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<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
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<th>PROVIDER'S PLAN OF CORRECTION</th>
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<tbody>
<tr>
<td>F164</td>
<td>PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</td>
<td>F164</td>
<td>☐ The facility will keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. 1. The DON and ADON inspected each laptop and physical record on 7/15/13 to ensure that patient information was kept confidential. 2. Nurses were in-serviced on 7/24/13 regarding the importance of protecting patient information by ensuring that no patient information is visible while the laptop on the medication carts are unattended. 3. The DON and ADON will perform random audits of the medication carts to ensure that patient information is not visible while unattended and report any abnormal findings to the QA Committee. 7/31/13.</td>
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The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.

Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.

Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.

The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.

The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.

This REQUIREMENT is not met as evidenced by:
Based policy review, observation and interview, it was determined the facility failed to ensure the confidentiality of medical information for 2 of 28 (Residents #10 and #207) sampled residents included in the stage 2 review.

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.
F 164  Continued From page 1

The findings included:

1. Review of the facility’s “FACILITY NOTICE OF PRIVACY PRACTICES” policy documented, "...Our Pledge regarding your PHI [Personally identifiable Health Information]... We understand that PHI about you and your health is personal. Protecting medical information about you is important... This notice applies to all of the records of your care generated by this Facility..."

2. Observations on the 2A hallway on 7/15/13 at 5:11 PM, revealed a medication cart with a computer screen which displayed Resident #10’s medical information with no nurse in the area. The medical information was in view to anyone who passed by.

3. Observations on the 2A hallway on 7/15/13 at 5:37 PM, revealed a medication cart with a computer screen which displayed Resident #207’s medical information with no nurse in the area. The medical information was in view to anyone who passed by.

Observations on the 2A hallway on 7/15/13 at 6:05 PM, revealed a medication cart with a computer screen which displayed Resident #207’s medical information with no nurse in the area. The medical information was in view to anyone who passed by.

4. During an interview in the conference room on 7/18/13 at 7:10 AM, the Director of Nursing (DON) was asked what kind of information of the residents does the facility protect. The DON stated, "Any information... health information..."
### STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

**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)** | **COMPLETION DATE**
--- | --- | --- | --- | --- | --- | --- | --- | ---
F 164 |  |  | Continued From page 2 The DON was asked about the information displayed on the computer screens when a nurse leaves the medication cart. The DON stated, "...[medical information is] expected to be minimized... shouldn't be any [medical] information on it [computer screen]..." |  |  | **F 315** The facility will ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary. 1. A physician's order was obtained and resident #5's was discontinued on 7/16/13. 2. Resident #160's catheter was changed on 7/19/13 per physician's order. 3. An audit of all patients was conducted by the DON on 7/19/13 to ensure that residents did not have a catheter without a physician's order or that the physician's order was being followed as directed. 4. On 7/17/13 nurses were in-serviced regarding following physicians orders for catheterization of residents. 5. The DON and ADON will ensure compliance by performing random audits of catheterized residents and report any abnormal findings to the QA Committee. | 7/31/13
F 315 |  |  | 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation and interview, it was determined the facility failed to provide appropriate care by not obtaining an order for the use of a Foley catheter for 1 of 2 (Resident #5) residents and failed to change a Foley catheter every 2 weeks as ordered by the physician for 1 of 2 (Resident #160) residents with a catheter of the 28 residents included in the stage 2 review. The findings included: 1. Medical record review for Resident #5 documented an admission date of 9/11/13 with diagnoses of Cellulitis of the Leg, Esophageal |  |  |  | **7/31/13**
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| F 315         | Continued From page 3 \nReflex, Hypertonicity of the Bladder, Irritable Bowel Syndrome, Hypothyroidism, Muscle Weakness and Congestive Heart Failure. Review of the admission orders dated 6/11/13 revealed no order for Resident #5's indwelling catheter.\nReview of the daily skilled nurse's note dated 6/12/13 documented, "...Bladder Control... Pads/Briefs used Catheter..." Review of the admission Minimum Data Set (MDS) dated 6/18/13 documented, "...Section H - Bowel and Bladder... HO100. Appliances... A. Indwelling catheter... [check mark]..." Review of the comprehensive care plan dated 6/25/13 documented, "...At risk for infection R/T [related to] indwelling catheter..." Review of a physician's order dated 7/16/13 documented, "...DC [discontinue] Foley catheter, re-insert if unable to void..."\n\nObservations in Resident #5's room on 7/15/13 at 2:30 PM, revealed Resident #5 lying in bed with an indwelling catheter draining clear yellow urine.\n\nDuring an interview at the 1st floor nurses' station on 7/16/13 at 10:47 AM, Nurse #5 was asked why Resident #5 had an indwelling catheter. Nurse #5 stated, "...I don't know... she had it when she came in..." Nurse #5 stated she was unable to find a physician's order for the indwelling catheter.\n\nObservations in Resident #5's room on 7/17/13 at 4:30 PM, revealed Resident #5 lying in bed without an indwelling catheter.\n\nDuring an interview in the conference room on 7/17/13 at 4:00 PM, the Director of Nursing (DON) confirmed there was no physician's order
F 315  Continued From page 4  
for the catheter.

During an interview in Resident #5's room on 7/17/13 at 4:30 PM, Resident #5 was asked if she had the indwelling catheter since she was admitted to the facility. Resident #5 stated, "...I believe so... I've had it in for quite a while..." Resident #5 was asked if the nursing staff ever discussed with her why she needed a catheter or the risks involved with a catheter. Resident #5 stated, "No." Resident #5 was asked if she had any problems with urinating since the nursing staff removed the catheter. Resident #5 stated, "No, I've had to go several times..."  

During an interview in the conference room on 7/18/13 at 7:10 AM, the DON was asked if the facility completes an assessment for the need of a urinary catheter including the risks and plans for removal of the catheter. The DON stated, "No, they [urinary catheter] are supposed to be taken out..."

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| F 315 | Continued From page 5
| | Appliances... A. Indwelling catheter... [check mark]..." Review of care plan dated 6/3/13 documented, "...At risk for infection R/T indwelling catheter... History of urinary tract infection within the last 30 days..." Review of treatment records dated 5/13, 6/13 and 7/13, documented Resident #5's urinary catheter has not been changed since 5/28/13.
| | Observations in Resident #160's room on 7/18/13 at 2:00 PM, revealed Resident #160 seated on the side of the bed with indwelling catheter to bedside bag draining yellow urine with sediment in tubing.
| | During an interview in the conference room on 7/18/13 at 2:15 PM, the DON was asked about the physician's order to change Resident #160's catheter every 2 weeks. The DON stated, "The order was put in the computer wrong... he [Resident #160] has not had the catheter changed every 2 weeks..." The DON confirmed the last documented change of Resident #160's catheter was 5/28/13.
| | F 325 | Based on a resident's comprehensive assessment, the facility will ensure that a resident:
| | (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and
| | (2) Receives a therapeutic diet when there is a nutritional problem.

**SPOTLIGHT**

- **F 325**: 483.25(I) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE

- **F 325** Based on a resident's comprehensive assessment, the facility will ensure that a resident:
  1. Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and
  2. Receives a therapeutic diet when there is a nutritional problem.
Continued From page 6

This REQUIREMENT is not met as evidenced by:
Based on policy review, medical record review, observation and interview, it was determined the facility failed to provide care to promote the nutritional status for 1 of 3 (Resident #182) residents with weight loss of the 28 residents included in the stage 2 review.

The findings included:

1. Review of the facility's "CLINICAL NUTRITIONAL CARE" policy documented, "...All patients are assessed to identify possible nutritional risk...Interventions must be completed in a timely and appropriate manner...Monitor for Patient Needs...Oral Nutrition Supplements (A physician's order is necessary for all medically related supplements ie [for example]: Ensure Plus, Juven, Provide Gold...Assessment of Weight Loss...Collaboratively notify the attending physician and the family of the weight loss...Implement interventions individualized for each patient..."

2. Medical record review for Resident #182 documented an admission date of 6/6/13 with diagnoses of Leptomeningeal Carcinomatosis, Myelodysplastic Syndrome with recent conversion to Acute Leukemia, Anemia of Chronic Disease, Thrombocytopenia and Mild Hypoglycemia. Review of the physician's admission orders dated 6/6/13 documented, "...STRAWBERRY BOOST TID [three times a day] WITH MEALS..." Review of the admission care plan dated 6/6/13 documented, "...NUTRITIONAL STATUS..."

1. The physician was notified on 7/17/13 of resident #182's weight loss. Resident #182's order for strawberry boost was discontinued on 7/17/13 and a new physician order was obtained on 7/17/13 for Hi Cal 4oz BID.
2. The ADON and FSS audited all resident records to ensure that nutritional supplements are being given as ordered and that all documented weight losses have had a physician notified.
3. The DON in-serviced nursing staff on 7/24/13 regarding notifying physicians of a resident's weight loss and giving nutritional supplements as ordered.
4. The DON, ADON and FSS will ensure compliance through random chart audits and report any abnormal findings to the QA Committee.

7/31/13
F 325 Continued From page 7

Fluids... [blank]..." Review of the nutritional assessment dated 6/10/13 documented, "...Supplements... To Be Determined..." There is no documentation that Resident #182 ever received Strawberry Boost while at this facility.

Review of the care plan dated 6/28/13 documented, "...Problems... Recent undesired weight loss... Goals... Will lose no further weight... Interventions... Refer to weekly weight loss assessment and MD [medical doctor] orders for current interventions..." Review of the "PHYSICIAN'S PROGRESS NOTES" dated 7/15/13 documented, "...O [objective]... Gan [general]... slim... AP [assessment and plan]... Weight - stable..." Review of Resident #182's weight record in the facility's computer system documented a weight of 147 on 6/12/13 and a weight of 139 on 7/12/13 which is a 5.4% [percent] weight loss in 30 days. The facility was unable to provide documentation that the physician was notified of the weight loss noted on 7/12/13.

Observations in Resident #182's room on 7/15/13 at 3:30 PM, revealed Resident #182 lying in bed with the blanket over his head with thin arms and legs visible.

Observations in Resident #182's room on 7/17/13 at 4:05 PM, revealed Resident #182 seated in a wheelchair with the blanket over his head. Resident #182 has a thin trunk, arms and legs.

During an interview in the 1st floor nurses' station on 7/16/13 at 11:00 AM, Nurse #4 confirmed Resident #182 was not currently receiving nutritional supplements.
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<td>F 325</td>
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<td>F 325</td>
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<td>During an interview in the conference room on 7/17/13 at 1:45 PM, the Assistant Director of Nursing (ADON) confirmed that there was no documentation Resident #182 ever received the Strawberry Boost as ordered by the physician on 6/6/13. The ADON was asked about Resident #182’s weight loss documented on 7/12/13. The ADON confirmed the physician was not notified of the weight loss. The ADON stated, ”We are way behind on our weights...”</td>
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<td>F 428</td>
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<td>483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON</td>
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<td>The drug regimen of each resident will be reviewed at least once a month by a licensed pharmacist.</td>
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<td>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.</td>
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<td>This REQUIREMENT is not met as evidenced by:</td>
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<td>Based on medical record review and interview, it was determined the facility failed to ensure appropriate medication doses were given to a resident based on pharmacy recommendations for 1 of 10 (Resident #160) residents reviewed for unnecessary medication use of the 28 residents included in the stage 2 review.</td>
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<td>The findings included:</td>
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<td>The drug regimen of each resident will be reviewed at least once a month by a licensed pharmacist.</td>
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<td>1. A physician’s order was obtained on 7/24/13 to change resident #160’s Aspirin 325 mg QD to Aspirin 81 mg QD per the pharmacist’s recommendation.</td>
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<td>2. The DON and ADON reviewed all pharmacist recommendations to ensure that they have been reviewed by the physician and an order written when indicated.</td>
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<td>3. The DON in-serviced nursing staff on 7/17/13 regarding following pharmacist recommendations and obtaining a physician’s order when indicated.</td>
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<td>4. The DON and ADON will ensure compliance by evaluating pharmacist’s recommendations and verifying a physician’s order was obtained. They will report any abnormal findings to the QA Committee.</td>
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F 428 Continued From page 9

Medical record review for Resident #160 documented an admission date of 5/17/13 with diagnoses of Urinary Tract Infection, Malnutrition, Dysphagia, Asthma, Diabetes Mellitus, Chronic Airway Obstruction, Hypertension, Dementia, Atrial Fibrillation, Chronic Kidney Disease Stage III, Acute Renal Failure and Anxiety Disorder.

Review of the admission physician's orders dated 5/17/13 documented, "...Plavix 75 mg [milligrams] oral tablet [tab]: 75 mg 1 tab(s), PO [by mouth], Daily... aspirin 325 mg oral tablet: 325 mg 1 tab(s), PO, Daily..."

Review of the "Note to Attending Physician / Prescriber" dated 5/30/13 from the Consultant Pharmacist documented, "...This patient [Resident #160] is receiving Aspirin 325 mg QD [daily] and Plavix 75 mg QD. This may increase the risk of bleeding. May I suggest to DC [discontinue] Aspirin 325 mg QD and start Aspirin 81 mg QD? This will decrease the risk of bleeding and maintain cardiovascular benefits..." The "Physician/Prescriber Response" section of this recommendation dated 6/4/13 completed by the Director of Nursing (DON) documented, "...Aspirin [changed]...

Review of the Medication Administration Record dated June 2013 and July 2013 documented Resident #160 continued receiving Aspirin 325 mg PO daily instead of Aspirin 81 mg PO daily documented on 6/4/13.

During an interview in the conference room on 7/17/13 at 5:00 PM, the Assistant Director of Nursing (ADON) was asked about Resident #160's aspirin. The ADON stated, "...the medication [aspirin] should have been changed..."
### F 428
Continued From page 10

The recommendation is there, but the order cannot be found for the change...

During an interview in the conference room on 7/18/13 at 9:53 AM, the Director of Nursing (DON) was asked about the facility's procedure for addressing pharmacy recommendations. The DON stated, "...after the pharmacist has made a recommendation for a medication to be changed, I will notify the doctor and tell him what the recommendations are... if he wants to change a medication, it is written on a telephone order sheet, and it is changed in the computer..." The DON was asked about the recommendation to decrease Resident #150's aspirin to 81 mg PO daily. The DON stated, "...I called the doctor, but I did not write an order for the recommendation... it should have been changed..."

### F 431

**SS=D**

483.60(b), (d), (e) **DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS**

The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

In accordance with State and Federal laws, the

### F 431

Drugs and biologicals used in the facility will be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

1. a. The #9 Xanax tablet from the medication cart on the 1B hallway was wasted in a sharps container by the nurse and a witness on 7/17/13.

b. The bottle of Magnesium Oxide 400 mg from the 1A-B split medication cart was properly disposed of by the nurse on 7/17/13.
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<td>F 431</td>
<td>Continued From page 11 facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, 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 policy review, observation and interview, it was determined the facility failed to ensure safe and secure storage of medications in 3 of 8 (1B medication cart, 1A-B split medication cart and 2A medication cart) medication storage areas. The findings included: 1. Review of the facility’s medication storage policy documented, &quot;...Medications must be properly stored in medication rooms or medication carts...&quot; Observations on the 1B hallway on 7/17/13 at 3:40 PM, revealed a medication card of Xanax 0.25 milligrams (mg) tablets in the 1B medication cart with the #9 tablet taped into the card. During an interview on the 1B hallway on 7/17/13</td>
<td>F 431</td>
<td>c. The open bottle of insulin from the 2A medication cart dated 5/29 was properly disposed of by the nurse on 7/17/13. 2. The DON and ADON inspected each medication cart to ensure that all medications were stored properly and within the expiration date. 3. The DON in-serviced nurses on 7/17/13 regarding the proper storage of medications and the proper procedure for disposing of expired medications. 4. The DON and ADON will ensure compliance through random medication cart audits and report any abnormal findings to the QA Committee. 7/31/13</td>
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at 3:40 PM, Nurse #1 was asked what the facility's protocol was for handling a Xanax tablet after it was removed from the medication card. Nurse #1 stated "...we would waste it with a witness if it was popped out by mistake... I'm not sure why that is taped..."  

During an interview on the 1A hallway on 7/17/13 at 4:00 PM, Nurse #3 was asked what she would do if she removed a controlled medication from a medication card by mistake.

During an interview in the Director of Nurse's (DON) office on 7/17/13 at 5:20 PM, the DON was asked what nursing staff should do if they removed a controlled medication from a medication card by mistake. The DON stated, "...they [nurses] would waste it in a sharps container with two nurses witnessing it..."

2. Review of the facility's medication storage policy documented, "...Routine checks must be accomplished to ensure that expired medications are discarded..."

Observations on the 1A hallway on 7/17/13 at 4:00 PM, revealed a bottle of Magnesium Oxide 400 mg tablets in the 1A-B split medication cart with a manufacturer's expiration date of 6/13.

During an interview on the 1A hallway on 7/17/13 at 4:00 PM, Nurse #3 was asked what she would do if she found an expired medication in the medication cart. Nurse #3 stated, "...I would throw it out..."

During an interview in the DON's office on 7/17/13 at 5:20 PM, the DON was asked about
**F 431** Continued From page 13

the facility's policy for expired medication on the medication cart. The DON stated, "...take it off the cart, put the remainder of medication in a sharps container and get rid of the bottle..."

3. Review of the facility's medication storage policy documented, "...Routine checks must be accomplished to ensure that expired medications are discarded... Whenever the seal of a multi-dose vial of medication is broken it must be initiated and dated by the nurse with an opened date... The vial must be discarded after 28 days unless the manufacturer specifies a shorter expiration date...

Observations on the 2A hallway on 7/17/13 at 5:45 PM, revealed an opened bottle of insulin in the 2A medication cart with an opened date of 5/29.

During an interview on the 2A hallway on 7/17/13 at 5:45 PM, Nurse #2 was asked how long insulin was good for after it was opened. Nurse #2 stated "...I'm pretty sure a month... I would go and get another one in the refrigerator and let my DON know..." Nurse #2 was asked about the insulin found in the 2A medication cart. Nurse #2 stated, "...It says 5/29 so I would say it's expired..."

During an interview in the DON's office on 7/17/13 at 5:20 PM, the DON was asked how long insulin was good for after it was opened and what nursing staff should do when it has expired. The DON stated, "...28 days...they [nurses] are to destroy it... put it into a sharps container and call pharmacy and order more..."