still being looked into. On 12/07/11 at 4:37 PM the Admissions Coordinator was interviewed. She stated that whenever anything went missing on the resident's unit, she was informed by staff, performed an initial investigation, and filled out a facility concern form which was turned over to the Administrator to review. She stated the Administrator reviewed the concern form and then assigned her to complete the investigation and report back to the Administrator. The Admissions Coordinator reported she had had multiple discussions with the resident and her family members during her admission, but did not recall a report of missing glasses. On 12/07/11 at 4:50 PM the Manager of the resident's unit was interviewed. The Unit Manager stated she was aware of the resident's missing glasses. She stated she had discussed them with the Admissions Coordinator who was investigating their disappearance. On 12/07/11 at 5:05 PM the Administrator was interviewed. She stated that any staff member could write a concern form for missing items and give it to her. She stated she kept copies of all the concern forms and then assigned a staff to complete the investigation for the missing item within seven days and report back to her. She stated she had not had a concern form turned in about the missing glasses of Resident #115. She stated she would expect any staff member who	F 166	tracking log and appropriate action taken. The facility Guest Satisfaction/Concern policy was reviewed at the facility general staff meeting on December 23, 2011. The Administrator will randomly talk to residents during rounds to validate concerns are being reported and resolved. Resident concerns will be reviewed during the morning clinical meeting to ensure concerns have been reported, facility follow-up has been initiated and the Administrator will ensure timely resolution. Resident satisfaction to facility follow up will be queried during the monthly resident council meeting for the next (3) three months and reviewed by the Administrator monthly. Concerns will be reported to the quality assurance committee for further recommendations. Continued compliance will be monitor through review of resident concerns during the morning clinical meeting, through monthly Resident council meetings, and through the facility's		

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F 166	Continued From page 2 knew about the missing glasses to complete a concern form. She stated she intended to contact the resident and the family about the missing glasses.	F 166	quality assurance program. Additional education and monitoring will be initiated for any identified concerns.	
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on staff interviews, facility record review, and medical record review, the facility failed to ensure that the facility policy was followed regarding immediate reporting of any abuse allegation to the Administrator for one (1) of four (4) residents (Resident #115). The findings are: A facility policy entitled Abuse Prohibition, Investigation, and Reporting, dated 12/09, read in part: "All facility personnel will promptly report any incident or suspected incident of guest mistreatment, injuries of unknown source or misappropriation of property/resources. Reports of alleged abuse and/or misappropriation will be immediately reported to the Administrator and thoroughly investigated." Resident #115 was admitted to the facility with diagnoses of history of falls, anxiety, and left hip fracture. An admission Minimum Data Set dated 08/23/11 revealed the resident was cognitively	F 226 F226	1/5/12	
			Resident #115 no longer resides in the facility. The Admissions Coordinator has been reeducated regarding the reporting of an abuse allegation. All facility staff will be re-inserviced on the facility's abuse policy by the Administrator by 1/5/12. In-servicing includes immediate notification of the Administrator upon awareness of any abuse allegation. New employees are provided abuse training during the new employee orientation program and all staff is in-serviced on the facility's abuse policy at least quarterly. The Administrator will review all abuse investigations to ensure	

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F 226	<p>Continued From page 3</p> <p>intact' and that she required extensive assistance for most activities of daily living.</p> <p>A review of a progress note dated 08/26/11 written by the Admissions Coordinator stated that a family member of Resident #115 had called to report that the resident was calling the family at night sounding "very nervous and scared." According to the progress note, the family member further reported the resident stated that a young man was coming in her room and being very rough with the resident and her roommate. The progress note by the Admissions Coordinator also noted that a "concern form" had been written.</p> <p>Review of facility abuse and neglect investigations revealed no abuse investigation initiated on 08/26/11 on behalf of Resident #115.</p> <p>On 12/08/11 at 8:43 AM the Admissions Coordinator was interviewed. She stated that roughness by staff was considered abuse and needed to be reported immediately to the Administrator. She confirmed that she had written the progress note documenting an allegation made by the resident's family member of rough treatment. She stated she documented the allegation on a facility concern form and immediately gave it to the Administrator.</p> <p>On 12/08/11 at 9:11 AM the Administrator was interviewed. The Administrator looked through her records for an abuse investigation and/or a concern form dated 08/26/11 which documented this allegation and stated she could find neither. She stated that if she had received the allegation that day, she would have initiated the facility</p>	F 226	<p>allegations have been reported timely to the Administrator, investigations initiated and completed and reported to the State agency as required. Variances will be corrected as identified. Resident concerns are reviewed during the morning clinical meeting and the Administrator will ensure that any concerns which may be considered abuse are properly investigated.</p> <p>Allegations and investigations are reviewed by the quality assurance committee during the monthly meeting. Additional education and monitoring will be initiated for any identified concerns.</p>		

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F 226	Continued From page 4 abuse protocol. She stated all allegations of abuse, which included any rough treatment by staff, should be reported to her immediately and she was not sure why the allegation had not reached her on 08/26/11.	F 226	F322 A physician's order for PEG tube care for Resident #39 was obtained on 9/7/11	1/5/12	
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews the facility failed to clean/apply a dressing to a gastrostomy tube site for one (1) of four (4) sampled residents with a gastrostomy tube (Resident #39). The findings are: Resident #39 was admitted to the facility with diagnoses that included gastrostomy tube feedings due to esophageal cancer. Admission orders included: Jevity 1.5 at 50 cc an hour from 4PM-8PM. Standing orders included, "May use facility's wound care protocol". In an interview on 11/22/11 at 5:25 PM the Director of Nursing (DON) stated although there was not a wound care policy specific to	F 322	DON audited physician orders for all residents with a gastrostomy tube to ensure there was appropriate orders for G tube care. Licensed nursing staff was in-serviced to request physician orders for G tube care upon admission and/or new insertion of a G tube and to document the order on the TAR on December 28, 2011. DON/ designee will monitor compliance with G tube care weekly for 4 weeks and then monthly thereafter. Variances will be promptly corrected. The DON reports concerns to the quality assurance committee for further recommendations. Continued compliance will be monitored through review of new admissions and new orders during the		

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F 322	Continued From page 5 gastrostomy (PEG) feeding tubes it was her expectation nursing staff would clean and place a dressing on a gastrostomy site on a daily basis. The DON stated if a resident was admitted to the facility without orders for cleaning and dressing a gastrostomy site she would expect staff to contact the resident's physician for orders. The DON stated her expectation was for the cleaning and dressing of a gastrostomy site to be included on a residents treatment record. On 11/22/11 at 5:55 PM this expectation was confirmed again by the DON as well as the facility corporate nurse consultant. Review of physician's orders for Resident #39 revealed orders on admission did not include cleaning or placing a dressing on the gastrostomy tube site. Review of the August Treatment Administration Record (TAR) for Resident #39 revealed no entry for daily cleaning or dressing of the gastrostomy site from admission through the end of the month. Review of nurses notes for Resident #39 revealed on 09/01/11 at 3:00 PM, Resident #39 was "Sent out to radiology to evaluate PEG tube, unable to infuse Jevity...." On 09/01/11 at 5:00 PM, Resident #39 "Returned from hospital. PEG tube flushed and stoma cleaned." Hospital paperwork returned to the facility on 09/01/11 noted treatments performed included, "flushed G-tube and cleaned around stoma" with recommendations including to "continue with routine care". On return to the facility no changes were made to the September TAR of Resident #39 to include routine cleaning/dressings to the gastrostomy site.	F 322	morning clinical meeting, routine record reviews and through the facility's quality assurance program. Additional education and monitoring will be initiated for any identified concerns.		

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F 322	Continued From page 6 Review of nurses notes for Resident #39 revealed on 09/06/11, "During PEG tube feeding around tube yellowish thin liquid possible TF draining from around PEG stoma." The physician was notified with orders written on 09/07/11 to "cleanse PEG tube with normal saline/wound cleanser and cover with dry dressing every day and as needed." This was transferred to the TAR and done 09/07/11 and 09/08/11. On 09/08/11 Resident #39 transferred to the hospital.	F 322			
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on staff interviews and medical record review, the facility staff failed to place a bed in the lowest position while the resident was unattended for one (1) of three (3) residents (Resident #166). The findings are: Resident #166 was admitted to the facility on	F 323	F323 CNA #1 was provided additional education and administrative action relating to the facility's expectations of safety. Current residents identified to be at risk for falls have been reviewed by the Administrative Nurses to ensure safety devices and interventions are documented on the nursing assistant care cards. Variances were corrected as identified. The Licensed Nursing Staff will be in-serviced by the DON/designee relating to documenting safety interventions on the nursing assistant care cards by 1/5/12.	1/5/12	

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F 323	<p>Continued From page 7</p> <p>10/06/11 with diagnoses of dementia and debility. The Minimum Data Set (MDS) dated 10/12/11 revealed that the resident had short and long term memory problems and was severely impaired in cognitive skills for daily decision making. The MDS revealed the resident required extensive to total assistance with activities of daily living. The MDS also stated the resident required extensive assistance for transfers and was non-ambulatory. The MDS further revealed the resident had a history of falls prior to and after admission to the facility.</p> <p>A review of the Nursing Admission Assessment, dated 10/06/11, documented that the resident had a total score of 26 on a scale in which a total score of 10 or above represented a resident at risk for falls.</p> <p>Review of an incident report dated 10/07/11 revealed Resident #166 was found on the floor in front of a chair in which he was sitting. The resident had no injury. The care plan updated on 10/08/11 included an intervention to use a chair alarm whenever the resident was out of bed.</p> <p>Review of an incident report dated 10/09/11 documented Resident #166 was found on the floor next to his bed. The care plan updated on 10/9/11 included an intervention of a fall mat at bedside and the bed to be kept in the lowest position when the resident was unattended.</p> <p>Further review of the medical record for Resident #166 and the facility fall incident reports revealed the following. On 10/29/11 at 12:30 PM Nursing Assistant (NA) #1 was performing incontinence care for the resident. He raised the bed to the up</p>	F 323	<p>The Nursing Assistants will be in-serviced by the DON/designee relating to checking the nursing assistant care cards for safety interventions prior to care by 1/5/12.</p> <p>The interdisciplinary team reviews new admissions, incidents and new orders during the morning clinical meeting. The Unit Managers will ensure safety interventions are documented on the nursing assistant care cards.</p> <p>The Unit Managers and charge nurses will randomly observe the nurse aide care cards and implementation of interventions (3) three times a week for the next (4) four weeks. Variances will be corrected at the time of observation.</p> <p>Observation results will be reported to the Director of Nurses weekly for the next (4) four weeks and concerns will be reported to the quality assurance committee during the monthly meeting.</p> <p>Continued compliance will be monitored through review of new admissions, orders and incidents during the morning clinical meeting,</p>		

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F 323	<p>Continued From page 8</p> <p>position and left the resident to go into the resident's bathroom. When he returned, the resident had fallen out of bed. The resident had no significant injuries. The resident's care plan for falls was updated on 10/29/11 to include an intervention of a bed alarm.</p> <p>Review of the Nursing Care Card for Resident #166, referenced by NAs to determine the care needs of a resident, revealed no documentation that the bed of Resident #166 should be kept in the lowest position when staff were not at bedside.</p> <p>On 11/22/11 at 5:40 PM the Director of Nursing (DON) was interviewed. She stated that her expectation was that when staff raised a bed to provide care, they should not leave the resident unattended with the bed in the high position. She stated that NA #1 should not have left Resident #166 unattended while his bed was raised because of his history of falls from bed. She stated that NA #1 had been counseled about this incident, but that no other NAs had been inserviced or other corrective plan implemented. She stated NA #1 was unavailable for interview.</p> <p>On 11/22/11 at 6:36 PM, Licensed Nurse (LN) #3 was interviewed by telephone. She stated that she was Resident #166's nurse on 10/29/11 and had completed the incident report of the fall. She stated she had interviewed NA #1 after the fall as part of her investigation and he reported to her that he was performing incontinence care for Resident #166 and had raised the bed above waist high to work with the resident. She stated NA #1 left the resident unattended with the bed up to go into the resident's bathroom. She stated</p>	F 323	<p>routine review of records and care cards, daily round observations and through the facility's quality assurance program. Additional education and monitoring will be initiated for any identified concerns.</p>		

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F 323	Continued From page 9 NA #1 returned to the bedside but then left to go into the bathroom again. LN #3 stated that while NA #1 was in the bathroom Resident #7 fell from the raised bed to the matt on the floor. She stated it was her expectation that NA #1 should have lowered the bed to the lowest position before leaving the resident unattended. On 11/28/11 at 3:15 PM, NA #1 was interviewed. He stated that on 10/29/11 he was providing incontinence care for Resident #166 and had raised the bed from the lowest position to approximately three feet from the floor. He stated he left the resident on the bed in that position to momentarily go into the bathroom and returned to bedside. NA #1 stated he returned to the resident bathroom a second time. He stated the resident fell from the bed onto the fall mat while he was in the bathroom, but did not injure himself. NA #1 stated he had been trained to place the bed in its lowest position when not at bedside for any resident, regardless of fall risk. He stated he should have lowered the bed for Resident #166 before going into the bathroom. NA #1 stated that NAs use the Nursing Care Card to reference the care needs of individual residents.	F 323			
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o 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: - Registered nurses.	F 356	F356 The daily staffing posting was corrected on December 8, 2011. The Staffing Coordinator was in-serviced on how to complete the Posted Nurse Staffing information to include accurate hours worked for	1/5/12	

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F 356	<p>Continued From page 10</p> <ul style="list-style-type: none"> - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. <p>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:</p> <ul style="list-style-type: none"> o Clear and readable format. o In a prominent place readily accessible to residents and visitors. <p>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.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to post the accurate resident census and actual hours worked for licensed and unlicensed nursing staff on four (4) of four (4) days of the survey.</p> <p>The findings are:</p> <p>On 12/05/11 at 3:00 PM the facility daily staffing information was observed posted at the main entrance and 200 Hall nurses station. The posted census and number of Nurse Aide (NA), Licensed Practical Nurse (LPN), and Registered Nurse (RN) staff included information pertaining</p>	F 356	<p>licensed and non-licensed staff for the nursing home unit.</p> <p>The DON/designee will review and sign the Posted Nurse Staffing information daily prior to posting.</p> <p>Nurse staffing information will be reviewed by the facility's Quality Assurance Committee monthly for 3 months.</p>	

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to the skilled nursing unit as well as assisted living. Posted daily staffing information also failed to include actual hours worked per shift by licensed and unlicensed nursing staff. Additional observations of inaccurately posted census, staffing, and actual hours worked included:

12/06/11 at 10:30 AM
12/07/11 at 08:35 AM
12/08/11 at 09:00 AM

During an interview, 12/08/11 at 9:35 AM, the Staffing Coordinator (SC) reviewed the posted daily staffing for 12/05/11, 12/06/11, 12/07/11, and 12/08/11 and confirmed the posted daily census and number of working NA, LPN, and RN staff reflected data pertaining to the skilled nursing unit as well as assisted living. The SC also confirmed the daily posted staffing did not include actual hours worked per shift by licensed and unlicensed nursing staff. The SC stated she was responsible for posting the daily staffing which she compiled from skilled nursing and assisted living data. The SC stated she was unaware that posted daily staffing information should only pertain to skilled nursing and that actual hours worked per shift was required.

On 12/08/11 at 10:45 AM an interview was conducted with the facility Director of Nursing (DON) and Quality Assurance Nurse (QAN). The DON and QAN reviewed the posted daily staffing and confirmed the information was not specific to the skilled nursing unit and did not include actual hours worked by licensed and unlicensed nursing staff. The DON stated posted staffing information should be accurate, complete, and specific to the skilled nursing unit.

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F 428 SS=D	<p>483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON</p> <p>The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.</p> <p>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interviews and medical record review, the facility failed to ensure that a monthly medication review was completed by the pharmacist for one (1) of ten (10) residents (Resident #115).</p> <p>The findings are:</p> <p>Resident #115 was admitted to the facility on 08/18/11 with diagnoses of a history of falls, degenerative joint disease, depression, anxiety, and left hip fracture. An admission Minimum Data Set (MDS) dated 08/23/11 revealed the resident was cognitively intact and that she required extensive assistance for most activities of daily living. The MDS also revealed the resident had a history of recent falls.</p> <p>A review of the resident's care plan dated 08/25/11 revealed she was at risk for mood issues with a history of anxiety. Interventions for this problem included a psychiatric consult,</p>	F 428	<p>F428</p> <p>Resident #115 no longer resides in the facility.</p> <p>Current residents' records have been audited to ensure the pharmacy consultant has reviewed each resident's drug regimen. Any variances were reported to the pharmacist for review.</p> <p>The consulting pharmacist will use a daily census sheet to reconcile his/her reviews to ensure that all residents' pharmacy reviews have been completed monthly. The daily census sheet will be reviewed by the Administrator/designee during the exit conference with the pharmacist.</p> <p>Continued compliance will be monitored through routine record reviews, review of the census sheet during exit with the consultant and through the facility's quality assurance committee. Additional monitoring will be initiated for any identified concerns.</p>	1/5/12	

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F 428	Continued From page 13 administration of psychotropic medications, and monitoring for side effects of these medications. A further review of the care plan revealed the resident was at risk for falls and injuries related to use of psychotropic medications. Interventions included observation of adverse side effects such as drowsiness, sedation, blurred vision, dizziness, fatigue, insomnia, and nausea/vomiting. A review of the progress notes for Resident #115 revealed a note by the Admission and Discharge Coordinator on 08/24/11 which stated the resident was "fidgety and upset." A second note by this staff on 08/26/11 revealed the family had called to report that Resident #115 was calling them at night and was "very nervous and scared." Further review of the progress notes revealed the resident was seen by the Physician Assistant (PA) on 08/31/11 for "anxiety" and adjusted the dosage of her psychotropic medications. On 09/14/11 the PA saw the resident again for "anxiety and bad reaction to medication" and again adjusted the dosage of her psychotropic medications. On 09/28/11 the PA saw the resident a third time for "followup on anxiety" but made no changes to her medications. Further review of the medical record revealed a monthly review of medications was completed by the facility Pharmacist on 09/05/11 and 11/10/11. Both reviews noted changes in psychotropic medications. There was no pharmacy review for the month of October, 2011. On 12/07/11 at 2:45 PM the facility Pharmacist was interviewed. She stated that the resident had anxiety but also had a history of orthostasis (changes in blood pressure with changes in	F 428			

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F 428	Continued From page 14 position which resulted in lightheadedness). She stated the PA had made medication changes to treat the resident's anxiety while trying to avoid making the resident lightheaded. The Pharmacist noted that these changes required monitoring to ensure the resident was safe as well as not anxious. She stated that she did a review of medications for all residents once a month, and had done a review for Resident #115 on 09/05/11 and 11/10/11. However, she stated she missed the review for this resident for the month of October, 2011. The Pharmacist stated she was in the facility on 10/02/11 and 10/03/11, but she could not find the resident's medical record and assumed the resident had been discharged. On 12/07/11 at 5:17 PM the Administrator was interviewed. She stated the Pharmacist came monthly to do medication reviews. She stated the facility gave the Pharmacist an updated census of all current residents to check off. She stated that if the Pharmacist was unable to find a resident's medical record, she would expect the Pharmacist to check with her or the Director of Nursing for assistance. If she was unable to complete pharmacy reviews for all residents on the census, the Administrator stated she would expect she would be informed.	F 428	F431 The vial of opened, undated insulin was discarded on December 6, 2011. All medication rooms and carts were inspected for out dated medications on December 6, 2011. Licensed nurses were in-serviced on December 28, 2001 regarding dating opened vials of insulin. Med carts/med rooms will be checked at the end of each shift for opened, undated insulin by the charge nurses and documented.	1/5/12	
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	F 431	Random review of the med carts/med rooms for undated insulin will be completed by the DON/designee weekly for the next (4) four weeks then randomly thereafter. Any variances will be corrected at the time of observation and concerns will be		

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F 431	<p>Continued From page 15 reconciled.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to label and/or discard outdated insulin in one (1) of one (1) medication room.</p> <p>The findings are: Review of manufacturer's recommendations, revised in March of 2007, for storage of Lantus</p>	F 431	<p>reported to the quality assurance committee for further recommendations.</p> <p>Continued compliance will be monitored through weekly auditing of the medication carts and med rooms and through the facility's quality assurance program. Additional education and monitoring will be initiated for any identified concerns.</p>	
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F 431	<p>Continued From page 16</p> <p>insulin revealed "Vials must be discarded 28 days after opening."</p> <p>On 12/06/11 at 3:15 PM the 200 Hall Medication Storage Room was inspected for expired medications. One opened and partially used 10 ml vial of Lantus insulin was observed to be undated. It was dispensed by the facility pharmacy on 07/27/11.</p> <p>On 12/06/11 at 3:33 PM Licensed Nurse (LN) #1 was interviewed. She stated the vial of Lantus insulin should have been labeled with the date it was opened and discarded after 28 days. LN #1 was unable to state when the vial was opened.</p> <p>On 12/06/11 at 3:36 PM the Unit Coordinator was interviewed. She stated the nurse who worked the night shift was responsible for checking for expiration dates of medications every night.</p> <p>On 12/08/11 at 11:30 AM the Director of Nursing was interviewed. She stated she expected Lantus insulin vials to be dated by staff when opened and discarded 28 days later.</p>	F 431			