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VIA CHRISTI VILLAGE MANHATTAN, INC	2800 WILLOW GROVE ROAD MANHATTAN, KS 66502

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F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey. The 2567 was sent electronically on 07/19/23.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the	F 550		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 07/19/2023

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resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.

§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 83. The sample included 18 residents. Based on record review, interview, and observation the facility failed to treat residents with respect, dignity, and privacy during blood glucose testing and insulin (hormone that lowers the level of glucose in the blood) administration. This placed the resident at risk for impaired psychosocial wellbeing.

Findings included:

- On 07/05/23 at 11:34 AM, observation revealed Licensed Nurse (LN) I obtained Resident (R)3's blood sugar reading using a glucometer (a blood glucose meter monitor device that you test the amount of glucose [sugar] in the blood) from R3's right index finger at the table in the dining room, with six other residents seated in the dining room eating lunch.

On 07/11/23 at 10:30 AM, Administrative Nurse D stated staff should not check residents' blood sugar or administer insulin injections at the dining room table, they should take the resident to the room or to a private area.

The facility's "Quality of Life and Dignity" policy,

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F 550	Continued From page 2 dated December 2021 documented each resident would be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality. The policy documented staff shall promote, maintain and protect resident's privacy, including bodily privacy during assistance with personal cares and during treatment procedures. The facility failed to promote care for R3 in a manner to maintain and enhance dignity and respect placing the resident at risk or impaired psychosocial wellbeing.	F 550		
F 726 SS=E	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs.	F 726		

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§483.35(c) Proficiency of nurse aides.
The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 83 residents. The sample included 18 residents. Based on observation, record review, and interview, the facility failed to ensure staff possessed the appropriate competencies to safely administer medications per the standards of practice when a licensed nurse administered Resident (R) 14 medications without reviewing R14's "Medication Administration Record" (MAR) verifying that the resident's morning medications had not already been given. Additionally, Certified Medication Aide (CMA) R set up all the residents in Court-C's medications and left them in the medication cart drawer to be administered at a later time. This placed the resident's at risk for medication errors.

Findings included:

- The Electronic Medical Record (EMR) for R14 documented diagnoses of anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), major depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, and emptiness), cerebral infarction (occurs as a result of disrupted blood flow to the brain due to problems with the blood vessels that supply it), hypertension (high blood pressure), and epileptic syndrome (a combination of symptoms or by the location in the

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brain where the seizures originate).

The "Quarterly Minimum Data Set" (MDS), dated 12/16/22, documented R14 had intact cognition and required extensive assistance of two staff for bed mobility, transfers, personal hygiene. The MDS further documented R14 had verbal and other behaviors and received antipsychotic (medication used to treat psychosis, and other mental emotional conditions), antidepressants (medication used to treat mood disorders and relieve symptoms of depression), and anticoagulants (medication to prevent blood clots) medication.

The "Annual MDS," dated 06/16/23, documented R14 had moderately impaired cognition and required extensive assistance of two staff for bed mobility, transfers, eating, and toileting. The assessment further documented R14 did not have any behaviors and received antianxiety, antidepressant, anticoagulant medication.

The "Care Plan," dated 07/05/22, initiated on 06/14/22, directed staff to administer medication as ordered, monitor for behaviors, monitor and notify for adverse effects of the medication.

The "Physician Order," dated 06/15/22, directed staff to administer gabapentin (an anticonvulsant and nerve pain medication), 1200 milligrams (mg) three times daily, for neuropathy (disease or dysfunction of one or more peripheral nerves), and administer magnesium (a supplement), 400mg, by mouth, twice a day, for hypomagnesemia (low magnesium).

The "Physician Order," dated 06/16/22, directed staff to administer potassium chloride (medication

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to treat and prevent low blood potassium), 20 milliequivalent (meq), daily for hypokalemia, protonix (acid reducer), 40 mg, daily, for gerd (gastro-esophageal reflux disease), aspirin (an anti-inflammatory and blood thinner medication), 81 mg, daily for anticoagulant, a multivitamin with mineral, daily, for nutritional deficit, and hydroxychloroquine (anti-inflammatory), 200mg, daily, for lupus (inflammatory disease caused when the immune system attacks its own tissues).

The "Nurse's Note," dated 02/07/23 at 11:13 AM, documented R14 received two doses of each of her morning medication and staff were directed to hold all duplicate medications until 02/08/23.

The "Safety Event Report," dated 02/07/23, documented R14 received two doses of gabapentin, magnesium, potassium chloride, protonix, aspirin, multivitamin, and hydroxychloroquine, and the physician was notified. The report further documented no clinical outcome or consequences from the event and the standard of care was not met.

The "Physician Note," dated 02/15/23 at 04:28 PM, documented an accidental overdose occurred and directed staff to monitor the resident and her vital signs per facility protocol. The note further documented the physician monitored the resident for six hours and determined the residentwas doing fine and did not have any symptoms related to her overdose.

On 07/06/23 at 09:00 AM, observation revealed CMA R administered medication to R14 without difficulty.

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On 07/10/23 at 01:33 PM, Administrative Nurse D stated R14 told the agency nurse that R14 had not received her morning medications. The nurse did not look at the MAR to check to see if the medications were administered, but gave R14 her pills. Administrative Nurse D further stated the CMA already gave R14 her medication and it was correctly documented in the MAR. Administrative Nurse D stated the agency nurse was coached and educated on medication administration.

The facility's "Adverse Effects and Medication Errors" policy, dated 12/2021, documented a medication error was defined as the preparation or administration of drugs or biologicals which are not in accordance with physicians' orders, manufacturer specification or accepted professional standards and principles of the professional providing the services. In the event of the significant medication related error or adverse
Effect immediate action is taken as necessary to protect the resident.

The facility's "Administering Medications" policy dated 12/2021, documented the individual administering the medication to document on the MAR after giving each medication and before administering the next ones.

The facility failed to ensure staff possessed the appropriate competencies to safely administer medications per the standards of practice when a licensed nurse administered R14 medications without reviewing the MAR.

- On 07/06/23 at 08:00 AM, observation revealed eight small plastic cups with various medications in the Court-C medication cart. The cups were

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labeled with resident room numbers on each cup.

On 07/06/23 at 08:00 AM, Certified Medication Aide (CMA) R stated she was the CMA for Court-C and Court-F. CMA R said she popped all the Court-C residents' morning medications into the medication cups earlier before going back to Court-F to pass some medications there. CMA R stated she did this because she needed to quickly pass the medications so she could get back to Court-F to pass medications to a couple of residents that wanted their medications at a specific time.

On 07/06/23 at 08:10 AM, Licensed Nurse (LN) G stated the CMA should administer medications to one resident at a time.

On 07/06/23 at 03:55 PM, Administrative Nurse D stated she reeducated the CMA and stated all staff passing medications were educated on medication administration in April.

The facility's "Administering Medications" policy dated 12/2021, documented
medications shall be administered in a safe and timely manner and as prescribed and the individual administering the medication must check the label three times to verify the right resident, right medication, right dosage, right time and right method of administration before giving the medication. The individual administering the medication to document on the MAR or EMAR after giving each mediation and before administering the next ones.

The facility failed to ensure staff possessed the appropriate competencies to safely administer medications per the standards of practice when

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F 726	Continued From page 8 one CMA set up all the residents in Court-C's medications and left them in the medication cart drawer to be administered later. This placed the resident's at risk for medication errors.	F 726		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and	F 756		

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maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by:

The facility had a census of 83 residents. The sample included 18 residents, with five reviewed for unnecessary medications. Based on observation, record review, and interview, the facility failed to ensure the Consultant Pharmacist (CP) identified and reported Resident (R) 14's PRN (as needed) clonazepam did not have a stop date, placing the resident at risk for unnecessary psychotropic (alters mood or thought) medications.

Findings included:

- The Electronic Medical Record (EMR) for R14 documented diagnoses of anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), major depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, and emptiness) and cerebral infarction (occurs because of disrupted blood flow to the brain due to problems with the blood vessels that supply it).

The "Annual Minimum Data Set" (MDS), dated 06/16/23, documented R14 had moderately impaired cognition and required extensive assistance of two staff for bed mobility, transfers, eating and toileting. R14 had no behaviors and received antianxiety medication for seven days of the lookback period.

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The "Care Plan," dated 07/05/23, initiated on 06/14/22, directed staff to administer medications as ordered, reassure and comfort R14 if she displayed symptoms of anxiety; encourage her to verbalize her feelings and provide her with emotional support as needed. The update, dated 02/10/23, directed staff to monitor and notify the physician of any side effects.

The "Physician Order," dated 02/09/23, directed staff to administer clonazepam, 0.5 milligrams (mg), by mouth, twice a day, PRN for anxiety. The order lacked a stop date.

The "Medication Administration Record" for February 2023 documented R14 received the PRN medication on 02/13/23, 02/17/23, and 02/21/23.

The "Medication Administration Record" for 2023 March documented R14 received the PRN medication on 03/18/23 and 03/19/23.

The "Medication Administration Record" for April 2023 documented R14 received the PRN medication on 04/06/23, 04/15/23, and 04/20/23.

The "Medication Administration Record" for May 2023 documented R14 received the PRN medication on 05/03/23, 05/07/23, 05/14/23, 05/22/23, 05/23/23, 05/25/23, and 05/31/23.

The "Medication Administration Record" for June 2023 documented R14 received the PRN medication on 06/01/23 and 06/06/23.

The "Medication Administration Record" for July 2023 documented R14 received the PRN

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F 756	Continued From page 11 medication on 07/02/23 and 07/03/23. The "Medication Regimen Review," dated 06/30/22 - 06/30/23 (12 months), lacked evidence the CP identified and reported R14's PRN medication did not have a stop date. On 07/06/23 at 09:00 AM, observation revealed Certified Medication Aide (CMA) R administered medication to R14 without difficulty. On 07/10/23 at 03:40 PM, Administrative Nurse D verified the clonazepam did not have a stop date and that the consultant pharmacist did not notify her that the clonazepam did not have a stop date. The facility "Pharmacy Services-Role of the Consultant Pharmacist" policy, dated 07/2020, documented the pharmacist report on the medication record review and submit recommendations to the physician and director of nursing or designee to ensure that the recommendations are followed through on a timely basis, which do not exceed 30 days. The pharmacist is required to notify the attending physician, director of nursing, and medical director of any irregularities found during the medication record review. The facility failed to ensure the CP identified and reported R14's PRN clonazepam did not have a stop date, placing the resident at risk for unnecessary psychotropic medications and adverse medication side effects.	F 756		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs.	F 758		

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§483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:
(i) Anti-psychotic;
(ii) Anti-depressant;
(iii) Anti-anxiety; and
(iv) Hypnotic

Based on a comprehensive assessment of a resident, the facility must ensure that---

§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;

§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;

§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and

§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and

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indicate the duration for the PRN order.

§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.
This REQUIREMENT is not met as evidenced by:
The facility has a census of 83 residents. The sample included 18 residents, with five reviewed for unnecessary medications. Based on observation, record review, and interview, the facility failed to place a stop date on Resident (R) 14's as needed (PRN) clonazepam (a class of medication used to treat anxiety, panic attacks, and seizures). This placed the resident at risk for unnecessary psychotropic (alters mood or thought) medications and related complications.

Findings included:

- The Electronic Medical Record (EMR) for R14 documented diagnoses of anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), major depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, and emptiness) and cerebral infarction (occurs as a result of disrupted blood flow to the brain due to problems with the blood vessels that supply it).

The "Annual Minimum Data Set" (MDS), dated 06/16/23, documented R14 had moderately impaired cognition and required extensive assistance of two staff for bed mobility, transfers, eating and toileting. R14 had no behaviors and received antianxiety medication for seven days of

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VIA CHRISTI VILLAGE MANHATTAN, INC	2800 WILLOW GROVE ROAD MANHATTAN, KS 66502

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the lookback period.

The "Care Plan," dated 07/05/23, initiated on 06/14/22, directed staff to administer medications as ordered, reassure and comfort R14 if she displayed symptoms of anxiety; encourage her to verbalize her feelings and provide her with emotional support as needed. The update, dated 02/10/23, directed staff to monitor and notify the physician of any side effects.

The "Physician Order," dated 02/09/23, directed staff to administer clonazepam, 0.5 milligrams (mg), by mouth, twice a day, PRN for anxiety. The order lacked a stop date.

The "Medication Administration Record" for February 2023 documented R14 received the PRN medication on 02/13/23, 02/17/23, and 02/21/23.

The "Medication Administration Record" for 2023 March documented R14 received the PRN medication on 03/18/23 and 03/19/23.

The "Medication Administration Record" for April 2023 documented R14 received the PRN medication on 04/06/23, 04/15/23, and 04/20/23.

The "Medication Administration Record" for May 2023 documented R14 received the PRN medication on 05/03/23, 05/07/23, 05/14/23, 05/22/23, 05/23/23, 05/25/23, and 05/31/23.

The "Medication Administration Record" for June 2023 documented R14 received the PRN medication on 06/01/23 and 06/06/23.

The "Medication Administration Record" for July

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F 758	Continued From page 15 2023 documented R14 received the PRN medication on 07/02/23 and 07/03/23. On 07/06/23 at 09:00 AM, observation revealed Certified Medication Aide (CMA) R administered medication to R14 without difficulty. On 07/10/23 at 03:40 PM, Administrative Nurse D verified the clonazepam did not have a stop date and that the consultant pharmacist did not notify her that the clonazepam did not have a stop date. The facility's "Psychotropic Medication" policy dated November 2022, documented residents would not receive PRN doses of psychotropic medications unless that medication was necessary to treat a specific condition that was documented in the clinical record. The policy further documented the need to continue PRN orders for psychotropic medications beyond 14 days required the practitioner to document the rationale for the extended order, and the PRN orders of psychotropic medication would not be renewed beyond 14 days unless the health care practitioner had evaluated the resident for appropriateness of the medication. The facility failed to obtain a stop date for R14's clonazepam medication. This placed the resident at risk for unnecessary medications and related complications	F 758		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced	F 760		

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by:
The facility had a census of 83 residents. The sample included 18 residents. Based on record and interview, the facility failed to prevent a medication errors when a licensed nurse administered Resident (R) 14 medications without reviewing the "Medication Administration Record" (MAR) and verifying that the resident's morning medications had not already been given which resulted in a medication error. This placed the resident at risk for complications and physical decline from and overdose of medications.

Findings included:

- The Electronic Medical Record (EMR) for R14 documented diagnoses of anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), major depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, and emptiness), cerebral infarction (occurs as a result of disrupted blood flow to the brain due to problems with the blood vessels that supply it), hypertension (high blood pressure), and epileptic syndrome (a combination of symptoms or by the location in the brain where the seizures originate).

The "Quarterly Minimum Data Set" (MDS), dated 12/16/22, documented R14 had intact cognition and required extensive assistance of two staff for bed mobility, transfers, personal hygiene. The MDS further documented R14 had verbal and other behaviors and received antipsychotic (medication used to treat psychosis, and other mental emotional conditions), antidepressants (medication used to treat mood disorders and relieve symptoms of depression), and

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anticoagulants (medication to prevent blood clots) medication.

The "Annual MDS," dated 06/16/23, documented R14 had moderately impaired cognition and required extensive assistance of two staff for bed mobility, transfers, eating, and toileting. The assessment further documented R14 did not have any behaviors and received antianxiety, antidepressant, anticoagulant medication.

The "Care Plan," dated 07/05/22, initiated on 06/14/22, directed staff to administer medication as ordered, monitor for behaviors, monitor and notify for adverse effects of the medication.

The "Physician Order," dated 06/15/22, directed staff to administer gabapentin (an anticonvulsant and nerve pain medication), 1200 milligrams (mg) three times daily, for neuropathy (disease or dysfunction of one or more peripheral nerves), and administer magnesium (a supplement), 400 mg, by mouth, twice a day, for hypomagnesemia (low magnesium).

The "Physician Order," dated 06/16/22, directed staff to administer potassium chloride (medication to treat and prevent low blood potassium), 20 milliequivalent (meq), daily for hypokalemia, protonix (acid reducer), 40 mg, daily, for gerd (gastro-esophageal reflux disease), aspirin (an anti-inflammatory and blood thinner medication), 81 mg, daily for anticoagulant, a multivitamin with mineral, daily, for nutritional deficit, and hydroxychloroquine (anti-inflammatory), 200 mg, daily, for lupus (inflammatory disease caused when the immune system attacks its own tissues).

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The "Nurse's Note," dated 02/07/23 at 11:13 AM, documented R14 received two doses of each of her morning medication and staff were directed to hold all duplicate medications until 02/08/23.

The "Safety Event Report," dated 02/07/23, documented R14 received two doses of gabapentin, magnesium, potassium chloride, protonix, aspirin, multivitamin, and hydroxychloroquine, and the physician was notified. The report further documented no clinical outcome or consequences from the event and the standard of care was not met.

The "Physician Note," dated 02/15/23 at 04:28 PM, documented an accidental overdose occurred and directed staff to monitor the resident and her vital signs per facility protocol. The note further documented the physician monitored the resident for six hours and determined the resident was doing fine and did not have any symptoms related to her overdose.

On 07/06/23 at 09:00 AM, observation revealed CMA R administered medication to R14 without difficulty.

On 07/10/23 at 01:33 PM, Administrative Nurse D stated R14 told the agency nurse that R14 had not received her morning medications. The nurse did not look at the MAR to check to see if the medications were administered, but gave R14 her pills. Administrative Nurse D further stated the CMA already gave R14 her medication and it was correctly documented in the MAR. Administrative Nurse D stated the agency nurse was coached and educated on medication administration.

The facility's "Adverse Effects and Medication

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F 760	Continued From page 19 Errors" policy, dated 12/2021, documented a medication error was defined as the preparation or administration of drugs or biological's which are not in accordance with physicians' orders, manufacturer specification or accepted professional standards and principles of the professional providing the services. In the event of the significant medication related error or adverse effect immediate action is taken as necessary to protect the resident. The facility's "Administering Medications" policy dated 12/2021, documented the individual administering the medication to document on the MAR after giving each medication and before administering the next ones. The facility failed to prevent a medication errors when a licensed nurse administered R14 medications without reviewing the MAR which resulted in duplicate administration of medications. This placed the resident at risk for complications and physical decline from an overdose of medications.	F 760		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(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. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and	F 761		

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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.

§483.45(h)(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:
The facility had a census of 83 residents. The sample included 18 residents. Based on observation, interview, and record review, the facility failed to label Resident (R)61, R33 and R231's insulin (hormone which allows cells throughout the body to uptake glucose) flex pen with the date opened and expiration date, failed to label R61's open insulin with her name, the date opened, and expiration date. The facility further failed to calculate R57 ' s expiration date from the date opened accurately. These deficient practices placed the affected resident at risk for ineffective medications.

Findings included:

- On 07/05/23 at 08:15 AM, observation of the B-Court treatment cart revealed the following:
R33's Victozia (non-insulin injection used to lower blood sugar) flex pen lacked an open date and expiration date.
R57's insulin glargine (long acting) flex pen was

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opened 06/27/23 and documented an an inaccurate expiration date of 08/22/23 (56 days). A Humalog (fast acting) insulin pen which had no name, and no open date. Staff identified the pen belonged to R61 but were unsure when it was opened.

On 07/05/23 at 08:25 AM, observation of A-Court treatment cart revealed the following:
R7's Novolog (a short acting insulin) flex pen lacked an open date, and a date of expiration.

On 07/05/23 at 08:50 AM, Licensed Nurse (LN) I verified the nurses were to date the insulin pens/vials when opened and discard the expired insulin.

On 07/11/23 at 10:30 AM, Administrative Nurse D verified the nurses should label and date the insulin pens with the resident's name and discard expired pens.

On 07/12/23 Medlineplus.gov directs unrefrigerated insulin glargine pens can be used within 28 days; after that time, they must be discarded. Opened Novolog and Humolog pens may be stored at room temperature for up to 28 days.

The facility's "Storage of Medications" policy, dated December 2021, documented the community shall store all drugs and biologicals in a safe, secure, and orderly manner. The community shall not use discontinued, outdated, or deteriorated drugs and biologicals.

The facility failed to label and date the resident's insulin vials, with date opened and expiration dates and failed to properly calculate the date the

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insulin could be used placing the residents at risk for ineffective medication.

-On 07/05/23 at 08:30 AM observation of the D-Court medication room revealed Resident (R) 231's Novolog (fast acting) insulin pen lacked an open date and expiration date.

On 07/05/23 at 08:30 AM Licensed Nurse (LN) H verified the insulin pen lacked open and expire dates for R231's Novolog insulin pen.

On 07/12/23 Medlineplus.gov directs open Novolog pens may be stored at room temperature for up to 28 days.

The facility's "Storage of Medications", policy dated12/2017, documented the community shall store all drugs and biologicals in a safe, secure, and orderly manner. The community shall not use discontinued, outdated, or deteriorated drugs or biologicals.

The facility failed to date R231's insulin pen, when opened, to ensure appropriate expiration, putting the resident at risk for receiving outdated medication/biological that may cause adverse consequences.