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	355104	A. BUILDING _____ B. WING _____	C 05/25/2023

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GOOD SAMARITAN SOCIETY - LAKOTA	608 4TH AVE SW LAKOTA, ND 58344

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The Standard Medicare/Medicaid recertification survey started on 05/22/23 and concluded 05/25/23. The concerns identified by the complainants were unsubstantiated.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.17.1), and staff interview, the facility failed to ensure accurate coding of the Minimum Data Set (MDS) for 3 of 12 sampled residents (Resident #28, #32, and #34). Failure to accurately complete the MDS does not allow each resident's assessment to reflect their current status/needs and may affect the accurate development of a comprehensive care plan and the care provided to the residents. Findings include: SECTION P: PHYSICAL RESTRAINTS The Long-Term Care Facility RAI User's Manual, revised October 2019, pages P-1 and P-5, stated, ". . . PHYSICAL RESTRAINTS: Any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or normal access to one's body. . . . Coding	F 641	1) For Resident #28, the MDS□s dated 3/3/23 and 12/3/22 will be modified to reflect that a bed rail was not used as a restraint. For Resident #32, the MDS dated 2/22/23 will be modified to reflect that a bed rail was not used as a restraint. For Resident #34, the MDS dated 3/19/23 will be modified to reflect no anticoagulant use in the look back period. 2) All residents have the potential to be affected by this deficient practice. 3) Education will be provided to all staff who code the MDS in our facility by the Administrator or designee on the requirement of accurate coding of MDS, to include restraints and anticoagulant on June 20, 2023. 4) Audits of completed MDS□ will be performed by the Clinical Care Leader or Designee for the correct coding of restraints as well as anticoagulants with the following frequency: 100% of MDS completed 1X / for 4 weeks, then 50% of MDS completed 1X / month for 2 months, then 3 completed MDS 1 X / quarter for 3	6/29/23

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

Electronically Signed | 06/08/2023

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F 641	Continued From page 1 Instructions: . . . After determining whether or not an item . . . is a physical restraint and was used during the 7-day look-back period, code the frequency of use: Code 0, not used: if the item was not used during the 7-day look-back or it was used but did not meet the definition. . . . Code 2, used daily: if the item met the definition and was used on a daily basis during the look-back period. . . ." - Observation on 05/22/23 at 5:17 p.m. showed bilateral side rails at the head of Resident #28's bed. Review of Resident #28's medical record occurred on all days of survey. The quarterly MDS, dated 03/03/23, and the annual MDS, dated 12/03/22, identified bed rail used daily as a restraint. The Physical Restraint Care Area Assessment (CAA), dated 12/03/22, stated, "Resident uses bed rail to aid in repositioning and getting out of bed. Resident is able to get around bed rail without any issues. . . . Assist bars do not restrain resident, she uses them to aid her in getting up from her bed and getting back into bed." The current care plan stated, "BED MOBILITY: . . . Resident is able to: position herself as desires in bed. . . . Assist bars on bed to aide in repositioning. . . ." A "Physical Device and/or Restraint Evaluation and Review" form, dated 03/07/23, showed staff checked "no" to the question, "Would the assist/grab bar(s) be a restraint for this resident?" - Review of Resident #32's medical record	F 641	quarters. Inaccurate coding will be immediately reported to MDS nurse, DNS and administrator for correction. The audit findings will be reviewed at our weekly department head meetings as well as integrated into our QAPI Program. 5) This corrective action will be completed by June 29, 2023.	

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F 641	Continued From page 2	F 641		

occurred on all days of survey. The quarterly MDS, dated 02/22/23, identified bed rail used daily as a restraint.

The current care plan stated, "The resident uses physical restraints assist bars R/T [related to] mobility E/B [evidenced by] independent bed mobility. . . STRENGTH: Resident is able to: reposition self in bed. . ."

A "Physical Device and/or Restraint Evaluation and Review" form, completed 02/22/23, showed staff checked "no" to the question, "Would the assist/grab bar(s) be a restraint for this resident?"

During an interview on 05/24/23 at 6:30 p.m., an administrative nurse (#1) confirmed the facility coded Resident #28 and #32's restraint use incorrectly.

SECTION N: MEDICATIONS

The Long-Term Care Facility RAI User's Manual, revised October 2019, pages N-6 and N7, stated, ". . . Coding Instructions N0410A-H: Code medications according to the pharmacological classification, not how they are being used. . . . N0410E, Anticoagulant [blood thinner] . . . Record the number of days an anticoagulant medication was received by the resident at any time during the 7-day look-back period (or since admission/entry or reentry if less than 7 days). Do not code antiplatelet medications such as aspirin . . . here."

Review of Resident #34's medical record occurred on all days of survey. The admission MDS, dated 03/19/23, identified the resident

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F 641	Continued From page 3 received an anticoagulant for six days of the look back period. The resident's orders showed the resident received Aspirin 325 milligrams one time a day for coronary artery disease and lacked an order for an anticoagulant. During an interview on 05/25/23 at 11:20 a.m., an administrative nurse (#1) confirmed the facility incorrectly coded Resident #34's MDS for an anticoagulant.	F 641		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(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. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the	F 657		6/29/23

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F 657	Continued From page 4 comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to review and revise comprehensive care plans to reflect the current status for 4 of 12 sampled residents (Resident #4, #26, #29, and #32). Failure to review and revise the care plan limited staffs' ability to communicate needs and ensure continuity of care. Findings include: Review of the facility policy titled "Care Plan" occurred on 05/25/23. This policy, dated 09/22/22, stated, ". . . Comprehensive care plan includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. . . . The plan of care will be modified to reflect the care currently required/provided for the resident. The care plan will emphasize the care and development of the whole person ensuring that the resident will receive appropriate care and services. . . ." - Observation throughout the survey showed Resident #29 in bed and requiring extensive staff assistance for all his activities of daily living (ADLs). Review of Resident #29's medical record occurred on all days of survey. A physician's order, dated 05/15/23, stated, "Admit to HOSPICE care effective 5/14/23 Dx [diagnosis]: Senile degeneration of brain."	F 657	1) Resident #29's care plan cannot be updated as he was discharged on 5/27/23. Resident #26's care plan will be updated to include diabetes mellitus, with dietary and insulin interventions and to include atrial fibrillation with anticoagulant intervention. Resident #4's care plan will be updated to reflect his toileting abilities. Resident #32's care plan will be updated to reflect the use of a bed alarm. 2) All residents have the potential to be affected by this deficient practice. During the audit process, over the period of six months, we do plan to review every care plan in our facility. 3) Education will be provided to all staff responsible for updating care plans by the Administrator or designee on accurate / timely updating of the care plan and its significance to the resident's care on June 20, 2023. 4) Audits will be performed by the Director of Nursing or Designee on the accurate / timely updating of care plans with the following frequency: three random residents per week for two months, two residents per week for one month, and one resident per week for three months. The audit findings will be reviewed at our weekly department head meetings as well as integrated into our QAPI Program. The audit findings will be reviewed at our weekly department head meetings as well as integrated into our	

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F 657	Continued From page 5 A significant change Minimum Data Set (MDS), dated 05/08/23, identified extensive assistance of two staff for most of the ADLs, non-ambulatory, and weight loss not prescribed. The Cognition Care Area Assessment (CAA) stated, "Resident has dementia and is currently experiencing overall decline in his health which is impacting not only his cognitive abilities but also his abilities to interact with and accurately interpret his environment. . . ." A nurse's note, dated 05/18/2023 at 11:40 a.m., stated, ". . . The CNA [certified nurse aide] reported that he was complaining of chest pain. Resident was unable to rate the pain or describe it. . . . Oxygen was applied at 5 LPM/NC [liters per minute per nasal cannula]. Sats [oxygen saturation] went up tp [sic] 100% so O2 [oxygen] was decreased to 2.5 LPM/NC. . . ." Resident #29's current care plan lacked revisions related to his significant change (decline in ADLs/increased assistance), admission to hospice, and oxygen use. During an interview on 05/25/23 at 11:40 a.m., an administrative nurse (#1) stated the facility staff should have updated Resident #29's care plan with changes related to his current condition. - Review of Resident #26's medical record occurred on all days of survey. Diagnoses included diabetes mellitus and atrial fibrillation. Physician's orders included long-acting insulin, oral antidiabetic agents, weekly blood glucose monitoring, and an anticoagulant.	F 657	QAPI Program. 5) This corrective action will be completed by June 29, 2023.	

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F 657	Continued From page 6	F 657		

Resident #26's current care plan lacked information related to diabetes mellitus such as dietary needs or insulin. The care plan lacked information related to the use of anticoagulants for atrial fibrillation.

During an interview on 05/25/23 at 11:10 a.m., an administrative nurse (#1) stated the care plan should include problems and interventions pertinent to current diagnoses.

- Review of Resident #4's medical record occurred on all days of survey. A quarterly MDS, dated 03/21/23, identified the resident as independent with toileting. Observation on 05/22/23 showed the resident utilized a urinal independently at bedside.

The current care plan lacked information related to Resident #4's toileting abilities.

During an interview on 05/25/23 at 11:00 a.m., an administrative nurse (#1) confirmed she expected the current care plan to reflect the resident's ADLs, including toileting.

- Review of Resident #32's medical record occurred on all days of survey.

A progress note, dated 04/29/23, stated, ". . . Writer heard bed alarm go off and responded. . ." The current care plan stated, ". . .The resident has had an actual fall with no injury R/T [related to] history of falls . . . ENVIRONMENTAL: Modify to maximize safety. Fall mat, low bed, and close proximity to nurses station. . ." The care plan failed to identify the use of a bed alarm for Resident #32.

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F 657	Continued From page 7 During an interview on 05/25/23 at 11:00 a.m., an administrative nurse (#1) confirmed facility staff failed to modify Resident #32's care plan to reflect the addition of a bed alarm.	F 657		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and resident and staff interview, the facility failed to ensure 1 of 1 sampled resident (Resident #25) on fluid restrictions received the care and services necessary to attain the highest degree of physical well-being possible. Failure to provide the appropriate amount of fluids and monitor accurate intake placed the resident at risk for adverse effects from fluid overload. Findings include: Review of the facility policy titled "Residents at Risk for Dehydration, Fluid Maintenance" occurred on 05/25/23. This policy, dated 05/08/23, stated, ". . . Fluid Restriction . . . Fluids will be distributed between meals, snacks and medication pass based on resident preferences, as able. . . . The fluid allocations will be added to	F 684	1) Resident #25's fluid restriction will be discontinued as he is consistently non-compliant with the order. 2) All residents with a fluid restriction have the potential to be affected by this same deficient practice. 3) Education will be provided to all staff whom have the ability to document intake and output on a resident, specifically how to handle a resident on a fluid restriction. In addition, GSS-Lakota begin to will follow GSS policy on fluid restrictions, namely, the GSS #195 will be utilized when any resident is on a fluid restriction. This form facilitates communication between nursing and food and nutrition services. Nursing and the Supervisor of Food and Nutrition will confer weekly and decide when and who will provide the	6/29/23

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F 684	Continued From page 8 the resident's care plan using two fluid restriction interventions. The care plan intervention Fluid Restriction (1 of 2) contains the detail of the fluid allocation and care plan intervention Fluid Restriction (2 of 2) places a notification on the Kardex that the resident is on fluid restriction. This notification is viewable by CNAs [certified nurse aides] and other department personnel . . ." During an interview on 05/22/23 at 12:10 p.m., Resident #25 stated he has water on his lungs and his doctor referred him to a "lung" doctor [appointment on 07/21/23]. He stated he is on a water restriction due to swelling in his legs. Observation showed a one liter (1000 milliliter [ml]) covered water mug with a straw on the bed side table. The resident stated he drank about half the water since staff filled it at around 2:00 or 3:00 a.m. and expressed dissatisfaction this mug of water was all he could have all day with the restriction. Review of Resident #25's medical record occurred on all days of survey. Diagnoses included heart failure and chronic kidney disease. The quarterly Minimum Data Set (MDS), dated 04/06/23, identified intact cognition and shortness of breath with exertion. A physician order, dated 01/29/23, stated, "Fluid restriction of 1500 ml daily [decreased from 2000 ml]. two times a day total intake for 24 hours documented." The current care plan stated, ". . . Monitor for (overconsumption of fluids) . . . Explain and reinforce to resident the importance of . . . 1500 ML fluid restriction . . . The resident has fluid	F 684	fluids, then complete the form and notify the CNAs and food and nutrition employees. A required task will also be added to Point of Care documentation for the CNAs, Activity Aides and various other staff that would chart in Point of Care. The MAR and TAR will also be edited to require documentation of fluid intake for the CMAs and Nurses. The diet card will reflect the information, and the amount of fluid for each shift will be entered into the resident's care plan under interventions. Documentation will be required on the water cart for anyone who passes water to the residents. This education will be provided by the Administrator or designee on June 20, 2023. 4) Audits will be performed by the Director of Nursing or Designee on the accurate documentation of fluid intake with the following frequency: three random residents per week for two months, two residents per week for one month, and one resident per week for three months. The audit findings will be reviewed at our weekly department head meetings as well as integrated into our QAPI Program. The audit findings will be reviewed at our weekly department head meetings as well as integrated into our QAPI Program. 5) This corrective action will be completed by June 29, 2023.	

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F 684	Continued From page 9	F 684		

overload or potential fluid volume overload R/T [related to] (. . . heart failure) . . . Resident will remain free of s/s [signs/symptoms] of fluid overload through review date, as evidenced by no SOB [shortness of breath], reduced edema [swelling due to excess fluid accumulation] to lower extremities. . . . FLUID RESTRICTION (2 of 2): Resident is on a fluid restriction. See charge nurse before giving any fluids between meals. Document all fluids provided. 1500 ml per day. . . ."

Care plan reviews completed by dietary staff stated the following:
* 01/10/23, "Weight . . . up 16 lbs [pounds] during quarter. Fluid? . . . 2000 ml fluid restriction to be split evenly with nursing. Often noncompliant with dining room and will consume 1200-1800 ml on average with meals. Independent with meals, makes needs and wants known. Will educate staff and resident on importance of following fluid restrictions. No changes at this time regarding care plan."
* 04/18/23 at 3:53 p.m., ". . . [Ate] 100% at meals with 6 cups of fluid with meals per day (1500 CCs [cubic centimeters -equivalent to milliliters]) Resident does have order for 1500 cc fluid restriction and is non compliant. . . ."

The meal intake record for April 25-May 24, 2023 showed staff documented from 990 ml to 1800 ml of fluid intake daily with meals. On 11 of the 30 days, Resident #25 consumed 1800 ml daily. Staff failed to ensure the resident followed the physician's order or have a plan to keep the intake within an average of 1500 ml daily, which put the intake over the restricted amount and left no fluids for snacks, medication pass, or to drink

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F 684	Continued From page 10 in his room. Resident #25's intake record for fluids outside of meals for April 25-May 24, 2023 showed staff recorded an entry during the day shift on five days, ranging from 0 to 700 ml water. Staff failed to document the resident's intake of water on 25 of the 30 days reviewed and twice daily as ordered. Staff failed to document other fluids offered with snacks or medication pass on all 30 days. On 05/24/23 at 5:20 p.m., an administrative nurse (#1) stated they recently started a book where staff record all of the residents' non-meal fluid intake for each shift. Observation showed the forms used, dated from May 1-11, 2023, had two columns labeled with times of 9:00 a.m. and 2:00 a.m. Staff entered fluid intake in both columns on three of the days and the other days in just one column. Resident #25's documented intake ranged from 600-880 ml on eight of the days. The facility failed to allocate the amount of the resident's 1500 ml fluid restrictions to be available for consumption with meals or at non-meal times, which increased the risk of exceeding the restrictions. During interviews on 05/24/23, staff stated the following: * 12:11 p.m., a dietary manager (#6) stated Resident #25 was on a 1500 cc fluid restriction but was "very noncompliant. If he was compliant, then we would split the fluid half and half with nursing, so dietary would total 750 [ml] and nursing 750 [ml] fluids." * 5:22 p.m., an administrative nurse (#1) stated, "The kitchen figures out how much fluid they give and let nursing know what they can give" when on fluid restrictions. The nurse stated staff pass	F 684		

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F 684	Continued From page 11 water three times daily, about 6:00 a.m., 2:30 p.m., and during the night. * 5:30 p.m., a CNA (#7) stated staff passed water between 1-2 p.m. and not everyone knew to record each residents' intake in the new book. The CNA stated staff usually passed water in the morning also and believed staff passed water during the night shift. Failure to have a consistent practice of passing water, ensure staff documented all fluid intake (not just with meals), ensure staff awareness of the amount of fluids allotted to meals and non-meal times, and ensure staff provide for and encourage adherence to fluid restrictions may contribute to a decline in health status, worsening edema, and shortness of breath.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed	F 686	1) Resident #34 has a new order as of 5/23/23 for the right gluteal fold wound,	6/29/23

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	355104	A. BUILDING _____ B. WING _____	C 05/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 686	Continued From page 12 to provide the necessary treatment/services to promote the healing and prevent the worsening of pressure ulcers for 1 of 2 sampled residents (Resident #34) with a pressure ulcer. Failure to consistently implement interventions to prevent the worsening of an existing pressure ulcer and failure to notify the physician of identified changes may have resulted in delayed treatment and deterioration of Resident #34's pressure ulcer. Findings include: Review of the facility policy titled "Skin Assessment Pressure Ulcer Prevention and Documentation Requirements" occurred on 05/24/23. This policy, dated April 2023, stated, ". . . If a pressure ulcer is identified, cleanse the area prior to observations being made to allow the wound bed and depth to be more accurately observed. . . . The registered nurse [RN] should record the type of wound and the degree of tissue damage on the Wound RN Assessment UDA [user defined assessment] (i.e., for a pressure ulcer, record the stage). . . . Notify the physician/practitioner of the ulcer and resident's condition to obtain orders for a treatment. . . ." A weekly skin assessment completed on 05/15/23 for Resident #34 identified a Stage 2 pressure ulcer of the right gluteal fold, application of a "duoderm" (type of dressing) but failed to include wound measurements. During an observation on 05/23/23 at 8:25 a.m., a CNA (#5) notified a staff nurse (#4) about a wound on Resident #34's gluteal fold. At 9:00 a.m., the nurse (#4) assessed, measured, and	F 686	which states, "Cleanse right gluteal fold with normal saline and apply Mepilex border dressing. Change daily and prn." 2) All residents with impaired skin integrity have the potential to be affected by this deficient practice. 3) Education will be provided to all nurses on the importance of communication with the physician with any new wound, worsening of wound, or need for new treatment of a wound. In addition, education will be provided on complete, timely and accurate wound and skin assessments. Lastly, wound rounds will begin on a monthly basis with at least RN and two other members of the interdisciplinary team. This education will be performed by the Administrator or designee on June 20, 2023. 4) Audits will be performed by the Director of Nursing or Designee on accurate and timely wound assessments as well as the proper notification of provider with the following frequency: one random resident with a wound or wounds per week for six months. The audit findings will be reviewed at our weekly department head meetings as well as integrated into our QAPI Program. The audit findings will be reviewed at our weekly department head meetings as well as integrated into our QAPI Program. 5) This corrective action will be completed by June 29, 2023.	

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F 686	Continued From page 13	F 686		

identified the wound as a "Stage 3" pressure ulcer. The nurse cleansed the wound and applied a dressing.

Review of Resident #34's medical record occurred on all days of survey. Diagnoses included diabetes mellitus, spondylopathy (arthritis of the spine), and pressure ulcer of left heel. The current care plan stated, ". . . The resident has Diabetes Mellitus . . . Check all of body for breaks in skin and treat promptly as ordered by health care provider . . . The resident has impairment to skin integrity R/T [related to] hip fx [fracture] leading to immobility EB [evidenced by] stage 2 to right gluteal and unstageable pressure sore to left heel. . . . Monitor location, size and treatment of skin injury. Report abnormalities, failure to heal, s/s [signs/symptoms] of infection, maceration, etc. to health care provider. . . ."

A Braden Scale (assessment for risk of skin breakdown) dated 04/20/23, identified the resident at mild risk for skin breakdown.

Review of Resident #34's May 2023 treatment administration record (TAR) lacked an order for wound care to the resident's right gluteal fold for eight days from May 15 to May 23, 2023. The medical record lacked documentation of physician notification of wound discovery on 05/15/23 or orders for intervention until 05/23/23.

During an interview on 05/25/23 at 11:10 a.m., an administrative nurse (#1) reviewed Resident #34's medical record and confirmed the record lacked physician notification and orders for treatment of the resident's right gluteal fold

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F 686	Continued From page 14 pressure ulcer.	F 686		
F 761 SS=D	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 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: Based on observation, review of facility policy, and staff interview, the facility failed to accurately label 3 of 8 opened multi-dose insulin vials (two vials of Lantus, a long-acting insulin, and one vial of Novolog, a short-acting insulin) in the refrigerator of the medication storage room. Failure to label multi-dose insulin vials with the	F 761	1) No residents were identified to be affected by this deficient practice. Upon discovery, insulin vials without opened date were destroyed. 2) All residents have the potential to be affected by this deficient practice. 3) Education will be provided to all	6/29/23

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F 761	Continued From page 15 opened date increases the risk of residents receiving outdated medications with reduced medication efficacy. Findings include: Review of the facility policy titled "Medication: Insulin Administration, Insulin Pens" occurred on 05/25/23. This policy, dated April 2023, stated, ". . . Multi-dose vials should have open date written on vial. Refer to Insulin Storage Parameters for storage times based on manufacturer recommendations. . . . Check label on vial carefully to ensure correct type of insulin and date vial was opened . . ." Observation of the medication storage room occurred on 05/25/23 at 10:10 a.m. with a staff nurse (#2). The locked medication refrigerator showed two open vials of Lantus insulin and one open vial of Novolog insulin that were not labeled with the opened date. The staff nurse (#2) stated staff should write on the vial or use a label affixed to the vials on which to write the opened date. The facility staff failed to follow facility policy for labeling multi-dose insulin vials with the opened date.	F 761	nurses on the GSS Medication: Insulin Administration policy and procedure specific to the requirement of labeling insulin vials with the opened date. Multi-dose vials should have an open date written on the vial. This education will be provided by the Administrator or designee on June 20, 2023. 4) Medication Storage Audits will be performed by the Director of Nursing or Designee to verify all open insulin vials have an “opened date” with the following frequency: weekly audit on all open insulins vials for six months. The audit findings will be reviewed at our weekly department head meetings as well as integrated into our QAPI Program. The audit findings will be reviewed at our weekly department head meetings as well as integrated into our QAPI Program. 5) This corrective action will be completed by June 29, 2023.	