STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415106	A. BUILDING _____ B. WING _____	09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANTOINE RESIDENCE	10 RHODES AVENUE NORTH SMITHFIELD, RI 02896

(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 A Recertification Survey was conducted at St. Antoine Residence from 09/20/2021 through 09/23/2021 to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. A State licensure and emergency preparedness surveys were also conducted at this facility. Deficiencies were identified and noted on the enclosed CMS "Statement of deficiencies" 2567L.	F 000	This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of any conclusion set forth in the statement of deficiencies.	10/15/21
F 578 SS=E	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the	F 578 10/8/21	Residents 27, 58, 73, 121, 135, 250 1. Advanced directives were reviewed by MD/ Patient/HCP and were clarified. MD and resident or responsible party with verification. All supporting paperwork is consistent with wishes of MC/Patient/HCP. 2. All residents in the building were assessed and all new advanced directives were written with families, residents, or power of attorney's verbal consent and reviewed by MD and signed to ensure that all residents have the code status that they wish. 3. Education with appropriate staff on the advanced directives policy and procedure and the importance of accuracy with the code status. 4. Weekly audit completed by social services/ and or designee, on a weekly basis for all new admissions for current codes status and proper documentation. 5. Review quarterly at care plan meeting all code status for changes. 6. All results of audits to be brought to QAPI process for review for minimal of 3 months or until QAPI team has determined that the facility is meeting the requirement. The Executive Director is ultimately responsible to ensure compliance.	10/15/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Nanett Sullivan	Administrator	10/8/2021

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 578	Continued From page 1 requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it has been determined that the facility failed to ensure that the resident's formulated advance directive would be followed as there was inconsistency between the paper medical record and the Electronic Medical Record (EMR) for 6 of 32 reviewed for advance directives, Resident ID #s 27, 58, 73,121,135, & 250. Findings are as follows: Record review revealed that the facility was using a form entitled,"Physician/ NP (Nurse Practitioner)/ PA (Physician Assisitant) Progress Note; Code status/Advance Directive (legal document that explains how you want medical decisions about you to be made if you cannot make the decisions yourself)Discussion." 1.Record review for Resident ID #27 revealed an advance directive for Full Code, with an illegible Provider date. An additional advance directive of DNR (Do Not Resuscitate), DNI (Do Not	F 578		

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F 578	Continued From page 2 intubate) and No Feeding Tube dated 5/21/2020 was found in the resident's paper chart, all documents were unsigned by the resident. The Physician's order revealed DNR, DNI, No Feeding Tube. 2. Record review for Resident ID #58 revealed an advance directive for DNR, DNI, DNH (Do Not Hospitalize) in the resident's paper chart dated 7/15/2021,without a resident signature. The Physician order in the EMR revealed DNR. 3. Record review for Resident ID #73 revealed an advance directive for DNR, DNI in the resident's paper chart dated 7/26/2021, without a resident signature. The Physician order in the EMR revealed DNR. 4. Record review for Resident ID #121 revealed an advance directive for DNR, DNI, DNH (except trauma), no feeding tube, in the resident's paper chart dated 11/3/2020, without a resident signature. The Physician order in the EMR revealed DNH except trauma and no feeding tube. 5. Record review for Resident ID #135 revealed an advance directive for DNR, DNI, DNH except for trauma, no feeding tube and no intravenous in the resident's paper chart dated 5/16/2019, without a resident signature. The Physician order in the EMR revealed DNR, DNI, DNH, Comfort Measures Only, no feeding tube, and no intravenous. 6. Record review for Resident ID #250 lacked evidence of an advance directive in both the resident's paper chart and EMR.	F 578	LLR 10/8/21	

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F 578	Continued From page 3 During a surveyor interview with the Director of Nursing Services on 9/22/2021 at 2:08 PM he acknowledged that the above mentioned Advance Directives were inconsistent between the EMR and paper record and were not signed.	F 578		
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 surveyor observation, record review, and staff interview, it has been determined that the facility failed to provide necessary treatment and services consistent with professional standards of practice to prevent pressure ulcers from developing for 1 of 12 residents reviewed for pressure ulcer, Resident ID #75. Findings are as follows: Record review revealed this resident was admitted to the facility in January of 2019 and has diagnoses which include, but are not limited to, type 2 diabetes mellitus with diabetic	F 686 lwr 10/8/21	1. Resident #75 assessed and care planned that she removes and refused to wear off loading positioning devices or booties. 2. Education with appropriate staff on pressure ulcers, using positioning devices and proper documentation when the residents refuse ofprofessional devices. 3. Audit all residents with pressure ulcers to ensure that they have proper positioning devices in place. 4. Monthly audit by DNS/ Unit managers and or designee, on all pressure sore residents to ensure that they have proper positioning device and it up todate on Plan of care 5. Monthly audit will be brought to QAPI team for minimal of 3 months. The Executive Director is ultimately responsible to ensure compliance.	10/15/21

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F 686	Continued From page 4 polyneuropathy (a condition that affects multiple nerves including the legs and feet). Record review revealed a Braden risk assessment (an assessment for predicting pressure ulcer) dated 1/19/2019 indicating the resident is at risk for developing a pressure ulcer. Record review of the resident's weekly skin assessments revealed s/he has a pressure ulcer on his/her left heel. Record review for this resident revealed a physician's order dated 8/9/2021 which states "Ensure that heels are off loaded in bed with pillows or cushion; and that resident is wearing heel protecting boots while in bed and in wheelchair." Surveyor observations of the resident's heels while lying in bed on 9/21/2021 at 9:18 AM, 11:03 AM and 1:28 PM revealed him/her not wearing the heel protecting boots as ordered and the boots were observed on a chair during each of these observations. Further observation of the resident's heels while seated in a reclining chair on 9/23/2021 at 9:18 AM, 9:25 AM, 10:07 AM, 10:35 AM, and 10:58 AM, revealed his/her heels resting on the footrest and s/he was not wearing the heel protecting boots as ordered. During a surveyor interview on 9/23/2021 at 10:59 AM with a Nursing Assistant, Staff A, she acknowledged that she did not put the resident's heel protecting boots on him/her. During a surveyor interview on 9/23/2021 at 11:30	F 686 MF 10/7/21		

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F 686	Continued From page 5 AM with the Director of Nursing Services, he acknowledged that the resident has a pressure ulcer on his/her left heel and the boots were to prevent further pressure. He further indicated that the resident should be wearing the heel protecting boots as ordered and could not provide evidence as to why s/he was not.	F 686		
F 692 SS=E	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it has been determined that the facility failed to maintain acceptable parameters of nutritional status relative to supplements and weight monitoring for 2 of 10 residents reviewed for weight loss,	F 692	1. Resident #104 weight assessed by Dietician and has been stable. MD DC weekly weights, her weight loss while unplanned has been beneficial to the resident and stable at this time. Care plan updated to reflect that the resident has benefited from the weight loss and is stable at this time. 2. Resident #6 Order for mighty shakes has been corrected for percentage taken to ensure that the resident is consuming the proper amount of supplement. 3. Review and update with new policy for the facility for weights. 4. Dietician conducted full house audit on all supplements and weight loss, to ensure that all have percentages documented by dietician. 5. Dietician/DNS and or designee, will conduct weekly audits, on all supplements to ensure that they have percentages documented. 6. Weekly Audit on weights to be conducted by Dietician/DNS and or designee. To be brought weekly to risk meeting. And any weight more than 5 lb, or5% within a month to be discussed in morning clinical to ensure reweight has taken place. 7. Education with appropriate staff to be completed on weights and supplements. 8. Audits will be taken to QAPI for a minimum of 3 months or until such time as QAPI team has determined that they can be discontinued.	10/15/21

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F 692	Continued From page 6 Resident ID #s 6 and 104. Review of the facility policy titled, "Weight Assessment and Intervention", states in part, "Any weight change of 5% or more since the last weight assessment will be retaken the next day for confirmation. If the weight is verified, nursing will immediately notify the Dietician in writing. Verbal notification must be confirmed in writing...threshold for significant unplanned and undesired weight loss will be based on the following criteria...1 month-5% weight loss is significant; greater than 5% is severe...6 months-10% weight loss is significant; greater than 10% is severe..." 1. Record review for Resident ID #104 revealed that s/he was admitted to the facility in November of 2017 and has diagnoses including, but not limited to, dysphagia (difficulty in swallowing) and protein and calorie malnutrition. Review of the documentation titled, "Order Summary Report", revealed a 7/28/2021 physician's order for weekly weights. Review of the September weights failed to reveal a weight for the week of 9/12/2021 through 9/18/2021. Review of the August weights failed to reveal a weight for the week of 8/15/2021 through 8/21/2021. Additionally, review of the weights for July and August 2021 revealed a severe weight loss of 7.75% between July 15th and August 11th. In addition, the record revealed a weight of 188.4 lbs. (pounds) on 7/15/2021 and 177.4 lbs. on 7/28/2021, indicating a severe weight loss of 5.84% in less than 2 weeks. Further review failed to reveal a re-weight was done as indicated in the	F 692	The Executive Director is ultimately responsible to ensure compliance.	

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F 692	Continued From page 7 policy. Review of the weight record for May and June 2021 revealed s/he weighed 206 lbs. on 5/25/2021 and 190.6 lbs. on 6/29/2021, indicating a severe weight loss of 7.48 % in one month. Further review of the record failed to reveal evidence of any weight loss interventions implemented. Review of the March through September 2021 weights revealed s/he weighed 178.6 lbs. on 9/22/2021 and 206.8 lbs. 3/25/2021, indicating a severe weight loss of 13.64% in 6 months. Review of a 7/20/2021 nutrition/dietary note revealed in part,"...188#[pounds] (7/15), 191# (6/29), 206# (5/25), 201# (4/20), 209# (3/3). 10.0% x 6 mo [month]SIGNIFICANT wt [weight] loss ...MNA [Mini Nutritional Assessment] score (7/20/2021) =4,"malnourished" status..." During an interview on 9/23/2021 at 10:55 AM with the Registered Dietician, Staff B, she was unable to provide evidence of any weight loss interventions implemented prior to 7/20/2021. During an interview on 9/23/2021 at 1:22 PM with the Director of Nursing Services, he stated that he would expect the weekly weight order to be followed and re-weights to be completed as stated in the policy. 2. Record review for Resident ID #6 revealed that s/he was admitted to the facility in September of 2016 and has diagnoses including, but not limited to, dysphagia and dementia. Review of the documentation titled, "Order	F 692	MK 10/8/21	

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F 692	Continued From page 8 Summary Report", revealed a 7/8/2021 dietary supplement order for mighty shakes three times a day. Review of the 7/20/2021 care plan states in part, "...supplement(s) between meals as ordered...supplements with meal(s) as noted on tickets..." Review of the Medication and Treatment Administration Record (MAR/TAR) and documentation from August and September 2021 failed to reveal evidence that a mighty shake supplement was administered as ordered. Review of the weights from March through September 2021 revealed s/he weighed 113 lbs. (pounds) on 3/11/2021 and 100 lbs. on 9/14/2021, indicating a severe weight loss of 11.5 % in 6 months. Review of a 7/20/2021 nutrition/dietary note revealed in part, ".. 99.6#[pounds] (7/12), 101# (6/12), 113# (4/15), 113# (2/22). 11.9% x 3 mo [month]SIGNIFICANT wt [weight] loss...Supplements: Mighty Shake . 4oz [ounces] TIO [three times a day] between meals.. MNA[Mini Nutritional Assessment] (4/18/21)=8, "at risk" for malnutrition .." During an interview on 9/23/2021 at 11:47 AM with the Staff B, she was unable to provide evidence that the supplement was administered as ordered. During an interview on 9/23/2021 at 12:39 PM with the Director of Nursing Services, he stated that he would expect the supplement order to be followed and supplement intake to be charted on the MAR/TAR.	F 692 KK 10/8/21		

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F 757	Continued From page 9	F 757		
F 757 SS=E	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it has been determined that the facility failed to ensure a resident's drug regimen is free from unnecessary drugs, related to inadequate monitoring of medications with parameters, for 2 of 7 sample residents reviewed for unnecessary medications, Resident ID #s 75 and 125. Findings are as follows: 1)Record review for Resident ID #75 revealed that s/he was admitted to the facility in January of	F 757 KLR 10/8/21	1. Residents that were identified were in the past and at this time unable to fix any potential problems with medications given. MD notified of issues and parameters reviewed by MD. 2. Education with all CMT and Nurses on proper medication administration and parameters. 3. DNS and or designee will conduct weekly audits on Medications with parameters and if they were given within their parameters. 4. Audits to be brought to QAPI for a minimum of 3 months or until such time as QAPI team has determined that action is corrected. The Executive Director is ultimately responsible to ensure compliance.	10/15/21

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F 757	Continued From page 10 2019 and has diagnoses which include, but are not limited to, type 2 diabetes mellitus. Record review revealed a physician's order dated 8/13/2021 for Levemir (insulin) 5 units subcutaneously at bedtime. Parameters state to, hold if the blood sugar is less than 150 and report to the nurse practitioner if the blood sugar is over 350. Record review of the September Medication Administration Record (MAR) revealed that the Levemir was administered for a blood sugar less then 150 on the following dates: On 9/1/2021-The blood sugar was documented as 147. On 9/17/2021-The blood sugar was documented as 143. During a surveyor interview with the Director of Nursing Services on 9/23/2021 at 11:26 AM, he acknowledged that the facility failed to follow the physician's order to hold the above doses of insulin based upon the parameters. 2) Record review for Resident ID #125 revealed thats/he was admitted to the facility in May of 2015 and has diagnoses which include, but are not limited to, hypertension, atrial fibrillation (an irregular and rapid heart rhythm), and chronic diastolic heart failure (heart failure). Record review of the physician's order summary report revealed the following orders: -Furosemide (a diuretic) 20mg in the morning every other day. Hold if the systolic blood pressure (sbp) is less than 100 or the heart rate	F 757	MR 10/8/21	

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F 757	Continued From page 11 (HR) is less than 70. This order had a start date of 8/13/2021 and was discontinued on 8/24/2021. -Losartan Potassium (a medication to treat high blood pressure) 50 mg two times daily. Hold if the systolic blood pressure is less than 100 or the apical pulse is less than 60. This order had a start date of 8/11/2021 and was discontinued on 8/12/2021. -Losartan Potassium 25 mg two times daily. Hold if the systolic blood pressure is less than 100 or the heart rate is less than 70. This current order had a start date of 8/12/2021. Record review of the Medication Administration Record for August and September 2021 revealed the Losartan was administered when the blood pressure or heart rate was less than the stated parameters on the following dates and times: 8/12/2021 at 9:00 AM- blood pressure (BP) 80/76 8/14/2021 at 7:00 AM- 11:00 AM-heart rate (HR)-69 8/16/2021 at 6:00 PM- 11:00 PM- HR-68 8/17/2021 at 6:00 PM- 11:00 PM- HR-64 8/20/2021 at 7:00 AM- 11:ODAM-HR 66 and 6:00 PM-11:00 PM- HR-64 8/22/2021 at 6:00 PM- 11:00 PM-HR- 66 8/26/2021 at 6:00PM- 11:00 PM- HR-60 8/27/2021 at 7:00 AM- 11:00 AM- HR-60 8/28/2021 at 7:00 AM- 11:00 AM- HR-67 8/29/2021 at 7:00 AM- 11:00 AM- HR 68 9/3/2021 at 7:00 AM-11:00 AM- HR-66 9/4/2021 at 6:00 PM-11:00 PM- BP- 93/67 9/6/2021 at 7:00 AM- 11:00 AM- HR-67 9/7/2021 at 6:00PM- 11:00 AM- HR-69 9/17/2021 at 7:00 AM-11:00 AM- HR-68	F 757	MR 10/8/21	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415106	A. BUILDING _____ B. WING _____	09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANTOINE RESIDENCE	10 RHODES AVENUE NORTH SMITHFIELD, RI 02896

(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 757	Continued From page 12 Record review of the MAR for August and September 2021 revealed the Lasix was administered when the heart rate was less than the stated parameters on the following dates and times: 8/17/2021 at 7:00 AM- 11:00 AM- HR 62 8/21/2021 at 7:00 AM- 11:00 AM- HR 64 8/23/2021 at 7:00 AM- 11:00 AM- HR 66 During surveyor interview on 9/22/2021 at 1:08 PM with the Director of Nursing Services he acknowledged that the facility failed to follow the physician's order to hold the above doses of Lasix and Losartan based upon the parameters.	F 757		
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 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	F 761 KLR 10/8/21	1. All medications identified during survey in the medication cart and medication room that were outdated were discarded. 2. All open vials are dated for when they are open and discarded after manufactures recommendation for open vials of those medications. 3. Education was conducted with appropriate staff on medications storage, expired medications and education on dates of expiration after opening medication. 4. One-time audit of all medication rooms and medication carts was conducted by the ADNS. 5. Weekly audits to be completed for compliance by Unit managers/ADNS and or designee. 6. All audits will be reviewed by DNS/ Designee and presented to QAPI for a minimum of 3 months and until such time as QAPI team deems appropriate. The Executive Director is ultimately responsible to ensure compliance.	10/15/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415106	A BUILDING_____ B. WING_____	09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANTOINE RESIDENCE	10 RHODES AVENUE NORTH SMITHFIELD, RI 02896

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F 761	Continued From page 13 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 surveyor observation and staff interview, it has been determined that the facility failed to store and label drugs and biologicals in accordance with currently accepted professional principles for 3 of 4 medication carts and 1 of 4 medication rooms observed. Findings are as follows: Review of the facility policy dated April 2019 titled "Storage of Medication" states in part "...Drug containers that have missing, incomplete, improper, or incorrect labels are returned to the pharmacy for proper labeling before storing...Discontinued, outdated drugs or biologicals are returned to the dispensing pharmacy or destroyed...Medications requiring refrigeration are stored in a refrigerator..." 1. Surveyor observation on 9/22/2021 at 7:54 AM of the Special Care Unit (SCU) Ewing medication storage room refrigerator, in the presence of Licensed Practical Nurse, Staff C, revealed the following: - Acetaminophen suppository 650 MG (milligram) with a manufacturer expiration date of July 2021. - Three bottles of Lorazepam concentration 2 MG (a medication used to treat anxiety) open and not dated. Manufacturer instructions states in part "...Discard opened bottle after 90 days..."	F 761		

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	415106	A. BUILDING _____ B. WING	09/23/2021

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F 761	Continued From page 14 2. Surveyor observation on 9/22/2021 at approximately 7:55 AM of the SCU Ewing medication cart revealed the following: - Ventolin HFAAlbuterol Sulfate inhaler (a medication used to prevent and treat shortness of breath) 90 MCG (microgram) with a manufacturer expiration date of August 2021. During a surveyor interview immediately following this observation with Staff C, she acknowledged that the Acetaminophen suppository and Ventolin inhaler were expired. Additionally, she acknowledged that the three bottles of Lorazepam were opened, in use, and not dated. 3. Surveyor observation on 9/22/2021 at 8:20 AM of the Transitional Care Unit nurse medication cart in the presence of Licensed Practical Nurse Staff D, revealed the following: - Humalog 100 Units/ML (milliliter, a medication used to control high blood sugar), unopened and stored in the medication cart. Manufacturer instructions written on the label states in part "...Refrigerate until opened..." - Lanius 100 Units/ML (milliliter, a medication used to control high blood sugar), unopened and stored in the medication cart. Manufacturer instructions written on the label states in part "...Refrigerate until opened..." - Fluticasone Propionate nasal spray 50 MG (a medication is used to treat the symptoms of allergies), opened in use with an expiration date that was unreadable.	F 761	MR 10/8/21	

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F 761	Continued From page 15 During a surveyor interview immediately following this observation with Staff D, she acknowledged that the insulins were unopened and stored in the medication cart and should have been refrigerated. She further acknowledged that the nasal spray expiration date was unreadable. 4. Surveyor observation on 9/22/2021 at 10:18 AM of the SCU D wing medication cart in the presence of Certified Medication Technician, Staff E, revealed the following: - Brimonidine Tartrate 0.2% (a medication used to lower pressure in the eyes) opened and not dated. Manufacturer instructions stated in part "...Discard the eye drops 4 weeks after opening..." - Brimonidine Tartrate 0.2% (a medication used to lower pressure in the eyes) opened with a discard date of 6/29/2021. Manufacturer instructions stated in part "...Discard the eye drops 4 weeks after opening..." During a surveyor interview immediately following this observation with Staff E, she acknowledged that the eye drops were opened, not dated, and had passed the discard date. During a surveyor interview on 9/22/2021 at 1:01 PM with the Director of Nursing Services, he indicated that he would expect that expired medications would be discarded and Lorazepam should have been dated when open. He further indicated that he would expect the insulin be refrigerated until open and medications without an expiration date be discarded and reordered.	F 761	UR 10/8/21	