STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495368	A. BUILDING _____ B. WING _____	10/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE NEWPORT	11141 WARWICK BLVD NEWPORT NEWS, VA 23601

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F 000	INITIAL COMMENTS An unannounced Medicare standard survey was conducted 10/10/17 through 10/12/17. Corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 60 certified bed facility was 41 at the time of the survey. The survey sample consisted of 14 residents, 11 current Resident reviews (Resident #1 through #10 and #14) and 3 closed record reviews (Resident #11 through #13).	F 000		
F 157 SS=D	NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) CFR(s): 483.10(g)(14) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to	F 157		11/10/17

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

Electronically Signed | 11/02/2017

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F 157	Continued From page 1 commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on observation during the medication pass and pour, clinical record review, staff interview and facility policy, the facility staff failed to notify the physician a medication was not available for administration as ordered for 1 of 14 residents (Resident #14) in the survey sample. Resident #14's Basaglar Insulin (a long-acting human insulin administered with the KwikPen used for blood sugar control) was not available for administration on 10/10/17 between 4:00 -	F 157	The plan of correction is respectfully submitted as evidence of alleged compliance. The submission is not an admission that the deficiencies existed or that we are in agreement with them. It is an affirmation that corrections to the areas cited have been made and that the facility is in compliance with participation requirements. 1. They physician was made aware of	

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F 157	Continued From page 2 6:00 p.m. The findings include: Resident #14 was admitted to the nursing facility on 8/1/17 with diagnoses that included diabetes. The most recent Minimum Data Set (MDS) assessment dated 8/8/17 coded Resident #14 as not having the ability to complete the Brief Interview for Mental Status (BIMS). The staff interview was coded for long and short term memory problems as well as moderately impaired for daily decision making. The resident was also coded as requiring limited assistance of 1 with transfers, corridor walking, locomotion and personal hygiene, extensive assistance of 1 with transfers, dressing and toilet use and total care of 1 with bathing. In section "H" the resident was coded as frequently incontinent of bladder and occasionally incontinent of his bowels. The care plan dated 8/10/17 had a problem which read; (name of resident) has diabetes. The goal the staff set for the resident was (name of resident) blood sugar will remain at level that does not require treatment outside of ordered parameters and (name of resident) and/or family will demonstrate understanding of diabetic care and potential complications. Some of the approaches the staff would use to accomplish this goal included; provide diet as ordered, provide low sugar dietary supplements, obtain labs as ordered and report per protocol, administer insulin and oral agents as ordered. Obtain blood sugars as ordered. Report findings	F 157	Resident #14 receiving insulin late due to supply not being available during the scheduled time. Resident's blood sugar was checked per provider order and the resident was without negative outcomes related to receiving medication late. The responsible nurse was re-educated on the importance of notifying the provider when a medication is not available for ordered administration. 2. The Director of Nursing/ designee will review the medication record from the past 30 days of current residents receiving insulin to ensure the provider has been notified of any insulin unavailable for administration. The nurses will be responsible for notifying the provider of any insulin that is unavailable for administration. 3. RNs and LPNs were re-educated on "Physician Notification of Changes" by the Director of Education/designee. The in-service included a review of the importance of notifying the provider regarding unavailable medications as well as a review of changes that a provider should be made aware of. 4. The Director of Nursing/ designee will review the medication administration records of 20% of residents receiving insulin weekly for six weeks to ensure the provider has been notified regarding any medication that is unavailable for administration. The Director of Nursing/ designee will identify any patterns or trends and report results to the Quality	

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F 157	Continued From page 3 outside of ordered blood sugar parameters, and/or any signs of hypo or hyperglycemia to the physician. Administer sliding scale insulin coverage as ordered. The physician's order summary revealed an order date 9/21/17 for Basaglar KwikPen 100 units/milliliters (3 milliliters) subcutaneously two times daily at 8:00 a.m. - 10:a.m., and 4:00 p.m. - 6:00 p.m. On 10/10/17 at 5:25 p.m., during the medication pass and pour observation for Resident #14, Licensed Practical Nurse (LPN) #1 removed the Basaglar Insulin KwikPen from the medication cart to administer the ordered dose but the pen had been opened and the opened dated was not recorded on it; therefore, LPN #1 did not know if the medication had been opened greater than 28 days. LPN #1 chose not to administer the medication from the undated KwikPen. LPN #1 stated Resident #14 did not have another Basaglar KwikPen in the facility; therefore, another was ordered but it was not expected to arrive until after 7:00 p.m. on 10/10/17. Review of the medication administration record revealed LPN #1 administered the Basaglar KwikPen insulin to Resident #14 on 10/10/17 at 7:20 p.m., and there was no documentation the physician was notified of the delay in administration. The facility's policy titled "Storage and Expiration Dating of Medications, Biologicals, Syringes and	F 157	Assurance and Performance Improvement committee.	

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Needles" dated 6/1/2011 read; "Medications biologicals, syringes and needles are stored under proper conditions as directed by state and federal regulations and manufacturer guidelines to ensure their stability, quality, safety and security." On page 113 bullet #1 read; "Facility should ensure that medications and biologicals that have an expiration date on the label; have been retained no longer than recommended by the manufacturer or supplier guidelines; or have been contaminated or deteriorated, are stored separate from other medications until destroyed or returned to the supplier." Bullet #2 read; "once any medication or biological package is opened, facility staff should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. Facility staff should record the date opened on the medication container when the medication has a shortened expiration date once opened."

The facility Insulin Storage Recommendations Per the Manufacturer read; "unopened insulin vial and pens; Basaglar KwikPen refrigerated 36 - 46 degrees Fahrenheit is good until the expiration date on the container. Unrefrigerated and kept at room temperature 59 - 86 degrees it is good only for 28 days." The recommendations further stated after Basaglar KwikPen is opened it is not to be refrigerated and it is good for use for only 28 days.

On 10/12/17 at approximately 11:50 a.m., the above findings were shared with the Administrator, and Director of Nursing. The Director of Nursing stated there was no

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F 157	Continued From page 5 documentation the physician had not been informed of the delay in administration of Resident #14's insulin. The Director of Nursing stated it is the expectation of the staff to keep the resident, physician, and resident representatives informed of changes in care unless it is the person centered plan of care states otherwise.	F 157		
F 274 SS=D	COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE CFR(s): 483.20(b)(2)(ii) (b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interviews and review of the Minimum Data Set (MDS) 3.0 Resident Assessment Instrument (RAI) manual the facility staff failed to complete a significant change assessment for 1 of 14 residents (Residents #7), in the survey sample. The facility staff failed to complete a significant change Minimum Data Set (MDS) assessment for Resident #7 after staff recognized she had experienced a decline in 2 or more areas.	F 274	The plan of correction is respectfully submitted as evidence of alleged compliance. The submission is not an admission that the deficiencies existed or that we are in agreement with them. It is an affirmation that corrections to the areas cited have been made and that the facility is in compliance with participation requirements. 1. A significant change assessment was initiated on Resident #7 with an ARD date	11/10/17

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F 274	Continued From page 6 The findings included; Resident #7 was originally admitted to the facility 6/16/17, and had no discharges. The current diagnoses include Parkinson's disease, psychosis, a panic disorder, dementia with behaviors, insomnia and osteoporosis. Resident #7 had a quarterly MDS assessment completed with an ARD of 9/22/17. It coded the resident as completing the Brief Interview for Mental Status and scoring 3 out of a possible 15. This indicated Resident #7's cognitive abilities for daily decision making were severely impaired. This MDS assessment also coded the resident in section "G" Functional Status, as requiring extensive assistance of 1 person with bed mobility and eating, extensive assistance of 2 persons with transfers and toileting and total are of 1 person with personal hygiene, bathing, dressing and locomotion. In section "H" Bladder and Bowel, the resident was coded as frequently incontinent of bowels and bladder. In section "K0200" Swallowing/Nutritional Status of the 9/22/17 MDS assessment, the resident was coded for weight loss, not on physician-prescribed weight-loss regimen. The resident's weight was 160 pounds and identified at "K0300" as a significant weight loss of 5% or more in the past 30 days or 10% or more in the last 180 days. Further review of the 9/22/17 quarterly MDS assessment revealed, in section "M" Skin Conditions the resident was coded with a newly acquired stage 2 pressure ulcer, identified	F 274	of 10/11/17. The care plan was reviewed to ensure it reflected the significant change. There were no negative outcomes identified. 2. The Director of Nursing/ designee reviewed current resident's charts to ensure a significant change MDS was initiated for any resident that met the criteria. 3. RNs and LPNs who are responsible for the MDS process were re-educated by the Assistant Director of Nursing Operations/ designee on "Criteria for Significant Change Assessments." The in-service included a review of the RAI manual instructions. 4. The Director of Nursing/ designee will audit 20% of OBRA required assessments weekly for six weeks to ensure a significant change assessment has been initiated when the guidelines are met. The Director of Nursing / designee will identify any patterns or trends and report results to the Quality Assurance and Performance Improvement committee.	

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F 274	Continued From page 7 8/16/17. Resident #7's admission MDS assessment with an assessment reference date (ARD) of 6/23/17 coded the resident as completing the Brief Interview for Mental Status with a score of 11 out of a possible 15. This indicated Resident #7's cognitive abilities for daily decision making were moderately impaired. This MDS assessment also coded the resident in section "G" Functional Status, as requiring extensive assistance of 1 person with bed mobility, personal hygiene, dressing eating, and toileting, extensive assistance of 2 persons with transfers and total care of 1 person with bathing, and locomotion. In section "H" Bladder and Bowel the resident was coded as always incontinent of bowels and bladder. In section "K0200" Swallowing/Nutritional Status, of the 6/23/17 Admission MDS assessment, the resident was coded as weighing 174 pounds and in section "M" Skin Conditions, she was coded as having no pressure ulcers. On 10/11/17 at approximately 2:10 p.m., an interview was conducted with the Director of Nursing. The Director of Nursing stated comparison of the MDSs indicated a significant change assessment should have been completed because there was a decline in cognition, a significant weight loss and development of a pressure ulcer over the quarter and the MDS Coordinator would be scheduling the significant change assessment to be conducted.	F 274		

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F 274	Continued From page 8 On 10/12/17 at approximately 11:50 a.m., the above findings were shared with the Administrator, and Director of Nursing. Confirmation that a significant change assessment would be completed was given. Coding Tips - A resident may experience weight variances in between the snapshot time periods. Although these require follow up at the time, they are not captured on the MDS. - If the resident is losing a significant amount of weight, the facility should not wait for the 30- or 180-day timeframe to address the problem. Weight changes of 5% in 1 month, 7.5% in 3 months, or 10% in 6 months should prompt a thorough assessment of the resident's nutritional status. (Chapter 2, page K-6, October 2016) The MDS 3.0 RAI manual states a significant change is a decline or improvement in the resident's status: Resident #7 experienced improvements in two or more of the following: - Any improvement in an ADL physical functioning area where a resident is newly coded as Independent, Supervision, or Limited assistance since last assessment; - Decrease in the number of areas where Behavioral symptoms are coded as being present and/or the frequency of a symptom decreases; - Resident's decision making changes for the better; - Resident's incontinence pattern changes for the better; - Overall improvement of resident's condition. RAI user's manual, (Chapter 2 page 2-26,	F 274		

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F 274	Continued From page 9 October 2016)	F 274		
F 280 SS=D	RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP CFR(s): 483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's	F 280		11/10/17

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F 280	Continued From page 10 strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.	F 280		

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F 280	Continued From page 11 (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview and review of the facility policy the facility staff failed to revise the person-centered plan of care as the resident's status changed for 1 of 14 residents (Residents #7), in the survey sample. The findings include: Resident #7 was originally admitted to the facility 6/16/17, and had no discharges. The current diagnoses include Parkinson's disease and dementia with behaviors. Resident #7 had a quarterly MDS assessment completed with an ARD of 9/22/17. It coded the resident as completing the Brief Interview for Mental Status and scoring 3 out of a possible 15. This indicated Resident #7's cognitive abilities for daily decision making were severely impaired. This MDS assessment also coded the resident in section "G" Functional Status, as requiring extensive assistance of 1 person with bed mobility and eating, extensive assistance of 2 persons with transfers and toileting and total are of 1 person with personal hygiene, bathing, dressing and locomotion. In section "H" Bladder and Bowel, the resident was coded as frequently incontinent of bowels and bladder. The person-centered plan of care dated 6/30/17	F 280	The plan of correction is respectfully submitted as evidence of alleged compliance. The submission is not an admission that the deficiencies existed or that we are in agreement with them. It is an affirmation that corrections to the areas cited have been made and that the facility is in compliance with participation requirements. 1. Resident #7's care plan was reviewed in its entirety and updated to reflect the weight loss with no negative outcomes identified. 2. Care plans for residents that have experienced weight loss of 5% or more in the past 30 days or 10% or more in the past 180 days were reviewed to ensure goals and interventions in their plan of care were updated appropriately. 3. RNs and LPNs who are responsible for the care planning process were re-educated by the Director of Education/ designee on "Care Plan Goals." The in-service included a review of updating the care plan goals and interventions regarding weight changes. 4. The Director of Nursing/ designee will audit care plans of current residents with a new weight loss weekly for six weeks to	

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F 280	Continued From page 12 read; "potential for weight change due to dementia, Parkinson's disease, behaviors, anxiety, GERD, use of anti-psychotropic medications and cardiovascular disease. She has behaviors that impact her ability to eat, has poor oral intake when assisted with her meals, has a weight loss 10/3/17; weight loss, new order Hi-Cal." The goal dated 6/30/17, read; "(resident's name) will not experience a significant unplanned weight change." The interventions read; "honor resident food choices. Provide assistance as needed with eating. Medications per MD order. Labs per physician order and notify of abnormal results. Diet as ordered. Obtain weights per facility policy unless otherwise ordered. RED program." The weight record reveals the following weight; 6/16/17 174.6 pounds, 6/26/17 170 pounds, 7/5/17 167.8 pounds, 7/13/17 167.8, 8/1/17 166.8 pounds, 9/1/17 160.3, 9/29/17 157 pounds, 10/6/17 147.2. An interview was conducted with Resident #7's husband on 10/11/17 at approximately 3:45 p.m. He stated they moved to the community together but as his wife's status deteriorated she relocated to the nursing center. He stated he was informed of his wife's weight loss and usually visits with her 2 times per day to keep her encouraged. A nutrition note dated 10/11/17 read; "resident is receiving a no added salt diet. She also receives Hi-Cal 90 milliliters twice daily and a frozen treat two times a day (initiated 10/3/17). Her PO (by mouth) intake has been variable at meals. At	F 280	ensure goals and interventions are updated appropriately. The Director of Nursing/ designee will identify any patterns or trends and report results to the Quality Assurance and Performance Improvement committee.	

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some she consumes 50-75% and at most she consumes 25%. Per documentation her appetite has been decreased and she refuses some meals. She also receives Remeron (an antidepressant used to stimulate the appetite). Will continue to monitor She is above the idea body weight range at 147% of her ideal body weight Body Mass Index of 28.74 indicates weight status is overweight. She has had significant weight loss of 8.17% over 30 days, 12.27 % over 90 days and 12.07% over 180 days. Will continue to monitor weights and follow-up as needed." The recommendation on 10/11/17 was to add 2 additional interventions to manage Resident #7's weight loss. They were; add fortified foods to the diet order and Promod (a protein supplement) 30 milliliters twice daily for 90 days.

A closer review of the person-centered plan of care revealed after the 27- pound weight loss, the goal remained the same; it read, (resident's name) will not experience a significant unplanned weight change and only 2 interventions were added to the care plan; the red plate RED program and Hi-Cal. The multiple interventions listed in the above nutrition note were not incorporated.

An interview was conducted with the Director of Nursing (DON) on 10/11/17 at approximately 2:10 p.m. The DON stated Resident #7's weight loss was constantly being reviewed and interventions were ongoing; indicating the care was provided though the person-centered plan of care was not updated.

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F 280	Continued From page 14 The Facility's policy titled "Comprehensive Care Plan" with a revision date of 1/25/17 read; the care plan is reviewed and updated at least quarterly, with any significant changes, and as needed. The Administrator and Director of Nursing were informed of the above findings at the pre-exit briefing on 10/12/17 at approximately 11:50 a.m. They both acknowledged the person-centered plan of care was without the updates.	F 280		
F 431 SS=D	DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS CFR(s): 483.45(b)(2)(3)(g)(h) 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 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	F 431		11/10/17

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F 431	Continued From page 15 (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 package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations during the inspection of the medication room and medication pass and pour, staff interviews and review of the facility's policy the facility staff failed to ensure medications and biological were safely and securely store and handled in accordance with manufacturers' specifications, state requirements and standards of practice.	F 431	The plan of correction is respectfully submitted as evidence of alleged compliance. The submission is not an admission that the deficiencies existed or that we are in agreement with them. It is an affirmation that corrections to the areas cited have been made and that the facility is in compliance with participation requirements.	

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F 431	Continued From page 16 1. The facility staff failed to ensure controlled substances stored inside the refrigerated locked box were accurately reconciled. 2. The facility's staff failed to record the date opened on a multi-dose vial of PPD (a purified protein derivative). 3. The facility's staff failed to date a Basaglar insulin pen so others would know the official expiration date once opened. The findings included; 1. On 10/10/17 at approximately 1:40 p.m., during inspection of the medication refrigerator with Licensed Practical Nurse (LPN) #2, the permanently affixed controlled substance box was unlocked and 2 unopened 1 millimeter vials of Lorazepam (a scheduled IV controlled medication with a potential for abuse, prescribed to slow activity in the brain to allow for relaxation) was removed. The Lorazepam was prescribed to a discharged resident and had a manufacturer's expiration date of 1/2019. The narcotic reconciliation sheet didn't indicate 2 vials were left. Two narcotic reconciliation sheets had been started and used, both indicated 4 vials were received and 2 vials were used but neither prompted the licensed nurse to look for 2 additional full vials. The above information was shared with the Director of Nursing on 10/12/17 at approximately 11:50 a.m., she stated she had reviewed the narcotic reconciliation sheets for the Lorazepam and she understood how a problem could occur	F 431	1. The reconciliation sheet was corrected for the Lorazepam. The undated vials of PPD and insulin were disposed of the day the undated items were identified. 2. Controlled substance logs were reviewed to ensure they accurately noted the amount to be reconciled. All multi-dose medication vials were inspected to ensure they were properly dated when they were opened. The medication nurses will be responsible for ensuring controlled medications are reconciled each shift as well as ensuring multi-dose vials are dated upon opening. 3. RNs and LPNs were re-educated on "Controlled Substance Reconciliation" and "Dating Multi-Dose Vial Medications" by the Director of Education/ designee. The in-service included a review of the process for ensuring the controlled medication utilization record was accurately reconciled as well as the importance of dating multi-dose medication vials when opened. 4. The Director of Nursing / designee will audit the controlled medication utilization records to ensure accuracy of the controlled count and will inspect any open vials of multi-dose medications to ensure appropriately dated weekly for six weeks. The Director of Nursing/ designee will identify any patterns or trends and report results to the Quality Assurance and Performance Improvement committee.	

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based on the manner the medication was reconciled. She stated the count sheets had been corrected to reflect the 2 vials on hand.

2. On 10/10/17 at approximately 1:40 p.m., during inspection of the medication refrigerator with Licensed Practical Nurse (LPN) #2 an undated multi-dose vial of PPD (a purified protein derivative) was observed stored among the medications to be administered. The multi-dose vial was inspected for an opened date on the vial and/or the box. LPN #2 stated when the vial is opened the date should be recorded on the vial or box to alert staff when to discard it. LPN #2 stated it should be discarded after 30 days. LPN #2 removed the undated vial of PPD from the refrigerator and stated it would be discarded.

Tuberculin purified protein derivative (PPD) is a sterile aqueous solution of a purified protein fraction for intradermal administration as an aid in the diagnosis of tuberculosis. (www.fda.gov/downloads, Food and Drug Administration).

The manufacturer package insert for the PPD testing biologic read under "Dosage and Administration"; "PPD vials should be inspected visually for both particulate matter and discoloration prior to administration and discarded if either is seen. Vials in use for more than 30 days should be discarded. Storage; Vials in use more than 30 days should be discarded due to possible oxidation and degradation which may affect potency." The label read; "Refrigerate/do not freeze. Protect from light."

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On 10/12/17 at 11:50 a.m., the Administrator and Director of Nursing (DON) were made aware of the above findings. The Director of Nursing stated, the PPD vial should be labeled with the date at the time it is opened and should be discarded after 30 days of being opened.

3. On 10/10/17 at 5:25 p.m., during the medication pass and pour observation for Resident #14, Licensed Practical Nurse (LPN) #1 removed the Basaglar Insulin KwikPen from the medication cart to administer the ordered dose but the pen had been opened and the opened dated was not recorded on it; therefore, LPN #1 did not know if the medication had been opened greater than 28 days. LPN #1 chose not to administer the medication from the undated KwikPen. LPN #1 stated Resident #14 did not have another Basaglar KwikPen in the facility; therefore, another was ordered but it was not expected to arrive until after 7:00 p.m. on 10/10/17.

On 10/12/17 at approximately 11:50 a.m., the above findings were shared with the Administrator, and Director of Nursing. The Director of Nursing stated the Basaglar KwikPen should have been dated when it was opened.

The facility's policy titled "Storage and Expiration Dating of Medications, Biologicals, Syringes and Needles" dated 6/1/2011 read; "Medications biologicals, syringes and needles are stored under proper conditions as directed by state and federal regulations and manufacturer guidelines to ensure their stability, quality, safety and security." On page 113 bullet #1 read; "Facility

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F 431	Continued From page 19 should ensure that medications and biologicals that have an expiration date on the label; have been retained no longer than recommended by the manufacturer or supplier guidelines; or have been contaminated or deteriorated, are stored separate from other medications until destroyed or returned to the supplier." Bullet #2 read; "once any medication or biological package is opened, facility staff should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. Facility staff should record the date opened on the medication container when the medication has a shortened expiration date once opened."	F 431		