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DANVILLE CARE CENTER	**1701 NORTH BOWMAN DANVILLE, IL 61832**

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F 000	INITIAL COMMENTS Complaint #1760663/IL91520- F155 Complaint #1760691/IL91549- F332, F431, F241	F 000		
F 155 SS=J	483.10(c)(6)(8)(g)(12), 483.24(a)(3) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES 483.10 (c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. (g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the	F 155		

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

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F 155	Continued From page 1 time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. 483.24 (a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to honor Advance Directives regarding Cardiopulmonary Resuscitation (CPR) as documented on the Physician Order for Life Sustaining Treatment (POLST) by failing to ensure resident requests for Advance Directives regarding Cardiopulmonary Resuscitation (CPR) were accurately incorporated into residents' medical record and physicians' orders for one of 27 residents (R1) reviewed for Advance Directives in the sample of 39. This failure resulted in R1 not receiving CPR when found unresponsive and subsequently expiring. This past non compliance occurred from 12/29/16 to 1/30/17.	F 155	Past noncompliance: no plan of correction required.	

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This failure resulted in an Immediate Jeopardy. The facility conducted a whole-house audit 1/16/17 of each residents' advanced directives to ensure there were no other residents with inaccurately recorded code status.
The immediacy was removed on 1/30/17 when the facility conducted a staff inservice regarding code status policy and procedure and new admissions.

Findings include:

The facility's policy Advanced Directive Policy and End of Life Decision Making dated 12/20/12 documents, "Purpose: To establish guidelines to ensure that resident's rights are provided opportunity and education on determining advance directives and the right to accept or decline treatment and other related interventions. ...The resident's choices will be documented in the medical record and orders related to treatment, care, and services. ...The facility will identify, clarify, and periodically review as part of the care planning process, the existing care instructions and whether the resident wishes to change or continue these instructions. ... The facility will also on an ongoing basis review the resident's condition and existing choices and modify approaches as appropriate. This would include a review for a resident condition change, significant decline or improvement in the resident's status."

The facility's policy Do Not Resuscitate (DNR) Order dated 1/7/01 documents "... Emergency Medical Services will ONLY recognize the standard form. A photocopy in the chart will not suffice..."

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F 155	Continued From page 3 R1's Electronic Profile Sheet documents R1 was admitted to the facility 1/12/16, subsequently discharged to the hospital 12/28/16, and re-admitted to the facility 12/29/16. R1's Physician Order for Life-Sustaining Treatment (POLST) dated 1/15/16, signed by R1, Z3 (R1's former Nurse Practitioner), and witnessed, documents "Attempt Resuscitation/CPR", and "Full treatment: Primary goal of sustaining life by medically indicated means including the use of intubation, mechanical ventilation and cardioversion, ... medically administered nutrition including feeding tubes." R1's Social Service History and Assessment date 1/19/16 documents an option for DNR (do not resuscitate) which was not selected by R1. R1's Care Plan dated as initiated 1/15/16 documents a focus area "pursuant to resident rights resident has elected full code status." The goal outlined in R1's Care Plan documents, "the resident's wishes for full code status as specified in (R1's) advanced directive document will be honored and clearly delineated in the medical record in compliance with state law." The interventions for R1's Care Plan were documented as "...document the code status on the POS (physician order sheet) ...." R1's Electronic Physician Order History documents physician orders dated 1/13/16 as "Full Code", dated 2/11/16 as "Full Code", and dated 12/29/16 as "DNR". The electronic Physician Order dated 12/29/16 does not match R1's POLST form.	F 155		

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R1's Hospital Discharge Orders for R1 dated 12/29/16 documents "yes" and "no" selection boxes for the option "DNR" and this discharge order documents R1 as "DNR, NO".

R1's Electronic Progress Notes dated 1/13/17 at 9:30 am, entered by E5, Nurse Practitioner, document R1 was "sitting up in the wheelchair, was continuing to work with therapy services, had no health complaints, was eating meals, had recently completed a course of antibiotic treatment due to a urinary tract infection, (R1's) recent blood laboratory values had no significant findings, no distress, and no pain." There were no subsequent progress notes in R1's medical record until 1/16/17 at 9:39 am.

R1's Progress Note dated 1/16/17 at 9:39 am, entered by E6, Licensed Practical Nurse (LPN), documents, "upon entering (R1's) room, (R1) was cold, clammy, pale color to skin and labored breathing. VS (vital signs) 100.4 (temperature), 82 (pulse), 26 (respirations), 101/85 (blood pressure). 82 percent oxygen saturation on room air. PERRLA (pupils equal, round, reactive to light and accomodation), pulse was weak and hard to palpitate in wrist and pedal pulse. Apical pulse was attempted but wasn't able to be heard. Equal weak grips. 2 L (liters) of O2 (oxygen) was applied and oxygen (sat) (saturation) is now stable at 90 percent. Resident has a slow response to verbal communication. (R1's) lower extremities are cold to touch and mottled up to hip. (E5) NP (Nurse Practitioner) completed an assessment on resident. She ordered the family be notified, continue on oxygen and keep resident comfortable. Resident's POA (Power of Attorney) (Z2) was notified of the change in condition and was advised to call the family. Resident is a DNR

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status."

R1's progress note dated 1/16/17 at 9:56 am, entered by E6, LPN, documents "Spoke with POA via phone in regards to resident's change in condition. The resident had a major decline in health. He (POA) was advised to call the family to visit (R1). POA stated he was the only family resident has but will come sometime today."

R1's progress note dated 1/16/17 at 12:26 pm, entered by E6, LPN, documents "resident has passed away at 10:30 am, discharged to (funeral home)."

On 2/2/17 at 9:22 am, E1, Administrator, stated, "(E10, LPN) was the nurse who entered the orders from the hospital upon (R1's) readmission from the hospital. The discharge orders from the hospital documented DNR = NO. (E10, LPN) was adamant about she thought the hospital orders documented DNR. (R1) was supposed to be resuscitated, (R1) was a full code. The orders were put into the computer as DNR. (R1) was a full code from a prior admission here at our facility. When (R1) died, the nurse on duty (E6, LPN) looked at the computer which said DNR, and then looked at our book which didn't match the computer. By the time we verified (R1's) code status, it was too late, we didn't call 911, we called the coroner to investigate. Our nurse practitioner (E5) was involved with the death (of R1), she was the one who found the computer and book didn't match. We did check with the hospital to make sure (R1) didn't have any new advanced directive while (R1) was there, but there wasn't. It was our mistake. (R1) is his own person, his brother (Z2) is not the legal power of attorney."

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F 155	Continued From page 6 On 2/2/17 at 12:06 pm, E3, Social Services director, stated, "With all new admissions either the resident or the POA will decide the code status, I write it on the POLST, I usually sign as a witness, then take the POLST to (E5, NP) and she signs it. Right across the desk (from E5) is (E11, Quality Assurance Nurse) who puts the code status in the Physician Orders on the computer. (R1) was a full code. For re-admissions, the nurse puts the orders into the computer." On 2/2/17 at 1:25 pm, E4, Acting Director of Nursing (Assistant Director of Nursing), stated, "When a resident stops breathing or having a heartbeat, I expect the nurses to look in the computer to verify a resident's code status, the second place to look is the code status books for the POLST which are on each medication cart for every resident in the building, and the third option would be to look in the social services office. I worked as an emergency room nurse, so I know seconds mean lives, so I would start CPR on everybody unless I have the POLST right there in front of me that says not to. If there is any doubt as to a resident's code status, I would start CPR." On 2/2/17 at 1:44 pm, E5, Nurse Practitioner, stated, "The nurse called me to come assess (R1) and I looked at (R1's) code status in the computer. Unfortunately, the status was not correct. Typically, it is the nurse who puts the orders into the computer when a resident is readmitted from the hospital." On 2/2/17 at 2:00 pm, E8, Registered Nurse, stated, "We have code status books on our medication carts, also in the computer. My	F 155		

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preference is to look at the hard copy in the book because that is where the DNR form (POLST) is signed by the resident. We used to have marks on the resident's charts, but we don't use the charts anymore, just the computer."

On 2/2/17 at 2:03 pm, E7, Registered Nurse, stated, "I look on the monitor (computer) for code status, also there is a book in the bottom drawer of the medication cart, and the POLST has a copy scanned into the computer."

On 2/2/17 at 2:13 pm, E9, LPN, stated, "Each resident's code status is in a book in the bottom drawer of our medication carts and in the computer system."

On 2/2/17 at 2:35 pm, E2, Director of Nursing, stated, "We found in the computer (R1) was supposed to be DNR, but we found in the books and clinical documents (R1) was a full code. I expect the nurses to look on the computer, or the book on the med cart with the copy of the POLST."

On 2/2/17 at 3:17 pm, Z1, Primary Care Physician for R1, stated, "If a resident has chosen to initiate CPR and is to have full medical treatment to sustain life, then yes I would expect the staff to initiate CPR if the resident has no pulse and no respirations, they needed to make an attempt. If (R1) was in declining health, they could have sent (R1) to the hospital for acute treatment."

On 2/3/17 at 1:54 pm, E6, LPN, stated, "Around breakfast time on (1/16/17) (R1) wasn't feeling too good, and wasn't looking too good. (R1) was cold and clammy, I had difficulty checking for a

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pulse, and (R1) was mottled. I asked the NP (E5) to come and check on (R1) and do an assessment, and I put oxygen on (R1). The NP (E5) checked the code status in the computer and (R1) was listed as DNR. The NP said we would not send (R1) to the hospital since (R1) was DNR, just keep (R1) comfortable. We decided to move (R1) to another room for privacy in case his family wanted to come visit. As soon as (R1) was taken to the other room, they came and told me (R1) wasn't breathing. I went to the room and there was no pulse and no respirations. It was less than an hour between our assessments and the time (R1) passed away. When the coroner came to the facility, he asked for a copy of (R1's) DNR sheet, and that's when I noticed the sheet said he was supposed a full code. By that time, it was too late to begin any CPR."

The Certificate of Death Worksheet certified dated 1/19/17 documents (R1's) date of death as 1/16/17 and the cause of (R1's) death as Acute Myocardial Infarction and Acute Congestive Heart Failure. This cause of death was determined by Z1, R1's Primary Care Physician.

On 2/7/17 an Immediate Jeopardy was identified. E1 was notified of the Immediate Jeopardy Past Noncompliance on 2/7/17 at 12:07 pm. The immediate jeopardy past noncompiance began on 12/29/16 when the facility transcribed the wrong code status in R1's medical record.

The surveyor confirmed onsite through record review and interview that the facility took the following actions to remove the Immediate Jeopardy:
1. Self-identified the issue on 1/16/17.

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F 155	Continued From page 9 2. R1 is deceased 1/16/17 and no longer resides in the facility. 3. Conducted a whole-house audit 1/16/17 of each residents' advanced directives to ensure there were no other residents with inaccurately recorded code status. 4. Conducted a staff inservice 1/16/17 regarding code status verification for admissions and readmissions. 5. Conducted a staff inservice 1/30/17 regarding code status policy and procedure and new admissions. 6. Confirmed with responsible parties the code status of each resident whose POLST form was 6 months old or older on 1/16/17. 7. Conducted an inservice 1/16/17 with the Director of Nursing, Nurse Practitioner, and Quality Assurance Nurse regarding their new responsibilities for reviewing and auditing advanced directives. 8. Formulated an improvement plan 1/16/17 to perform ongoing audits on the 15th of each month to review each residents' code status. 9. Initiated an employee disciplinary memorandum 1/17/17 for E10, LPN.	F 155		
F 241 SS=D	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to address a resident in a respectful	F 241		

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manner. This failure has the potential to affect one resident (R5) out of three residents reviewed for privacy and dignity on the sample of 39.

Findings include:

The electronic medical record for R5 documents R5 was admitted to the facility on 1/25/10 with medical diagnoses including Cerebral Vascular Disease, Chronic Pain Syndrome, Nicotine Dependence, Alcoholic Polyneuropathy, Osteoarthritis, Peripheral Vascular Disease, Type 2 Diabetes, Coronary Artery Disease, Heart Failure, and Hemiplegia. This medical record documents R5's chosen preferred name is "Mr. P".

The facility's List of Interviewable Residents dated 1/31/17 identifies R5 as interviewable.

R1's Minimum Data Sets dated 10/2/16 and 1/2/17 document R5 scored a 15 out of a possible 15 and 12 out of a possible 15, respectively, for the Brief Interview for Mental Status (BIMS), rating R5 as cognitively intact.

On 2/8/17 at 2:35 pm, R5 stated, "(E12) (Certified Nursing Assistant), came into my room in the morning a couple of months ago and said, 'Why isn't your black a## out of bed yet?' We did not have any kind of joking atmosphere prior to that, I don't know why (E5) came up on me like that."

On 2/8/17 at 2:45 pm, E3, Social Services Director, stated, "I saw (R5) that morning (12/11/16). (R5) always has a smile in the morning, but (R5) was not smiling that morning. After (E12) propelled (R5) into the dining room and got (R5) situated at the table, I went and

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F 241	Continued From page 11 asked (R5) if everything was alright. (R5) told me, 'That (explicative) CNA (Certified Nursing Assistant) came into my room and asked me 'Why isn't my black a## out of bed yet?' ' Then I called (E1, Administrator) who told me to walk (E12) out of the door until we do an investigation. After I walked (E12) out of the door, one of the nurses (unnamed) showed me a text message from (E12) asking the nurse to report that (R5) was yelling at (E12) in the dining room. I was in the dining room the whole time (E12) and (R5) were in the dining room that morning and (R5) never raised his voice." The facility's Employee Memorandum Progressive Disciplinary Form dated 12/10/16 documents E12 was terminated from employment at the facility pursuant to "Employee (E12) was being investigated for a suspected resident abuse, contacted multiple staff members in an attempt to have them falsly (falsely) report (R5's) behaviors." On 2/9/17 at 12:35 pm, E1, Administrator, stated, "The result of the abuse investigation against (E12) was undetermined because I had a resident (R5) who is alert and oriented, is a good historian, and says (E12) treated (R5) disrespectfully, but I have an employee (E12) who denies (E12) said that to (R5) and (E12) went through the background checks, reference checks, and drug tests without any issues. As soon as (E12) attempted to interfere with a facility investigation, (E12) was subsequently terminated. I did report (E12) just in case anything like this had happened at any of (E12's) previous places of employment."	F 241		
F 332	483.45(f)(1) FREE OF MEDICATION ERROR	F 332		

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F 332 SS=E	Continued From page 12 RATES OF 5% OR MORE (f) Medication Errors. The facility must ensure that its- (1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to administer medications according to Physician Orders, Manufacturer's Specifications, and Facility Policy for six residents (R3, R18-R20, R26, R27) in the sample of 39. There were 25 opportunities observed with seven errors, for a medication error rate of 28%. Findings include: 1. R19's Order Review Report dated February 2017 documents orders for Sucralfate (Antiulcer) 1 gram by mouth four times daily, Tramadol (pain medication) 50mg by mouth every four hours and Alprazolam (Xanax) (Antianxiety) 0.25mg by mouth two times a day. On 2/7/17 at 11:10am, E7, RN administered Tramadol 50mg tablet and Sucralfate one gram tablet to R19 at the same time. On 2/7/17 at 4:10pm, E13, RN administered Tramadol 50mg tablet, Xanax 0.25mg tablet and Sucralfate 1 gram tablet to R19 at the same time. R19's medication card containing the Sucralfate tablets documents, "Take this Product At Least 2 Hours Before or 2 Hours After Your Other Medications."	F 332		

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F 332	Continued From page 13 Sucralfate package insert dated March 2013 documents, "... Because of the potential of CARAFATE (Sucralfate) to alter the absorption of some drugs, CARAFATE should be administered separately from other drugs..." 2. R20's Order Review Report dated February 2017 documents orders for Novolog (Insulin) Flexpen 100 units/ML-3ML (milliliter) inject per sliding scale, "if (blood sugar)... 201-250= (administer) 4 units..." and Novolog solution, inject 6 units subcutaneously before meals meals. On 2/7/17 at 11:38am, E7 prepared R20's insulin from R20's Novolog vial dated 12/21/17. This bottle had a sticker that read to discard unused medication after 28 days. E7 used an insulin syringe to inject air in to the vial and withdrew the Novolog insulin in to the vial. E7 stated she drew up 10 units total to administer to R20. E7 looked at the syringe and stated, "Oh, there is a bubble in there (in the syringe)." There was a bubble that occupied 2 unit marks on the syringe. E7 administered the insulin without attempting to remove the bubble to ensure accurate dosing of R20's insulin. The manufacturer's instructions for use for Novolog dated March 2013 documents, "... If there are air bubbles, tap the syringe gently a few times to let any air bubbles rise to the top... Slowly push the plunger up until the black tip reaches the line for your Novolog dose... Check the syringe to make sure you have the right dose of Novolog... Opened Novolog vials should be thrown away after 28 days, even if they still have insulin left in them..."	F 332		

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F 332	Continued From page 14 3. R3's Order Review Report dated February 2017 documents an order for Novolog (Insulin) Flexpen 100 units/ML-3ML (milliliter) Inject five units subcutaneously with meals. On 2/7/17 at 11:38am, E9, Licensed Practical Nurse (LPN) took R3's Novolog Flexpen that did not have a date when it was opened or delivered and prepared to administer the Novolog to R3. E9 placed the needle on the end of the Flexpen and took the Flexpen to R3's room. When in R3's room, E9 turned the dial on the Flexpen to 5units and administered the Novolog to R3. E9 did not prime the needle with 2 units prior to administering the insulin to R3. The manufacturer's Instructions for Use of the Novolog FlexPen dated 4/2016 documents, "... Giving the airshot before each injection Before each injection small amounts of air may collect in the cartridge during normal use. To avoid injecting air and to ensure proper dosing... Turn the dose selector to select 2 units... Hold... FlexPen with the needle pointing up. Tap the cartridge gently with your finger a few times to make any air bubbles collect at the top of the cartridge... Keep the needle pointing upwards, press the push button all the way in... The dose selector returns to 0. A drop of insulin should appear at the needle tip. If not, change the needle and repeat... The Novolog FlexPen... should be thrown away after 28 days, even if it still has insulin left in it..." 4. R26's Order Review Report dated February 2017 documents an order for Ipratropium-Albuterol Solution 0.5-2.5 (3) MG/3ML (Nebulizer medication) inhale 1 vial orally every six hours.	F 332		

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F 332	Continued From page 15 5. R18's Order Review Report dated February 2017 documents an order for Artificial Tears instill one drop in both eyes four times a day. On 2/7/17 at 11:05am, E7, Registered Nurse (RN) administered R18's medications. E7 took R18's Refresh Tears (Artificial Tears) medication bottle dated opened on 10/25/16 and administered one drop in each of R18's eyes. The manufacturer's directions for Refresh Tears dated 5/2016 document, "...discard 90 days after opening." R26's Medication Administration Records dated February 2017 document administration times of midnight, 6:00am, 12:00pm and 6:00pm. On 2/7/17 at 1:51pm, E9, LPN administered R26's 12:00pm dose of Ipratropium-Albuterol Solution. This is one hour and 51 minutes after the scheduled administration time. 6. R27's Order Review Report dated February 2017 documents an order for Valproic Acid (Antipsychotic) Capsule 250mg give 2 capsules by mouth two times a day. On 2/7/17 at 4:23pm, E8, RN administered Valproic Acid 250mg, 1 capsule by mouth to R27. E8 did not administer 2 capsules as ordered. The facility's Administration of Medications policy dated 8/14/16 documents, "... Residents shall receive their medications on a timely basis in accordance with state and federal guidelines, and within established facility policies... It is the	F 332		

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F 332	Continued From page 16 responsibility of the Charge Nurse to ensure that all medications are passed within a timely manner..." The facility's Insulin Injections policy dated 11/15/14 document, "... To provide guidelines to Licensed nursing staff for performing insulin injections effectively and safely... It is the responsibility of the D.O.N (Director of Nursing)/Designee to provide education and training to ensure knowledge of procedure... Procedure... Date and time bottle when opening. Insulin can be used for up to 30 days after opening... Check for air bubbles in the syringe and proper dosage... Tap the barrel of syringe to expel air bubbles... If using a FlexPen small amounts of air may collect in the cartridge during normal use. To avoid injecting air and ensure proper dosing... Turn the dose selector to 2 units... Hold your FlexPen with the needle pointing up and tap the cartridge gently a few times, which moves the air bubbles to the top... Press the push-button all the way in until the dose selector is back to 0. A drop of insulin should appear at the tip of the needle... If no drop appears repeat..."	F 332		
F 431 SS=E	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide	F 431		

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F 431	Continued From page 17 pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (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. (h) Storage of Drugs and Biologicals. (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. (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	F 431		

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F 431	Continued From page 18 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 observation, record review, and interview, the facility failed to maintain pharmacy labels on stored medications, failed to date medications when opened, and failed to dispose of medications after the discard date. These failures have the potential to affect 10 residents (R4, R11, R20, R27, R30, R32, R34, R35, R37, and R38) in the sample of 39. Findings include: On 2/8/17 at 11:00 am, the East Hall Medication Cart contained medications without pharmacy labels, undated and/or expired medications including the following: 1. Liqui-Tears, one 15 milliliter (ml) plastic bottle of opthalmic solution. No pharmacy label. 2. Symbicort 160/4.5 micrograms (mcg), four hand-held aerosol inhalers with names hand-written on the inhaler case, 2 for R27, one for R34, and one for R35. All four inhalers had no pharmacy label. 3. Ipratropium Bromide/ Albuterol inhalation solution 0.5 milligrams (mg) per 3 ml, three 3 ml plastic vials. Not labelled in any manner. 4. Promethazine 25 mg per ml, one 1 ml glass vial of injectable solution, expired 7/20/16. 5. Proventil 108 mcg, one hand-held aerosol inhaler with R27's name hand-written on the inhaler case. No pharmacy label. 6. Ventolin 90 mcg, one hand-held aerosol inhaler. No pharmacy label. 7. Spironolactone 25 mg, two tablets. No	F 431		

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F 431	Continued From page 19 pharmacy label. 8. Cipro 250 mg tablet, one tablet. No pharmacy label. 9. Eliquis 5 mg tablet, one tablet. No pharmacy label. 10. Metronidazole 250 mg tablet, one tablet. No pharmacy label. 11. Fluphenazine 5 mg tablet, one tablet. No pharmacy label. 12. Haldol 5 mg per ml injectable solution, two opened glass 1 ml vials. No pharmacy labels. 13. Levimir Insulin 100 units (U) per ml, one 3 ml pen-type injectable device. Discard date 1/24/17. 14. Novolog Insulin 100 U per ml, one 10 ml glass vial injectable solution for R11. Not dated when opened, unable to determine discard date. 15. Levimir Insulin 100 U per ml, one 3 ml pen-type injectable device for R34. Discard date 1/22/17. 16. Humulin R Insulin 100 U per ml, one opened 10 ml glass vial injectable solution. No pharmacy label, not dated when opened, unable to determine discard date. 17. Humalog Insulin 100 U per ml, one 10 ml glass vial injectable solution for R34. Discard date 2/2/17. 18. Asmanex 200 mcg, one hand-held aerosol inhaler. No pharmacy label, not dated when opened, unable to determine discard date. On 2/8/17 at 11:35 am, the West Hall medication cart contained medications without pharmacy labels, undated medications and/or expired including the following: 1. Advair Diskus 500/50 mcg, one hand-held aerosol inhaler for R30. Not dated when opened, unable to determine discard date. 2. Combivent 20/100 mcg, one hand-held aerosol	F 431		

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F 431	Continued From page 20 inhaler for R30. Not dated when opened, unable to determine discard date. 3. Latanoprost 50 mcg per ml, two 5 ml plastic bottles of opthalmic solution for R32. Not dated when opened, unable to determine discard dates. 4. Symbicort 160/4.5 micrograms (mcg), one hand-held aerosol inhaler for R32. Not dated when opened, unable to determine discard date. 5. Latanoprost 50 mcg per ml, one 5 ml plastic bottle of opthalmic solution for R20. Not dated when opened, unable to determine discard date. 6. Brimonidine 0.2 percent opthalmic solution, one 5 ml plastic bottle. No pharmacy label. On 22/8/17 at 11:49 am, the Rehab Hall medication cart contained medications without pharmacy labels, undated medications and/or expired including the following: 1. Novolog Insulin 100 U per ml, one 10 ml glass vial of injectable solution for R37. Dated opened 12/12/16, discard date 1/9/17. 2. Symbicort 160/4.5 mcg, one hand-held aerosol inhaler for R4. No pharmacy label. 3. Novolog Insulin 100 U per ml, one 10 ml glass vial of injectable solution. Illegible pharmacy label. 4. Symbicort 160/4.5 mcg, one hand-held aerosol inhaler. No pharmacy label. 5. Proventil 108 mcg, one hand-held aerosol inhaler for R38. Not dated when opened, unable to determine discard date. 6. Latanoprost 0.005 percent opthalmic solution, two 5 ml plastic bottles. No pharmacy labels. On 2/8/17 at 11:00 am, E7, Registered Nurse, stated, "We all really should be responsible for the medication carts maintenance and cleaning." On 2/9/17 at 3:00 pm, E1, Administrator, stated, "Our pharmacist should be catching that kind of	F 431		

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F 431	Continued From page 21	F 431		

thing. We just recently switched our pharmacy and they brought in all new medication carts. Our Director of Nursing was the one who physically moved all the medications from the old carts to the new carts and should have caught all of that too."

The facility's policy Labeling of Medications dated 6/15/98 (revised 9/6/15) documents "...The facility will ensure that medications are properly labeled in accordance with current state and federal requirements... It is the responsibility of the Charge Nurse to ensure that all medications are properly labeled. MD or Pharmacist responsible for changing medication labels... Drug labels must be legible at all times... Any drug label that is soiled, incomplete, illegible, worn or makeshift must be returned and replaced by the issuing pharmacy... Labels for individual drug containers must include" A. Resident's name, B. MD's name, C. Name, address, and telephone number of the issuing pharmacy, D. Name. strength, and quantity of medication, E. Prescription number, F. Date drug dispensed, G. Appropriate accessory and cautionary statements, H. Expiration date, I. Directions for use..."

The manufacturer's directions for Novolog Insulin dated 4/2015 document, "Novolog lasts up to 28 days without refrigeration after first use."

The Humulin Insulin manufacturer's directions dated 10/2016 document, "Once opened, throw away the pen device you are using after 28 days, even if there is still insulin left... a vial must be thrown away within 40 days of opening even if insulin remains."

The manufacturer's directions for Asmanex

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F 431	Continued From page 22 Inhaler dated 9/2014 document, "Remove the Asmanex Twistinhaler from the foil pouch and write the date on the cap label... throw away the inhaler 45 days after this date..." The manufacturer's directions for Advair dated 2017 document, "...Safely throw away Advair in the trash 1 month after opening the foil pouch..." The manufacturer's directions for Combivent Inhaler dated 11/3/14 document, "Throw away your Combivent Inhaler 3 months after the insertion of the cartridge into the inhaler, even if all the medicine has not been used." The manufacturer directions for Latanoprost opthalmic solution dated 2/2016 document, "After opening, you can store them at room temperature for up to 6 weeks. After this time, you should not use the eye drops and should discard them." The manufacturer's directions for Symbicort Inhaler dated 1/2017 document, "Throw away Symbicort 3 months after you take Symbicort out of it's foil pouch..."	F 431		