STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001689	A. BUILDING: _____ B. WING _____	09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYMPHONY OF BRONZEVILLE	3400 SOUTH INDIANA CHICAGO, IL 60616

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Annual Licensure Survey	S 000		
S9999	Final Observations Statement of Licensure Violations 1 of 3 300.610 a) 300.1210 b) 300.1210 d)3) 300.3240 a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general nursing	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee, or agent of a facility shall not abuse or neglect a resident. These requirements were not met as evidenced by: Based on observation, interview, and record review the facility staff failed to follow their policies, failed to assess, take vitals and provide continuous monitoring of a resident who was hemorrhaging puddles of blood after returning from the hospital less than 48 hours prior, failed to notify the physician and other floor nurse of R7's condition, failed to call for an ambulance or make any hospital arrangements prior to the assigned nurse going on her lunch break, and failed to accurately document the event in progress notes for one resident (R7) of one resident reviewed for a medical crisis in the sample of 9 residents. These failures of neglect resulted in R7 hemorrhaging puddles of blood and baseball-sized blood clots with her blood pressure dropping to 69/37 becoming hypotensive along with her eyes rolling back into her head. The findings include:	S9999		

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S9999	Continued From page 2 On 9/8/21 at 10:25 AM, V14 (Certified Nurse Assistant /CNA) was providing personal care to R7 who was in the bed. R7 has a colostomy, an indwelling catheter and is a very obese woman. R7 is oriented, non-ambulatory female who was admitted to the facility on 9/22/20 with diagnoses that include paraplegic due to motor vehicle accident, dialysis dependent, diabetes mellitus, congestive heart failure, colostomy, stage 3 sacral wound, anemia, malignant neoplasm of uterus and sleep apnea per the quarterly minimum data set (MDS) dated 7/11/21. R7 brief interview mental score is 15 (oriented in all spheres.) On 9/8/21 at 12:35 PM, R7 is in a room with common-law husband R14 who shares the room with R7. R7 had just received her noon meal. As we spoke, R7 stated she has had colostomy for over 20 years, 4 months for the indwelling catheter due to urinary retention and sacral pressure sore. R7 stated she goes to dialysis in-house on Tuesday, Thursday, and Saturday. As we ended the conversation, R7 was asked if there was anything else, she wanted to discuss. R7 and R14 stated that they are concern with the bleeding. There were a couple of dried blood stains on R7's hospital gown. Then R14 pulls the sheet covering R7's bottom half from the waist to feet and there are puddles of blood in the bed surrounding R7's pelvis area. R7's hospital gown and adult brief is saturated with blood. Blood is seen gushing out of her vaginal area and blood is seen in the catheter tubing. R7 stated that no one has assessed her or taken any vitals. R7 stated that V9 (Nurse Practitioner) did come to the room around 11:30 AM and looked at her adult brief and asked R7 what had happened when she was sent out the last time. R7 stated she was given a	S9999		

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S9999	Continued From page 3 pint of blood and returned to the facility. This was 2 days ago. R7 stated R9 said he was going to send R7 back to the hospital for a workup. Both R7 and R14 asked how long it would be before R7 is sent out to hospital. R14 stated to be very concerned because he says he has been asking about R7 and no one is taking him seriously or telling him or R7 anything. R7 stated that the bleeding has never been this bad before and they are worried. Both were complaining that no one has taken any vitals or assessed R7 the whole morning. On 9/8/21 at 1 PM, V7 (Licensed Practical Nurse/LPN) is sitting at the 4th floor nurses' station looking at her cell phone. V13 (Nurse Practitioner/NP) is also seated at the other end of nurses' station and is there to assess her assigned residents. R7 is not her assigned resident. V7 is asked if she is the nurse assigned to R7. V7 stated V10 (LPN) is the assigned nurse, and she went to lunch. V7 was asked if she knew anything about R7's status. V7 stated "no". V7 is told that R7 is bleeding profusely and what is the plan. V7 makes a call on her cell phone and asking questions about R7. Later it was determined it was V10 that V7 was talking to on phone. Then V7 immediately calls 911 without ever looking or assessing R7. V7 gets up and we go to R7's room. It is 1:17 PM, V13 had taken the initiative to go see R7 and is applying pressure at the vaginal area where blood is gushing. V13 is asking V7 questions about R7 and V7 kept saying she does not know. V13 tells V7 to take R7's vitals. V7 leaves the room and is gone for 5 minutes looking for blood pressure machine. V13 is using towels and gauze to soak up all the blood but there is too much blood. V7 returns with blood pressure (BP) machine and takes R7's BP and it is 69/37. R7 is very weak and her eyes are seen	S9999		

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S9999	Continued From page 4 to roll back in her head. At 1:11 PM, the paramedics arrive and assist V13 with R7. V13 removes 2 large baseball sized blood clots from R7's perineal area. V7 brought in the bag of saline but never tries to insert an IV. The paramedics are told of R7's blood pressure and it is the paramedics who start the intravenous saline solution into R7. V7 was outside the room more than inside the room. V13 asked for vitals to be taken again when paramedics arrived, but no nurse in room to do vitals. V19 (Assistant Director of Nursing - ADON) comes into R7's room and hands the paramedics R7's paperwork. V19 had popped her head into the room 2 times. The first time looking at V13 taking care of the situation and second time to give paramedics paperwork. R7 is taken away by the paramedics. On 9/8/21 at 1:27 PM, V10 is seated at the 4th floor nurses' station. V10 was asked if she gave report to V7 before leaving the floor and she said "no". V10 stated she did see dried blood on R7's hospital gown but did not check her private area because R7 has had this issue before so she did not assess R7 or take any vitals. V10 stated R7 has a history of bleeding and has been sent out 5 other times in the past year for the same issue. V10 stated there is no explanation for the bleeding. V10 could not have called for an ambulance because she left the floor for her lunch break before V9 (Nurse Practitioner) came to look at R7 and to give the order to transfer to hospital for medical evaluation. On 9/8/21 at 2:20 PM, as V7 (LPN) is recalling the incident that was an hour and a half ago. V7 is reminded that surveyor was present during the whole scenario. V7 stated she went to the room and saw the blood saturated linens. V7 stated she did no assessment but says she called V9	S9999		

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S9999	Continued From page 5 NP and was told an ambulance has been called. (During interview with V9 NP, V9 stated he never spoke to V7 on the phone.) It was determined later that V7 was calling V10 and asking about R7. On 9/8/21 at 2:40 PM, V9 (Nurse Practitioner) stated he was informed of the bleeding and went up to see R7. V9 stated R7 had only been back 2 days from the hospital. V9 stated he saw the saturated hospital gown and linens. V9 stated he asked R7 what happened the last time she was sent out to hospital. V9 stated R7 informed him that the hospital gave her a pint of blood and returned her to the facility without determining the reason for the bleeding. V9 stated he did fail to take any vitals or speak to any 4th floor nurse. V9 stated he went to 1st floor and gave the 1st floor nurse the order to send R7 to the hospital for a medical evaluation. V9 stated he wanted R7 to go to a different hospital for a complete workup because the last trauma hospital did no workup. V9 stated that R7 has had this issue before maybe 5 times in the past year (2021). V9 thanked the surveyor for doing what he failed to do with R7. V9 stated he left the building at 12:20 PM. On 9/9/21 at 10:30 AM, V14 (assigned CNA to R7) stated that R7 has had the issue of bleeding before but never this bad. V14 stated that the blood could be contained before but this time it was gushing. V14 stated she changed and cleaned R7 up two times within a half hour yesterday morning and each time informing V10 that R7 is bleeding large quantities of blood. V14 stated as she was leaving the floor for her break around 11:45 AM, V10 tells her if she sees V9 tell him V10 is looking for him. V14 stated when she returned from her break at 12 PM and was	S9999		

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S9999	Continued From page 6 getting on elevator from the first floor when V9 was leaving the elevator onto 1st floor. On 9/9/21 at 11:30 AM, V19 (ADON) stated it was her that V9 gave the order to call for an ambulance because V9 could not find any 4th floor nurse to give order to. V19 stated she wrote the entry 9/8/21 at 12:53 about receiving orders from V9 and sending R7 out 911 for medical evaluation. V19 insists that when she wrote the nurses' entry it was the correct time. Informed V19 that surveyor was in front of V7 when she called 911 at 1:05 PM. V19 stated that when entries are put into the electronic system that the time can be altered if is recorded within a 24-hour period. V19's interview and progress note are inaccurate because when V9 gave order to have R7 sent out to a particular hospital it was not to be 911. V19 stated that R7 was sent out the last time due to low hemoglobin. Before leaving the interview, V19 asked surveyors what she could have done differently. Informed we can't tell her what she should do but suggested she read the facility's policy and talk to her staff. V19 stated V7 is the kind of nurse that has to be monitored and followed to ensure she does what she is supposed to do. Review of R7's nurses' progress notes show inaccurate times and false documentation. The progress note (9/8/21 at 12:15) by V10 documents she was informed by staff of R7's moderate bleeding noted on chux (disposable under pads). Foley bag is empty with no blood in bag. V10 informs R7 that V9 is in the building and will be notified of R7's current condition. (Per interview with V14, the blood was gushing and saturating everything not moderate amount and V10 was informed.) During interview with V10, V10 stated she did not assess R7 so she would	S9999		

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not know how bad the bleeding was or if there was blood in the catheter bag or tubing.

The progress notes by V7 dated 9/8/21 12:50 documents she was informed of R7's bleeding by family member. Writer assess resident and noted bleeding from perineal area but unable to determine exact location of bleeding. Resident is alert, denies pain or discomfort, no breathing issue or changes in mental status. Primary NP made aware. NP reiterates previous orders given to the charge nurse to send out resident to emergency room. Writer calls 911, further assessment in progress while 911 alerted for patient transfer vitals taken resident noted hypotensive however remains asymptomatic. Attempted to insert IV but 911 arrives and takes over. This progress note does not reflect accurately the actions taken during the incident observed by the surveyor. Surveyor present and witnessed everything that happened. See the above documentation.

Review of progress notes 9/5/21 documents R7 being sent out to hospital for abnormal laboratory values. Nursing progress note 9/6/21 at 00:49 documents R7 in hospital and receives a pint of blood and would be returning soon. Nursing progress note 9/6/21 02:17 documents R7 return from the hospital with diagnoses of Macrocytic Anemia. There is no documentation seen on R7's monitoring after returning from hospital on 9/6/21.

V21's (Attending Physician) Progress note dated 9/6/21 01:36 documents resident has laboratory value of 5.5 for hemoglobin which is very low.

The facility's policy labeled Physician Order documents under Execution of Order and Notification: the nurse that takes the physician

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S9999	Continued From page 8 order will be responsible for executing the order or provide for safe hand-off to next nurse. Notify internal staff of changes and updates, notify resident/resident representative of changes or new orders, notify attending and document notification in the electronic medical record. This was not followed. Facility's policy labeled Physician Notification documents in non-emergent but acute medical situation (including critical laboratory values and other diagnostic test results) the physician will be paged and if there is no return call in 15 minutes, the physician will be notified again. If there is no return call in 5 minutes, the medical director will be notified. Any questions about how to notify the physician should be directed the Director of Nursing -DON, ADON or nursing supervisor. None of this was done. The facility's policy labeled Emergency Management documents the objective of the emergency management of a resident is to administer necessary care until paramedics arrive. Someone should call the physician and 911. Someone should stay with resident at all times, monitor and treat bleeding, take vital signs and provide reassurance to the resident. Vital signs should be taken every 10 to 15 minutes based on resident need until the resident is stable or transferred. Once resident has left the facility, call family and document the events. Under Hemorrhage section, find out where resident is bleeding from, apply manual pressure over the wound to stop bleeding, take and record vital signs, notify physician and family, document events leading to hemorrhage and care provided. This was not followed.	S9999		

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S9999	Continued From page 9 "A" Statement of Licensure Violations 2 of 3 300.2100 300.2210 Section 300.2100 Food Handling Sanitation Every facility shall comply with the Department's rules entitled "Food Service Sanitation" (77 Ill. Adm. Code 750). Section 300.2210 Maintenance b) Each facility shall: 7) Maintain the grounds free from refuse, litter, insect and rodent breeding areas. This requirement is not met as evidenced by: Based observation, interview and record review the facility failed to ensure the dish machine was sanitizing; failed to ensure wiping buckets have correct amount of sanitizer; failed to ensure the walls, ceilings and floors in the walk-in fridge and dry food storage room were free of black, mold-like substances; failed to maintain the steam tables and food carts in a clean and sanitary condition; failed to store pureed turkey loaf and pureed mixed vegetable at the correct temperature on the steam table; and failed to ensure the kitchen is pest free of flies. These failures have the potential to affect all 215 residents in the facility. The findings include: On 9/9/21 at 9:28 AM in the main kitchen with V16 (Food Service Supervisor), V18 (cook) is preparing the noon meal. V18 stated she already had prepared the puree turkey loaf and mixed	S9999		

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vegetables and placed them on the steam tables at 9 AM, a normal practice. Asked where she recorded the temperature, V18 shows the recorded temperature of 179 degrees Fahrenheit (F.). V18 stated the temperature of 179 is when the turkey loaf was removed from the oven. Asked V18 where the recorded temperature was for the pureed product prior to placing on steam table. V18 stated it was still hot and did not record the temperature. Requested temperatures be taken for the pureed products on the 3 steam tables in the kitchen. The facility's digital thermometer was used. Upon taking the temperatures, the 4th floor steam table wells had yellow, brownish water and floating debris and a corrosive substance inside the well. The splash window was splattered with dried spills. The 4th floor steam table pureed meat was 112 degrees F. and pureed vegetable was 110 degrees F. The 2nd floor steam table pureed meat was at 125 degrees F. and pureed vegetable is at 124.5 degrees F. V16 removed the pureed products and placed in pan on the stove range. Numerous flies are noted in the kitchen landing on clean surfaces and staff's heads. V16 stated the flies are from the receiving door being left open.

Inside the walk-in refrigerator, there was heavy accumulation of black substances on the fan grid. There is mildew-like substance in crevices of the shelves. There is black, mildew-like substance and white corrosive substance on walls and ceiling of the walk-in.

In the dish machine room, V20 (dishwasher) was running the dish machine and sent many dishes through the dishwasher. V16 stated it is a hot water sanitizing dish machine. V20 had a plate with thermolabel sticker to determine if the dish machine is sanitizing ready to put in the dish

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machine. The thermolabel strip will change color if the dish machine is achieving the correct temperature to sanitize the dishes. The thermolabel came out of machine unchanged. Asked V20 for the original thermolabel she used this morning to see if machine is working. V20 stated that the strip she used is the original one. V20 stated she put this strip in 5 times, but the strip did not change. V16 hears this and is upset with V20. Asked V20, why did she wash the dishes if the dish machine was not sanitizing. V20 had no response. The ceiling suspension grids were coated with rust and dirt. The walls in dish room were streaked with dried black streaks. The wall-mounted fan had a heavy accumulation of black dust and pieces of dirty tape on the fan grids which was blowing on the clean dishes. The small ware utensils were used for the noon meal. There was a clean food cart noted with black removable substance on the bottom shelf of cart.

In the Dry Food Storage Room, the walls were coated with black, mold-like substances. Four of five metal food racks were encrusted with food debris, splatters, and black mold-like substances. There were live spiders and cobwebs in the windowsills of dry food storage room.

Back in kitchen at 12:07 PM, V18 (cook) stated the pureed foods were brought up to 197 degrees before placing on steam tables at 11:15 AM. V18 stated she failed to document the temperature but recalls the temperature. V17 (Diet Aide) is asked to test the wiping bucket for sanitizer. V16 states he ordered the wrong quaternary ammonia test kit. Surveyor hands V17 a quaternary ammonia test strip to test the wiping bucket solution. V17 puts the strip in for 3 seconds and pulls it out. The test strip is in excess of 400 ppm (parts per million) of quaternary ammonia. The

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test strip should have remained in the solution for 10 seconds prior to removal but V17 stated it should be 5 seconds. V16 states that the level of quaternary ammonia should be 200 ppm.

Steam tables are sent to the floors where the temperature will be taken prior to serving per V16. The kitchen is using the small ware utensils. The surveyor asked V16 what was wrong with the dish machine, he seemed confused. Reminded him that the dishwasher was not achieving sanitation temperatures earlier. V16 had no response about the dish machine.

At 12:49 PM, on the 2nd floor there is no steam table. V16 remembers that the 2nd floor cart goes to the first floor first to serve 10 residents on that floor before coming to the 2nd floor. V16 was asked about seeing 4 steam tables in the kitchen. V16 stated that only 3 steam tables work. The 2nd floor steam table arrives with V17 (diet aide). V17 was asked about the recording of the food temperatures on the 1st floor and V17 stated he did not take temperatures. The bottom shelf of the steam table was extensively rusted from the water that drains from the wells.

The facility's census report dated 9/7/21 documents 215 residents residing in the facility.

On 9/9/21 at 3 PM, V16 bring the blank cleaning schedule. Asked for the cleaning schedule in use in kitchen that staff sign off when completion of work is done. V16 shook his head no. Meaning the cleaning is not done on schedule.

Review of the pest control reports for 9/8/21, 8/23/21, 8/18/21 and 6/7/21 show no treatment for flies.

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	IL6001689	A. BUILDING: _____ B. WING _____	09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYMPHONY OF BRONZEVILLE	3400 SOUTH INDIANA CHICAGO, IL 60616

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S9999	Continued From page 13 The kitchen policies are not on the facility's letter head but are taken from the consultant's dietary manual. The policy labeled MACHINE WASHING AND SANITIZING documents dishwashing machines may be used if the wash water is no less than that specified by the manufacturer which can vary between 150 degrees F. to 165 degrees F. depending on machine and if the final temperature is no less than 180 degrees. The final rinse temperature is tested with paper thermometer (thermolabel). Place the paper thermometer on the plate prior to loading the dish machine. Run the machine. Check the test strip. The paper thermometer turns color when it registers 160 degrees F. indicating sanitizing is taking place. The paper thermometer can be saved on the dishwashing machine log. In the even the paper thermometer does not show the correct temperature, the diet aide notifies the person in charge who will then notify the maintenance department. Maintenance will determine the source of malfunction. If maintenance can't determine the problem, maintenance will contact the customer supply service company. No reusable small wares including plates, flatware, glasses, cups, and trays will be used for meal service if dish machine does not meet temperature requirement as indicated on the paper thermometer. Policy labeled SANITATION BUCKETS/WIPING CLOTHS, FOOD CONTACT SURFACES AND EQUIPMENT TOO LARGE TO IMMERSE IN THE SINK documents the types of chemicals that can be used, the concentration needed, and length of time to sanitize and temperature of the water for sanitation purposes. The facility is using a quaternary ammonia as their sanitizer in buckets and 3 compartment sink. The policy directs one to follow the manufacturer's directions	S9999		

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S9999	Continued From page 14 for the quaternary ammonia because the quaternary ammonia can be between 150 to 400 or 200 to 400 for sanitizing properties. The facility failed to have the correct quaternary ammonia test strip kit. The policy addresses the length of time that a test strip is to be immersed into the solution per the test kit directions and compared to the color on the test kit. If color on test strip is not within the correct temperature range, adjustments are made until the sanitizing solution is correct. The cleaning policies presented by V16 are out of the consultant's dietary manual and not on facility's letterhead. The policies document the walk-in refrigeration's shelves are to be pulled out and cleaned weekly. The policy does not document how often some of the kitchen areas are to be cleaned. No policy presented on holding food items on steam table for hours at a time. "C" Statement of Licensure Violations 3 of 3 300.610 a) 300.1640 a) 300.1640 h) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part.	S9999		

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S9999	Continued From page 15 The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1640 Labeling and Storage of Medications a) All medications for all residents shall be properly labeled and stored at, or near, the nurses' station, in a locked cabinet, a locked medication room, or one or more locked mobile medication carts of satisfactory design for such storage. h) Medication in containers having soiled, damaged, incomplete, illegible, or makeshift labels shall be returned to the issuing pharmacist, pharmacy, or dispensing licensed prescriber for relabeling or disposal. Medications whose directions for use have changed since the medication was originally dispensed and labeled may be retained for use at the facility, in accordance with the licensed prescriber's current medication order. Medications in containers having no labels shall be destroyed in accordance with federal and State laws. These requirements were not met as evidenced by: Based on observations, interviews, and record review the facility failed to follow their policy on labeling opened insulin and storing expired insulin inside medication carts for 2 out of 5 medication carts reviewed for a total of 9 medication carts. These failures have the potential to affect 4 residents (R10, R11, R12 and R13) currently receiving insulin reviewed for their medication in a total sample of 13. Findings include:	S9999		

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S9999	Continued From page 16 On 09/07/2021 at 10:45 AM during a medication storage room inspection surveyor found R10's insulin Novolog FlexPen that was opened and not labeled with a date it was open and not labeled with an expiration date. On 09/07/2021 at 11:19 AM during second floor Medication Cart # 3 inspection, the surveyor found 2 Insulin Lispro 100 units flex pens and 2 Semglee 100-unit flex pens opened with no open date and no expiration date labeled for R11. On 09/07/2021 at 11:42 AM during a 3rd floor cart number 1 inspection, the surveyor found a total of 3 insulin pens. A Humalog (Lispro) 100 units pen which was expired and labeled with an opened date of 08/03/2021. The second Humalog flex pen was labeled opened on 04/22/2021 and labeled expired 05/22/2021, A third Humalog insulin pen labeled with an open date of 07/27/2021 and expiration date of 08/21/2021 for R12. During the 3rd floor cart number 1 inspection, the surveyor found 2 insulin Lispro (Humalog) bottles opened but not labeled with a date it was opened and not labeled with an expiration date for R13. On 09/07/2021 at 11:19 AM V2 (Registered Nurse) stated, "As soon as we open insulin either insulin pen or vial, it is the facility policy to label the pen or vial with a date it was open and an expiration date. The facility policy states that if the insulin is not opened, we put it in the refrigerator. Once the insulin is opened, we can keep it in the medication cart, but it must be labeled with an open date and an expiration date. There should not be an insulin pen or vial without a label of open date. Insulin that is expired should never be given to the resident and should be removed from the cart immediately. Once the expired insulin or expired medication is removed from the cart, it is sent back to pharmacy. No, there should not be	S9999		

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S9999	Continued From page 17 insulin in the cart that is not labeled. Insulin should always be labeled with an open date and expiration." On 09/07/2021 at 11:45 AM V3 (Licensed Practical Nurse) stated, "The insulin is good for 28 or 30 days after it is opened. We are supposed to label the insulin with a date it was opened. That is the policy of the facility. We are supposed to open the insulin with an open date and an expiration date. So, when the insulin is expired, we remove that expired insulin from the cart, and we send it back to pharmacy. We must reorder new insulin for that resident as well. So, we call our pharmacy, and we order more. But once the insulin is expired, we send it back to the pharmacy. The insulin should always be opened and labeled with an open date and labeled with an expiration date. Expired insulin should be removed from cart and sent back. We should be inspecting the insulin in the nursing cart to assure that every insulin vial is labeled appropriately, and the expired insulin should be removed in a timely manner." On 09/09/2021 at 10:32 AM V12 (Director of Nursing) stated, "From the moment that we open the insulin it should have an opened date and an expiration date. If it is a new bottle of insulin and it is not opened, it should be refrigerated. If the insulin is opened, then put a date it was open and expiration date and it can stay in the cart. Insulin is good for an average of 28 days and some insulins can be good for 30 days after it is opened. We remove insulin that had expired, and we send it back to the pharmacy. Insulin that is expired should not be in the cart anymore, it needs to be removed and sent back to pharmacy. If there is an insulin vial that was not labeled with	S9999		

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S9999	Continued From page 18 an opened date, it should be discarded, and a new insulin should be ordered." Policy titled, Storage and Expiration of Medications, Biologicals, Syringes and Needles (dated 01/01/2013) shows that facility should ensure that medications and biologicals have an expiration date on the label. Policy states that once any medication is opened facility staff may record the calculated expiration date based on the date opened on the medication container. "C"	S9999		