| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| **ARMA OPERATOR, LLC** | **605 E MELVIN STREET PO BOX 789 ARMA, KS 66712** |

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| F 000 | INITIAL COMMENTS<br><br>The following citations represent the findings of a Health Resurvey and complaint investigation #153890.<br><br>This 2567 was electronically sent to the facility on 8/31/21. | F 000 | | |
| F 657 SS=D | Care Plan Timing and Revision<br>CFR(s): 483.21(b)(2)(i)-(iii)<br><br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(2) A comprehensive care plan must be-<br>(i) Developed within 7 days after completion of the comprehensive assessment.<br>(ii) Prepared by an interdisciplinary team, that includes but is not limited to--<br>(A) The attending physician.<br>(B) A registered nurse with responsibility for the resident.<br>(C) A nurse aide with responsibility for the resident.<br>(D) A member of food and nutrition services staff.<br>(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.<br>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.<br>(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.<br>This REQUIREMENT is not met as evidenced | F 657 | | |

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

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by:
The facility reported a census of 41 residents. The sample contained 12 residents. Based on interview and record review, the facility failed to review and revise the care plan for two sampled residents including, Resident (R)6, related to interventions following falls to prevent further accidents and R31, related to care and services for a urinary catheter to prevent urinary tract infections and/or urethral trauma.

Findings included:

- The signed "Physician Order Sheet" (POS), dated 07/16/21, documented R6's diagnoses included anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), depressive disorder (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, emptiness and hopelessness), and unspecified dementia (progressive mental disorder characterized by failing memory, confusion).

A significant change "Minimum Data Set" (MDS), dated 05/27/21, documented the resident as unable to complete the "Brief Interview for Mental Status" (BIMS). Staff assessed R6 with short and long-term memory problems. R6 required extensive assistance with bed mobility, transfers, dressing, toileting, and personal hygiene.

A "Falls Care Area Assessment," dated 06/09/21, documented R6 was at risk for falls. She was non-compliant with asking for assistance for standing and often attempted to stand without staff assistance. The staff reviewed and revised the plan of care to ensure proper interventions

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were in place to prevent falls.

The fall care plan contained interventions including but not limited to the following:

Dycem (thin non-slip material) in the recliner seat, dated 03/06/21.

Moved bedside table closer so the resident could reach her drink, dated 03/14/21.

Staff education on current care plan including the use of dycem in the resident's recliner, dated 03/15/21. This intervention planned on 03/06/21 was to be implemented 9 days prior to this fall.

Provide 2 glasses of water for the resident while sitting in the day area, dated 04/17/21.

The resident was to sit in the recliner next to the nurse's station, dated 05/05/21.

When the resident sits in the recliner at the nurses' station, have distractions available for her. Magazines, snacks, pen, paper, dated 05/12/21.

Staff to toilet the resident at 06:00 AM, dated 05/18/21.

Staff to assisted the resident to the recliner, dated 07/14/21.

Nurses notes revealed the resident experienced several falls, including the following, in which the staff failed to provide/ensure planned interventions remained in place to prevent further falls, or failed to plan and implement new

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interventions following falls to prevent further falls.

1.) A Nursing Note, dated 05/02/21, documented R6 had an unwitnessed fall. The staff found the resident seated on the floor near the toilet in a peer's room. R6 stated she needed to use the bathroom.

A Fall Investigation, dated 05/02/21 at 02:00 PM, documented the resident needed to use the toilet, and the staff assisted the resident to the toilet. However, the staff failed to plan and implement an intervention to reduce her risk for additional falls when she need to go to the bathroom.

2.) A Nurses Note, dated 07/14/21, documented R6 had an unwitnessed fall from her wheelchair while attempting to transfer to a recliner. Staff assisted R6 to the recliner and her sock was adjusted.

A Fall Investigation, dated 07/14/21 at 06:11 PM, documented the resident wanted to sit in a recliner. The wheelchair was uncomfortable and she tried to take the cushion out. Staff transferred R6 to the recliner. However, the staff failed to plan and implement an intervention to reduce her risk for additional falls when she wanted in the recliner.

Observation, on 08/25/21 at 04:09 PM, revealed Certified Nursing Aide (CNA) Q assisted R6 to a recliner close to the nurses' station. However, the staff failed to ensure the recliner seat contained the planned intervention of the dycem and the staff also failed to provide any drinks to

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the resident as planned to prevent falls. Continued various observations over the next hour revealed the staff failed to provide the resident with any available drinks to prevent falls.

On 08/25/21 at 02:02 PM, CNA P stated something new was supposed to be in the care plan after a resident fell.

On 08/25/21 at 05:03 PM, Licensed Nurse I stated when a resident falls, nurses are expected to update the care plan with a new intervention to prevent further falls.

On 08/26/21 at 04:26 PM, Administrative Nurse D stated she would expect after a resident fell that some different intervention to try to keep residents from falling again would be put in place after each fall. Having dycem in the seat of the recliner and having two drinks beside the resident when in the recliner were care planned interventions for this resident to prevent further falls. It was expected that the staff followed the care planned interventions to prevent falls.

The facility failed to review and revise this resident's care plan to include interventions following falls to prevent further falls.

- The signed "Physician Order Sheet" (POS), dated 07/12/21, documented R31's diagnoses included benign prostatic hyperplasia (non-cancerous enlargement of the prostate which can lead to interference with urine flow, urinary frequency and urinary tract infections), and unspecified dementia (progressive mental disorder characterized by failing memory,

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| F 657 | Continued From page 5<br>confusion).<br><br>An annual "Minimum Data Set" (MDS), dated 06/24/21, documented R31's "Brief Interview for Mental Status" (BIMS) score was 15, which indicated he was cognitively intact. He did not have a urinary catheter.<br><br>The "Urinary Incontinence and Indwelling Catheter Care Area Assessment" documented the resident was always incontinent, and often declined to use a urinal or alert staff to need to use the toilet.<br><br>The current care plan, dated 06/23/21, lacked instruction for caring for his catheter.<br><br>A signed physician order, dated 07/12/21, instructed staff to change the resident's urinary catheter monthly and to change the bag weekly.<br><br>On 08/26/21 at 02:05 PM, Administrative Nurse D stated R31's catheter was identified in the plan of care, but instructions to the staff related to how to care for the urinary catheter were not.<br><br>A facility policy for updating the resident care plans was unavailable.<br><br>The facility failed to update this resident's plan of care with care instructions to the staff for his urinary catheter. | F 657 | | |
| F 689 SS=D | Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains | F 689 | | |

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as free of accident hazards as is possible; and

§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 41 residents with 12 selected for review including two reviewed for falls. Based on observation, interview, and record review, the facility failed to follow interventions on the care plan for Resident (R)35 to prevent further falls and failed to follow interventions on the care plan for R6 and implement new interventions following falls to prevent further falls.

Findings included:

- The "Order Summary Report," dated 07/16/21, for Resident (R)35 included diagnoses of muscle weakness, abnormalities of gait and mobility, unsteadiness on feet, and Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure).

The "Annual Minimum Data Set" (MDS), dated 04/19/21, assessed R35 with short and long term memory impairment and severely impaired decision making. She required extensive assistance of one staff for bed mobility, walking in and out of the room, locomotion on and off the unit, and toilet use. R35 required extensive assistance of two or more staff for transfers and her balance during transitions and walking was not steady and required staff assistance to stabilize. She used a wheelchair for mobility and had one non-injury fall since the last assessment.

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The "Falls Care Area Assessment" (CAA), dated 05/03/21, indicated R35 was at risk for falls and would not ask for assistance prior to ambulating, and would sometimes ambulate without proper footwear.

The "Quarterly MDS," dated 07/20/21, revealed no changes to the prior assessment except she did not walk in the corridor, she had two non-injury falls, and she had two falls with injury that were not major.

The "Care Plan," dated 08/24/21, included R35 was at risk for falls, was unaware of her safety needs, had confusion, comprehension was poor, she wandered, and had gait and balance problems. The interventions on the care plan included, but were not limited to, the following interventions:

1. A revised intervention, on 12/28/17, for gripper strips in the bathroom.

2. On 02/03/20, remove bedside table on wheels from my room, only take it into the room for short periods of time such as for meals in the room so R35 did not use it to regain balance.

3. On 06/30/21, Dycem (a thin nonslip material) in the wheelchair at all times.

The "Progress Notes," located in the EMR, revealed that R35 fell on these dates: 05/04/21, 05/15/21, 06/30/21, 07/13/21, 07/14/21, and 08/04/21.

On 08/23/21 at 09:22 AM, R35 was laying on her

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bed with eyes closed and a table with wheels sat parked several feet from the foot of the bed with a foam cup and a hairbrush on top.

On 08/23/21 at 03:10 PM, R35 exited her room walking while pushing her wheelchair and started down the hallway, Licensed Nurse (LN) G responded and provided assistance to walk with her for a short distance and then to sit in the wheelchair.

On 08/24/21 at 02:23 PM, R35 was resting in bed with her eyes closed. The wheelchair sat parked next to the bed which lacked the planned Dycem in place. The bathroom lacked the planned gripper strips, and there was a table with wheels parked in front of the recliner in her room.

On 08/25/21 at 08:35 AM, R35 was in her room in the wheelchair that was next to her bed. A table with wheels was in her room parked next to the wall just to the right of the doorway.

On 08/25/21 at 10:23 AM, Certified Nurse Aide (CNA) M and CNA N transferred R35 from the wheelchair to her bed. The wheelchair lacked the planned Dycem in place in the seat.

On 08/25/21 at 10:33 AM, CNA M stated that R35 was a fall risk and any new interventions would be communicated by the charge nurse, during other staff at shift change, and the electronic charting system. CNA M confirmed that at one point Dycem was to be in R35's wheelchair, the table with wheels should not be in her room as she will get up and use it as a way to walk and potentially fall because she will get up at times and walk around the room by herself. CNA M

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also believed that the gripper strips should be in the bathroom.

On 08/25/21 at 01:20 PM, LN G stated that R35 was a fall risk and interventions included Dycem to her wheelchair, gripper strips in front of the toilet in the bathroom, and she should not have a wheeled table in her room as she has used as a walker before. Initially with a new intervention, staff monitored it to make sure the intervention was in place and collectively as a team the aides know, for example, who has Dycem in their chair, and if the interventions are not in place they should be fixed. The CNA's should be told in report who has had a fall and the interventions, and it is also made available on the communication board in the electronic charting that we print off for the nurse for that shift report.

On 08/26/21 at 03:03 PM, Administrative Nurse D stated that interventions following a fall are placed on the care plan and would expect the staff to follow the care plan. The intervention regarding the table with wheels was one the family had built, and it was by the window with plants on it, we had it removed. Administrative Nurse D stated she did not feel the overbed table with wheels in her room was a safety issue because it would be more like a walker for her to use.

The facility policy "Falls and Fall Risk, Managing," dated 05/2021, instructed the staff will identify interventions related to a resident's specific risks and causes to try and prevent the resident from falling, and trying to minimize complications from falling. The interdisciplinary team will attempt to identify appropriate

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interventions to reduce the risk of falls. If interventions have been successful in preventing falling, staff will continue the interventions or reconsider whether these measures are still needed if a problem that required the intervention (dizziness, weakness) has resolved.

The facility failed to follow interventions on the care plan for R35 to reduce her risk of repeated falling.

- The signed "Physician Order Sheet" (POS), dated 07/16/21, documented R6's diagnoses included anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), depressive disorder (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, emptiness and hopelessness), and unspecified dementia (progressive mental disorder characterized by failing memory, confusion).

A significant change "Minimum Data Set" (MDS), dated 05/27/21, documented the resident unable to complete "Brief Interview for Mental Status" (BIMS). Staff assessed R6 had short and long-term memory problems. R6 required extensive assistance with bed mobility, transfer, dressing, toileting, and personal hygiene.

A "Falls Care Area Assessment," dated 06/09/21, documented R6 was at risk for falls. She was non-compliant with asking for assistance with standing and often attempted to stand without staff assistance. The staff reviewed and revised the plan of care to ensure proper interventions were in place to prevent falls.

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| F 689 | Continued From page 11<br><br>The fall care plan contained interventions as follows:<br><br>Resident likes to sit on the floor and at times gets out of bed to sit on the fall mat, dated 03/02/21.<br><br>New call light in the room and toileted, dated 03/05/21.<br><br>Dycem (thin non-slip material) in the recliner, dated 03/06/21.<br><br>Assisted to wheelchair to propel self, dated 03/14/21.<br><br>Moved bedside table closer so the resident could reach her drink, dated 03/14/21.<br><br>Staff education on current care plan including the use of dycem in the resident's recliner, dated 03/15/21.<br><br>Ensure restrooms near the front lobby are locked at all times, dated 03/20/21.<br><br>Ensure that resident wears appropriate footwear tennis shoes or non-skid socks when ambulating or mobilizing in w/c, dated 04/08/21.<br><br>Keep frequently used items next to resident, dated 04/14/21.<br><br>Provide 2 glasses of water for resident while sitting in day area, dated 04/17/21.<br><br>Resident to sit in recliner next to nurse's station, dated 05/05/21. | F 689 | | |

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Check orthostatic blood pressures for 72 hours, dated 05/12/21.

When resident is sitting in recliner at nurses' station have distractions available for her. Magazines, snacks, pen, paper, dated 05/12/21.

Toilet resident at 06:00 AM, dated 05/18/21.

Assisted resident to recliner, dated 07/14/21.

Offer snack in bed if agitated, dated 07/20/21.

Do not leave resident unattended in bathroom. Resident has a tendency to attempt self-transfers and not alert staff for need to toilet or wait for staff assistance, dated 08/05/21.

Resident needs a safe environment with: even floors free from spills and/or clutter; adequate, glare-free light; a working and reachable call light, the bed in low position at night; Slide fails as ordered, handrails on walls, personal items within reach, dated 08/05/21.

A "Nursing Note," dated 03/15/21 at 06:49 PM, documented R6 scooted her bottom to the foot of the recliner, then onto the floor. Intervention identified to place dycum in the recliner per care plan. Staff educated on the current plan of care.

A "Fall Investigation," dated 03/15/21, documented R6 sat on the footrest of the recliner and slid down.

On 08/26/21 at 04:30 PM, Administrative Nurse D verified staff were not following the care plan,

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failing to put dycem in the recliner, and she reeducated staff regarding the plan of care.

A "Nursing Note," dated 05/02/21 documented R6 had an unwitnessed fall. Resident sat near the toilet in a peer's room. R6 stated she needed to use the bathroom.

A "Fall Investigation," dated 05/02/21 at 02:00 PM, documented the resident needed to use the toilet, and the staff assisted the resident to the toilet.

However, the staff failed to plan and implement an intervention to reduce her risk for additional falls.

A "Nurses Note," dated 07/14/21, documented R6 had an unwitnessed fall from her wheelchair while attempting to transfer to a recliner. Staff assisted R6 to the recliner and her sock was adjusted.

A "Fall Investigation," dated 07/14/21 at 06:11 PM, documented the resident wanted to sit in a recliner. The wheelchair was uncomfortable and she tried to take the cushion out. Staff transferred R6 to the recliner. Staff failed to plan and implement an intervention to reduce her risk for additional falls.

On 08/24/21 at 02:20 PM, R6 perused a magazine while seated in a recliner close to the nurses' station. No dycem was in the recliner, and she had no drinks available.

On 08/25/21 at 04:09 PM, Certified Nursing Assistant (CNA) Q assisted R6 to a recliner close

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to the nurses' station. No dycem was in the recliner seat, and staff failed to provide any drinks to the resident. Continued various observations over the next hour revealed the resident lacked any available drinks.

On 08/25/21 at 11:12 AM, CNA P stated when R6 was in the recliner, someone was there to keep an eye on her. In the afternoon she was awake and so we give her magazines to keep her occupied. We generally just give her magazines unless she asks for something else.

On 08/25/21 at 03:53 PM, CNA Q stated we have to keep her so we supervise her as we walk by. We have to check on her. At night, she gets more active, so then she is in the recliner. She gets magazines to keep her occupied.

On 08/25/21 at 05:16 PM, Licensed Nurse I stated R6 is very impulsive and sundowns (condition where a person tends to become confused or disoriented toward the end of the day) badly in the evening, and voices delusions. Sometimes she thinks that her son is coming to get her, or that her car is outside. She becomes angry and threatens things such as her intent to throw her wheelchair out the window. She is happy and pleasant during the day, but very angry in the evenings. We keep an eye on her when she is in her wheelchair and give her snacks and whatever she asks for.

On 08/26/21 at 04:26 PM, Administrative Nurse D stated she would expect some different intervention to try to keep residents from falling again be put in place after each fall. Having dycem in the seat of the recliner and having two

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| F 689 | Continued From page 15<br>drinks beside the resident when in the recliner are care planned interventions in place for this resident to prevent falls. It is expected that care planned interventions to prevent falls are followed by the staff.<br><br>A facility policy titled "Falls and Fall Risk, Managing F689," dated 05/21, instructed the Interdisciplinary Team (IDT) will attempt to identify appropriate interventions to reduce risk of falls ... If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant. The IDT will identify and implement relevant interventions.<br><br>The facility failed to reduce risk for falling by failing to implement care planned interventions of providing dycem and drinks when in the recliner and failed to identify and implement new interventions for two falls in this resident. | F 689 | | |
| F 690 SS=D | Bowel/Bladder Incontinence, Catheter, UTI<br>CFR(s): 483.25(e)(1)-(3)<br><br>§483.25(e) Incontinence.<br>§483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.<br><br>§483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-<br>(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the | F 690 | | |

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resident's clinical condition demonstrates that catheterization was necessary;
(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and
(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.

§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 41 residents. The sample contained 12 residents, with one selected for review of urinary catheters. Based on observation, interview and record review, the facility failed to appropriately manage the catheter of one of one resident, to prevent urinary tract infections and or urethral trauma to Resident (R) 31.

Findings included:

- The signed "Physician Order Sheet" (POS), dated 07/12/21, documented R31's diagnoses included benign prostatic hyperplasia (non-cancerous enlargement of the prostate which can lead to interference with urine flow,

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urinary frequency and urinary tract infections), and unspecified dementia (progressive mental disorder characterized by failing memory, confusion).

An annual "Minimum Data Set" (MDS), dated 06/24/21, documented R31's "Brief Interview for Mental Status" (BIMS) score was 15, which indicated he was cognitively intact. He did not have a urinary catheter.

The "Urinary Incontinence and Indwelling Catheter Care Area Assessment" documented resident was always incontinent, and often declined to use a urinal or alert staff to need to use the toilet.

The current care plan, dated 06/23/21 lacked instruction for caring for his catheter.

A signed physician order, dated 07/12/21, instructed staff to change the catheter monthly and change the bag weekly.

On 08/23/21 at 09:37 AM, R31's tubing touched directly on the ground, approximately 5 inches, as he sat in his wheelchair in the dining room.

On 08/23/21 at12:04 PM, R31 sat in his room in his wheelchair. He did not have an anchor to secure his catheter and approximately five inches of the catheter tubing touched directly on the floor.

On 08/23/21 at 01:51 PM, approximately five inches of R31's catheter tubing dragged along the floor as he propelled himself in his wheelchair.

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On 08/23/21 at 02:27 PM, R31 used a pedal exerciser in his room. Approximately five inches of the catheter tubing raised and lowered and scraped directly across on the floor with each pedal rotation.

On 08/25/21 at 07:33 AM, R31's Licensed Nurse (LN) I verified R31's catheter was unanchored and unsecured.

On 08/25/21 at 08:10 AM, Certified Nursing Assistant (CNA) O and CNA P used a full lift to transfer R31 from his bed to his wheelchair. During transport, the foley bag remained suspended from a loop on the sling, causing the foley bag to hang at the level of the resident's neck and above the bladder, throughout the transfer.

On 08/25/21 at 08:15 AM, CNA O stated the catheter urine collection bag should remain lower than R31's bladder and verified that they failed to do so during the transfer. His catheter should be anchored and the tubing should remain off the floor.

08/25/21 at 09:10 AM, LN I stated catheter tubing should be off of the floor at all times, and the urine collection bag should remain below the level of his bladder. The catheter should remain anchored to prevent any urethral trauma.

On 08/26/21 at 02:05 PM, Administrative Nurse D stated she expected R31's catheter tubing to remain off of the floor, and the urine collection bag kept below the level of the resident's bladder. Catheter tubing should be anchored to secure it

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| F 690 | Continued From page 19<br>from causing urethral trauma.<br><br>A facility policy titled "Indwelling Urinary Catheters F690," dated 05/2021, instructed the urinary drainage bag must be held or positioned lower than the bladder at all times to prevent the urine in the tubing and drainage bad from flowing back into the urinary bladder ...be sure the catheter tubing and drainage bag are kept off the floor. Ensure that the catheter remains secured with a leg strap to reduce friction and movement.<br><br>The facility failed to appropriately manage the urinary catheter to prevent urinary tract infections and or urethral trauma to this resident. | F 690 | | |
| F 761 SS=E | Label/Store Drugs and Biologicals<br>CFR(s): 483.45(g)(h)(1)(2)<br><br>§483.45(g) Labeling of Drugs and Biologicals<br>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.<br><br>§483.45(h) Storage of Drugs and Biologicals<br><br>§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.<br><br>§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 | F 761 | | |

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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 reported a census of 41 residents. Based on interview and observation, the facility failed to appropriately label and store drugs for five residents; when two insulin medications lacked open dates for Resident (R ) 31 and 147; two eye drops lacked opened dates for R30 and R19; and two expired medications remained in the medication carts for R15 and R21.

Findings included:

- On 08/24/21 at 02:24 PM, inspection of the Certified Medication Aide (CMA) medication cart with CMA R revealed the following:
One opened bottle of flonase nasal spray, with pharmacy labeled for Resident (R)15, with an expiration date of 05/15/20.
One open bottle of pataday eye drops, with pharmacy labeled for R19, which lacked an opened date.
One opened bottle of latanoprost eye drops, with pharmacy labeled for R30, which lacked an open date.

Furthermore, on 08/24/21 at 04:58 PM, inspection of the west nurses' medication cart, with Licensed Nurse (LN) H, revealed the following:

One open aspartamine insulin pen, ready for use, with pharmacy labeled for R147, which lacked an

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open date. LN H stated she opened it today and forgot to date it.

One open humalog insulin pen, ready for use, with pharmacy labeled for R31, which lacked an open date. LN H verified the pen was undated and almost empty.

One open bottle of ondanstron oral drops, ready for use, with pharmacy labeled for R21, expired on 05/25/21.

On 08/24/21 at 02:30 PM, CMA R stated eye drops should be dated when they are opened. There should not be expired medications in the medication cart.

On 08/24/21 at 05:05 PM, LN H stated she would expect to see open dates on the insulin pens and other medications like eye drops. She would not expect to find expired medications in the medication carts.

On 08/26/21 02:05 PM, Administrative Nurse D stated she expects expired medications would be removed from the medication carts, and would expect eye drops, and insulin pens to be labeled with the date they are opened.

A facility policy titled "Storage of Medications F761," dated 05/2021, instructed the facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. The policy lacked instruction regarding dating medications with open date.

The facility failed to appropriately label and store drugs for these five residents.

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