STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345330	A. BUILDING ______ B. WING ______	06/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GRAYBRIER NURS & RETIREMENT CT	**116 LANE DRIVE TRINITY, NC 27370**

(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
E 000	Initial Comments An unannounced recertification survey was conducted on 5/30/23 through 6/1/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID REYM11.	E 000		
F 000	INITIAL COMMENTS A recertification survey was conducted from 5/30/23 through 6/1/23. Event ID# REYM11. There were no complaints investigated during the survey.	F 000		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on record reviews, observations, and staff interviews, the facility failed to trim and clean dependent residents' nails (Residents #46 and #32) and failed to provide showers as scheduled (Resident #42). This was for 3 of 3 residents reviewed for Activities of Daily Living (ADLs). The findings included: 1. Resident #46 was initially admitted to the facility on 02/19/18 with diagnoses which included chronic kidney disease, macular degeneration, and hypertension. A quarterly Minimum Data Set (MDS) assessment dated 04/0423 indicated Resident #46's cognition was moderately impaired and	F 677	The refusal of nail care during routine showering for resident #46 was not documented. Resident's nails were trimmed on 6/1/2023. Following a conversation with surveyor, a nurse's note dated 5/31/2023 states that Nurse #4 and Certified Nursing Assistant (CNA) #7 trimmed resident #32's nails. The note states, "Resident screamed loudly while the nails were trimmed stating that 'the staff' were cutting her fingers off." Resident #32's initial refusal of nail care was documented on 5/31/2023. On 6/1/2023, Director of Nursing (DON) was made aware by state surveyor that resident #42 reported not receiving her showers on her scheduled shower days.	6/14/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 06/14/2023

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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displayed no behaviors or rejection of care. She required limited assistance from staff for personal hygiene and total dependence on staff for bathing.

Resident #46's active care plan, last reviewed 04/04/23, indicated she required assistance with all ADL care related to functional decline. The interventions, in part, included provide assistance with bathing as needed and ensure her preferred way of bathing is honored.

A review of Resident #46's nursing progress notes from 05/22/23 to 06/01/23 revealed no refusals of nail care documented.

On 05/30/23 at 10:21 AM, an observation of Resident #46 occurred while she was in her room, sitting in her wheelchair. Underneath her fingernails on her right hand contained a thick dark substance.

Resident #46 was observed on 05/31/23 at 3:10 PM, in the dining room with other residents and eating a cookie. Her nails were unchanged from prior observation.

On 06/01/23 at 9:01 AM, Resident #46 was observed sitting in her wheelchair in her room. Her fingernails remained with dark substance under the nails to the right hand.

An observation and interview occurred with Nurse Aide (NA) #5 on 06/01/23 at 9:48 AM. She indicated she was familiar with Resident #46 and her care needs. She stated she was the NA assigned to care for Resident #46 on 05/30/23. 05/31/23, and 06/01/23. She stated Resident #46 did not refuse care and was receptive to

F 677

Resident #42 was interviewed on 6/1/2023 by the Social Worker and she reported satisfaction with shower regimen. She also reported receiving a shower on 5/31/2023.

To ensure compliance with all other residents, a facility-wide nail care analysis was conducted on 6/1/2023 by the CNA supervisor, Social Worker, and Social Work Assistant. All residents were interviewed, and nails were inspected. No other residents were identified with nails that appeared to require corrective care. An in-service was conducted with facility CNAs to educate about nail care and the importance of documentation. All regularly scheduled CNAs were in-serviced by the nursing team, which includes DON, DON assistant, Unit Coordinator, and Staff Scheduler, on or before 6/7/2023. Any “as needed” CNAs will be in-serviced prior to their next scheduled shift.
To ensure compliance with all other residents, a facility-wide bathing analysis was conducted on 6/1/2023 by the CNA supervisor, Social Worker, and Social Work Assistant. All verbal residents were interviewed regarding the frequency of their showers and their shower schedules. All residents were satisfied with their current shower schedule, with the exception of one resident who requested a different shower schedule; the change was made to their schedule. Through root cause analysis, it was determined that CNA education regarding accurate shower charting was required. All regularly scheduled CNAs were

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assistance by the staff. She stated she gave Resident #46 a bed bath every morning. She stated nail care should be completed when there was a need during a shower or personal care. An observation occurred with NA #5 of Resident #46's nails. NA #5 confirmed a dark substance was under the nails to the right hand and stated she had not noticed the need for nail care during her morning care.

The Director of Nursing was interviewed on 06/01/23 at 10:03 AM and stated she would expect fingernails to be observed on shower days and during personal care with nail care rendered as needed.

2. Resident #32 was admitted to the facility on 03/09/17 with diagnosis that included dementia with behavioral disturbances, paranoid schizophrenia, and heart failure.

A quarterly Minimum Data Set (MDS) assessment dated 04/0423 indicated Resident #32's cognition was moderately impaired. She exhibited verbal behavioral symptoms directed toward others 1 to 3 days, other behavioral symptoms not directed toward others occurred daily, and rejection of care on 1 to 3 days during the observation period. She was totally dependent on staff x 2 for personal hygiene and totally dependent on staff x 1 for bed mobility, dressing, eating, toilet use, and bathing. She had range of motion (ROM) impairment on both sides of upper and lower extremities.

Resident #32's active care plan, last reviewed 04/05/23, revealed a focus that read Resident #32 had an ADL self-care performance deficit and required assistance with bed mobility, transfers, toileting and hygiene related to Dementia with

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in-serviced by the nursing team, which includes DON, DON assistant, Unit Coordinator, and Staff Scheduler, on or before 6/7/2023. Any “as needed” CNAs will be in-serviced prior to their next scheduled shift.

To ensure that continued improvement and quality outcomes are achieved, the “Resident Appearance Weekday Rounding Tool” has been initiated. Daily audits by the Unit Coordinator, DON Assistant, Minimum Data Set (MDS) nurse, CNA scheduler, Activity Director, and DON will occur for four weeks. After four weeks the frequency will change to weekly for six months.

To ensure continued compliance with shower documentation, including refusals, a daily audit of shower charting has been conducted. The DON will be responsible for this audit. The CNA scheduler, Unit Coordinator, and DON assistant will assist with on-going education related to documentation to ensure compliance. Daily audits will be conducted for four weeks. After four weeks, and satisfactory progress with documentation, weekly audits will be conducted for six months.

To monitor continued compliance with this objective, results of the “Resident Appearance Weekday Rounding Tool” and audits of daily and weekly shower charting will be tracked and discussed weekly at the quality improvement interdisciplinary team meeting. Progress of this audit will be reported by the DON to the Quality Assessment and Assurance

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behavioral disturbances and decreased range of motion (ROM) to bilateral upper extremities (BUE). Interventions included she required extensive to total assistance.

A review of Resident #32's nursing progress notes from 05/15/23 to 06/01/23 revealed no refusals of nail care documented.

A review of Resident #32's personal hygiene and showers/baths under Activities of Daily Living (ADL) documentation revealed no refusals documented.

An observation was conducted with Resident #32 on 05/30/23 at 1:09 PM. She was observed in bed in her room resting. Fingernails on left hand were long, extending out 1/8th to 1/2 of an inch past the tip of fingers. Left hand contracted, pointer finger and pinky fingernail resting on palm of left hand with slight indentions to areas where the nails were resting. Middle fingernail 1/2 inch long extended out with no contact with skin. Middle fingernail and pinky on left hand also jagged on the ends. Fingernails on her right hand were long and jagged, extending out 1/8th to 1/4th of an inch past the tip of fingers.

A continuous observation was conducted with Resident #32 on 05/31/23 at 9:27 AM through 10:32 AM. Resident #32 yelling out "hey". Nurse #4 went into her room and asked Resident #32 what was wrong and if she needed anything. Resident #32 stated my hands are hurting, take these things off. (Splint and carrot to hands). Nurse removed splints from hands and Resident #32 stated that was better. When nurse left room, she started yelling again.

Committee at the next Executive Quality Assurance meeting, scheduled July 18, 2023 and on-going for the duration of the audits.

The facility alleges full compliance with this plan of correction on June 14, 2023.

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F 677	Continued From page 4 An interview with Nurse #4 was conducted on 05/31/23 at 9:28 AM. Nurse #4 stated she had worked at the facility for 20+ years. She stated Resident #4 had just received a shower and that normally after requesting a shower she will yell out afterwards. She also stated this was her normal behavior. She yells out often and she had several medication adjustments, but nothing seems to help it. Staff go in and redirect and talk with her when she yells out. An interview with Resident #32 was conducted on 05/31/23 at 9:33 AM. She stated she just had a shower as she was yelling out at times during interview. She denied pain or discomfort. Stated she didn't know why she was yelling. She then stated staff needed to cut her nails because they were too long and were hurting. She further stated staff had not cut her nails in a long time. Review of shower sheets which were located at the nurses ' station in a binder revealed Resident #32 ' s shower days are every Wednesday and Saturday. No documented refusal of showers or nail care on the written and signed sheets. An interview with Nurse Aide (NA) #7 was conducted on 05/31/23 at 2:14 PM. She stated she normally provided nail care when she gave a resident their shower/bath. She was the direct care NA for Resident #32 for first shift from 05/30/23 through 06/01/23. She also stated she normally cared for Resident #32, and she gave her a bed bath on non-shower days. She then stated Resident #32 received a shower this AM, but she did not cut her nails because she was yelling out. She also stated her nails are very long and jagged and need to be cut because they are digging into her palm. She further stated she had	F 677		

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not tried to go back and cut them this shift but she would reattempt at this time. If the resident refused, she would notify the nurse and would then document under "comments" on the Activities of Daily Living (ADL) flow sheet.

An interview was conducted on 05/31/23 at 2:22 PM with Nurse #4. She stated she would document shower/bath and/or nail care refusals in the residents nursing notes when the NAs notified her.

A continuous observation was conducted on 05/31/23 at 2:25 PM of NA #7 and NA #8 cutting & filing Resident #32 ' s nails. Resident was tolerating well, no yelling out observed. NA #8 stated they are long.

The Director of Nursing was interviewed on 06/01/23 at 10:03 AM and stated she would expect fingernails to be observed on shower days and during personal care with nail care rendered as needed. She also stated the NA should also inform the nurse and document the refusal on the shower record.

3. Resident #42 was admitted to the facility on 4/4/23 with diagnoses that included difficulty in walking, lymphedema, and venous insufficiency.

The admission Minimum Data Set (MDS) assessment dated 4/11/23 indicated Resident #42 was cognitively intact and displayed no behaviors or rejection of care. She required extensive assistance for bathing.

Resident #42's active care plan, dated 4/13/23, included a care area for self-care deficit related to

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F 677	Continued From page 6 resident requires assistance in all Activities of Daily Living (ADLs) related to functional decline and diagnosis of arthritis. The interventions included assistance of one person for ADLs (bathing, toileting, transfers, personal hygiene). A review of the nursing progress notes from 4/11/23 until 5/30/23 revealed Resident #42 required limited to extensive assistance for ADLs and had one refusal specific to scheduled showers on 4/21/23. A review of the medical records indicated Resident #42 was to receive a shower every Tuesday and Friday on the 3:00 PM to 11:00 PM shift. A review of Resident #42's shower/bathing records for April 2023 and May 2023 indicated she had not received any showers on her scheduled shower days. An interview occurred with Resident #42 on 5/30/23 at 12:30 PM, and stated she was to receive showers on Tuesday and Friday evenings. She recalled being offered a shower once on those days but had refused as she was already in bed and felt it was too late in the evening. She stated she had only received sponge baths on those scheduled days. Resident #42 stated there was a nurse aide (NA) on Saturday that offered her showers sometimes. On 5/31/23 at 3:15 PM, an interview occurred with NA #1 who stated he was familiar with Resident #42 and scheduled to care for her at times on the 3:00 PM to 11:00 PM shift. He stated he normally offered a bed bath/sponge bath to Resident #42 on her scheduled shower days but	F 677		

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F 677	Continued From page 7 was unable to state why. He could not confirm or deny attempts to provide the scheduled showers on the Tuesday and Fridays that were not documented as refused or given in the personal care records. A phone interview occurred with NA #3 on 6/1/23 at 9:37 AM who was familiar with Resident #42. She explained she worked the weekend day shift and would offer a shower to Resident #42 when time allowed or if Resident #42 asked for one. A phone interview was completed with NA #4 on 6/1/23 at 11:36 AM, who worked the 3:00 PM to 11:00 PM shift and was assigned to care for Resident #42 at times. She was unable to confirm or deny attempts to provide the scheduled showers on Tuesdays and Fridays that were not documented as refused or given in the personal care records. The Director of Nursing (DON) was interviewed on 6/1/23 at 10:00 AM. She reviewed the shower sheets for Resident #42 and confirmed she was to receive a shower on the 3:00 PM to 11:00 PM shift on Tuesday and Friday. The DON stated she was unaware Resident #42 was not being provided her showers as scheduled but stated if a resident refused, the NA should alert the nurse so a progress note could be written, and an alternate means of bathing provided. The DON added the NA should also document the refusal on the shower record.	F 677		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning.	F 695		6/15/23

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F 695	Continued From page 8 The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to implement the standing order for changing an oxygen (O2) nasal cannula tubing and failed to initiate the order to change the water container used to humidify the O2 for Resident #134. This was for 1 of 2 residents reviewed for respiratory care. The findings included: Resident #134 was admitted on 5/17/23 with Acute Renal Failure, Cerebral Vascular Accident (CVA) and Chronic Obstructive Pulmonary Disease (COPD). Review of a nursing note dated 5/19/23 at 6: 02 PM read Resident #134's blood pressure dropped to 76/44 while on the therapy bike with a O2 saturation of 79% on room air. Resident #134 was taken back to his room where his blood pressure was 102/62 and his oxygen saturation was 76 % on room air. The standing order for O2 at 2 liters per minute (L/M) via nasal cannula tubing was initiated and his O2 saturation percent increased to 99%. The Medical Director (MD) was notified and he ordered the continuation of his oxygen, a stat (immediate) chest x-ray, stat bloodwork and the administration of Rocephin (antibiotic) intramuscularly on 5/20/23 and 5/21/23.	F 695	Resident #134 received an order for oxygen at 2 liters per nasal cannula to maintain oxygen saturations greater than 90% on 5/19/2023. Oxygen was applied per order. Humidifier was also applied. Through Root Cause Analysis and upon review of resident’s record, on 6/1/2023, it was noted that the order for the nasal cannula and humidifier change had not been initiated. Nurse #2 changed the oxygen tubing and humidifier canister on 6/1/2023. The humidifier was not empty and the oxygen tubing was noted to be clean. This was reported to the surveyor when the deficient practice was brought to the attention of the Director of Nursing (DON) on 6/1/2023. To ensure compliance with all other residents, oxygen orders have been checked and found to be accurate on 6/1/2023, by the DON. To improve this practice all licensed nurses were in-serviced, by the DON, regarding tubing/humidifier order(s) needed for oxygen administration. All regularly scheduled facility and contract nurses were in-serviced by 6/5/2023. Any “as needed” nurses will be in-serviced	

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The chest x-ray results dated 5/19/23 were positive for pulmonary infiltrates present in his right lung based compatible with pneumonia.

Review of Resident #134's May 2023 orders included an order dated 5/19/23 for O2 at 2L/M using a nasal canula tubing continuously to maintain a O2 saturation of 90% or above. The order also read for the nurse to check placement of oxygen, settings, concentrator function and O2 saturation percent every shift. There were no orders to change his nasal cannula tubing and humidification water container weekly.

Review of Resident #134's electronic standing orders included an order to change the O2 tubing and the container of humidifying water every Tuesday night shift (7:00 PM-7:00 AM). This order was not marked as initiated.

The admission Minimum Data Set dated 5/24/23 indicated Resident #134 had severe cognitive impairment, no behaviors and coded for the use of O2 while at the facility.

Resident #134 was care planned on 5/26/23 for the use of supplemental O2 due to his COPD and recent diagnosis of pneumonia. Interventions included O2 per nasal cannula as ordered by the MD.

Resident #134 was observed on 5/30/23 at 11:45 AM. He was lying in bed with his unlabeled nasal cannula tubing and a container of humidifying water in use with his O2 concentrator running at the ordered rate.

Review of Resident #134's May 2023 medication administration record (MAR) and his treatment

F 695

prior to their next shift. To ensure continued compliance with this objective, a weekly audit of oxygen and change/replace oxygen tubing and humidifier orders has been initiated by the DON and the DON assistant.

To monitor continued compliance with this objective, results of this audit will be tracked and logged on the “Oxygen Tubing/Humidified Changing Tracking Tool” that was created. The DON will be responsible for monitoring this audit. This audit will continue weekly for six months. Results of the audit will be tracked and discussed weekly at the quality improvement interdisciplinary team meeting. Progress of this audit will be reported by the DON to the Quality Assessment and Assurance Committee at the next Executive Quality Assurance meeting, scheduled July 18, 2023 and on-going for the duration of the audits.

The facility alleges full compliance with this plan of correction on June 14, 2023.

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administration record (TAR) did not include anything about changing his O2 tubing and the container of humidifying water.

Resident #134 was observed on 5/30/23 at 4:02 PM. His O2 tubing and container of humidifying water were unchanged from previous observation.

An observation was completed on 5/31/23 at 11:00 AM with the Treatment Nurse. She stated the facility did not routinely label oxygen tubing or containers of humidifying water when changed but rather it was charted on the electronic medical record on the MAR or TAR and would pop up when it was due again. She stated the tubing and the container of humidifying water were changed weekly on the night shift.

Resident #134 was observed on 6/1/23 at 10:15 AM. His O2 tubing and container of humidifying water were unchanged from previous observation.

An interview was completed on 6/1/23 at 10:20 AM with Nurse #2. She stated there were standing orders to change the oxygen tubing and the container of humidifying water weekly on the night shift. Nurse #2 reviewed the electronic medical record, but she stated she found no documented evidence that the standing order was ever initiated on 5/19/23.

An observation was completed on 6/1/23 at 10:30 AM with Nurse #1. He stated the nurses were supposed to put a label with the date on the oxygen tubing and date the container of humidifying water were replaced. Nurse #1 stated if the standing order to change his oxygen tubing

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	345330	A. BUILDING ______ B. WING ______	06/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GRAYBRIER NURS & RETIREMENT CT	116 LANE DRIVE TRINITY, NC 27370

(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 695	Continued From page 11 and container of humidifying water were initiated in the electronic medical order, it would appear on the TAR for the night shift nurse to do. Nurse #1 verified that the standing order to change oxygen tubing and the container of humidifying water weekly was not initiated when the original order was put in on 5/19/23. An interview was completed on 6/1/23 at 10:55 AM with Nurse #3. She recalled the evening Resident #134 experienced a drop in his blood pressure and oxygen saturation level. She initiated the standing order for supplemental oxygen but it appeared she did not initiate the standing order to change his oxygen tubing and his container of humidifying water weekly. An interview was completed on 6/1/23 at 11:55 AM with the Director of Nursing (DON). She stated when Nurse #3 initiated the standing order for supplemental oxygen on 5/19/23, she forgot to also initiate the standing order to change his oxygen tubing and the container of humidifying water weekly on Tuesday nights. The DON stated it appeared that Resident #134 had been using the same oxygen tubing and container of humidifying water since 5/19/23.	F 695		
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.	F 761		6/15/23

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F 761	Continued From page 12 §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 observations and staff interviews the facility failed to date multi-dose medications upon opening on 2 of 3 medication carts reviewed (Upper Ashley River, and Lower Ashley River medication carts). The findings included: A. An observation was conducted on 05/31/23 at 11:05 AM of the medication cart on Upper Ashley River Hall in the presence of Medication aide (MA) #1 and Nurse #1. The observation revealed no opened date on the following multi-dose medications: 1. One multi-dose package of Ipratropium Bromide and Albuterol Sulfate 0.5mg/3ml inhalation vials. 2. One multi-dose package of Albuterol Sulfate	F 761	All undated multi-dose medications were removed from the medication carts on 5/31/2023. No residents were affected by the lack of dating on the multidose medications. The medications were not expired. All regularly scheduled licensed nurses and medication aides were in-serviced, by the DON about dating multi-dose medications by 6/5/2023. Any as needed nurses or medication aides will be in-serviced prior to their next shift. All future new hire nurses and medication aides will be in-serviced about the dating of multi-dose medications during the orientation process. Medication carts audits have been initiated to include visual inspections, twice weekly for six months	

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F 761	Continued From page 13 0.63mg/3ml inhalation vials. 3. One Tresiba (insulin degludec) FlexTouch® insulin pen (150units left in pen). Medication Aide (MA) #1 removed the undated medications from the medication cart. Nurse #1 stated he did not notice the insulin was not dated. He stated insulin should be labeled and dated when opened. An interview was conducted with MA #1 on 05/31/23 at 2:01 PM. She stated she was aware the nebulizer treatments were to be dated when opened and she removed them from the medication cart. B. An observation was conducted on 05/31/23 at 2:06 PM of the medication cart on the Lower Ashley River Hall in the presence of Medication aide (MA) #2. The observation revealed 1 multi-dose opened pack of Ipratropium Bromide and Albuterol Sulfate 0.5mg/3ml inhalation package with 1 individual vial left in package with no opened date. MA #2 verified the multi-dose pack of Ipratropium Bromide and Albuterol Sulfate 0.5mg/3ml inhalation package was not dated. MA #2 stated she was aware it was to be dated when opened and she removed them from the medication cart. An interview was conducted on 05/31/23 at 2:11 PM with Nurse #1. He confirmed he did administer the Tresiba (insulin degludec) FlexTouch this AM. He stated he did not realize the pen was not dated. He was aware the pen should have been dated when opened.	F 761	by the DON assistant. If any errors or discrepancies from visual inspections are noted, issue(s) will be corrected and logged on the audit tool that has been created, the “Dating Discrepancies Log.” To monitor continued compliance with this objective, results of the “Dating Discrepancies Log” will be tracked and discussed weekly at the quality improvement interdisciplinary team meeting. Progress of this audit will be reported to the Quality Assessment and Assurance Committee at the next Executive Quality Assurance meeting, scheduled July 18, 2023 and on-going for the duration of the audits. The facility alleges full compliance with this plan of correction on June 14, 2023.	

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F 761	Continued From page 14 An interview was conducted on 05 06/01/23 at 12:24 PM with the Director of Nursing (DON). She stated nurses were to date all nebulizer packages and insulin vials and pens upon opening and they should be checking dates daily prior to administration.	F 761		