STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056471	A. Building B. Wing	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Baypoint Healthcare Center	442 Sunset Boulevard Hayward, CA 94541

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44771 Based on interview and record review, the facility failed to implement a comprehensive person-centered care plan to address the risk of elopement (leaving a facility without staff knowledge) for two (Resident 52 and Resident 4) out of three sampled residents, when 1. Resident 52's Wanderguard (a type of alarm to help protect those at risk for elopement) interventions were not implemented and Resident 52 eloped from the facility. 2. Resident 4's Wanderguard interventions were not implemented. These failures resulted in Resident 52 eloping from the facility for almost one hour without staff knowledge (Cross reference F689) and had the potential for Resident 4 to elope from the facility which could result in injury and/or death. Findings: 1. A review of Resident 52's Admission Record indicated Resident 52 was admitted to the facility with diagnoses of alcoholic cirrhosis of the liver (liver damage caused by alcohol) and encounter for palliative care (care focused on pain and symptom relief of an illness rather than curing). A review of Resident 52's Elopement Risk Assessment, dated 11/10/23, indicated resident was a high risk for elopement. A review of Resident 52's care plan, dated 5/14/24, indicated resident 52 was a high risk of elopement and interventions, entry created on 11/17/23, included, Use WanderGuard system to alert staff of exit seeking behaviors and Check for proper functioning of the audible alarm system as needed. During an observation on 5/15/24 at 9:32 a.m., Resident 52 did not have any Wanderguard bracelet on ankles or wrists. 2. A review of Resident 4's Admission Record indicated Resident 4 was admitted to the facility with a diagnosis of dementia (the loss of cognitive functioning - thinking, remembering and reasoning - interfering with a person's daily life and activities). (continued on next page)

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 4's care plan, dated 5/15/24, indicated resident was high risk for elopement and interventions included, Use WanderGuard system to alert staff of exit seeking behaviors and Check for proper functioning of the audible alarm system as needed. During an interview on 5/14/24, at 5:54 p.m., with Administrator (ADM), ADM stated facility had alarms on the side exits, but the alarms were not activated. ADM also stated that facility had WanderGuard system installed but was unsure whether it works or not because it had not been in use. ADM stated will have to check whether the WanderGuard system works but will have to contact the vendor to check the system. He further stated he did not have any Wanderguard bracelets and will have to order them. During a concurrent observation and interview on 05/15/24, at 9:46 a.m., with Maintenance Assistant (MA), the side door nearest the laundry room, the side door next to the payroll office, the side door near room [ROOM NUMBER], the side door near room [ROOM NUMBER]/27, and the side door near room [ROOM NUMBER]/8 were able to be opened from the inside, and the alarms sounded. MA stated side exit doors should be alarmed on at all times and the side doors are locked from the outside. During a subsequent interview on 05/16/24 at 11:05 a.m., MA stated facility just started alarming the side exit doors on night shift (11 p.m. - 7 a.m.) on 05/14/24.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46487 Based on observations, interviews, record reviews, for two of three (Resident 53 and 43) sampled residents who were reviewed for close supervision, the facility failed to ensure Resident 52 and 43 were supervised when, 1. Resident 52 who was high risk for elopement left the facility unattended on 5/14/2024 between 10:15 a.m. and 11:14 a.m., and 2. Resident 43 who had a history of frequent seizures and falls was not monitored for 50 minutes. These failures resulted in Resident 52 eloping from the facility unattended on a sidewalk in a street intersection and had the potential for Resident 43 to sustain an injury if experienced an unwitnessed seizure. The Administrator (ADM) was notified by the survey team of the Immediate Jeopardy (IJ, a situation in which a provider's noncompliance with one or more requirements of participation have caused or is likely to cause serious injury, harm, impairment or death to a patient/resident) on 5/14/24 at 4:39 p.m. The facility failed to ensure Resident 52 who was a high risk for elopement eloped from the facility unattended for almost one hour. During an on-site survey on 5/15/24, and through observation, interviews, and record reviews, the facility showed they initiated a plan of correction through monitoring/updating residents in the elopement binder, activated all the exit door alarms, all exit door alarms will be activated from 7 a.m. to 8 p.m., the front door will be disarmed at 7 a.m. and be monitored by the receptionist and/or designated staff from 7 a.m. to 8 p.m., and the maintenance department will conduct weekly inspection of the exit door alarms. The IJ was abated on 5/15/24 at 4:53 p.m. Findings: 1. A review of Resident 52's Facesheet (information containing contact details, brief medical history at-a-glance) indicated Resident 52 had diagnoses of alcoholic cirrhosis of the liver (a condition in which the liver is permanently damaged because of drinking alcohol), and hepatic encephalopathy (impaired brain function due to damaged liver). A review of Resident 52's Order Summary Report (OSR), dated 5/17/24, indicated Resident 52 had an order on 2/18/24 for hospice care (program that gives special care to people who are near the end of life), due to end stage liver disease (disease where the liver cannot be repaired). A review of Resident 52's quarterly Minimum Data Set (MDS - an assessment screening tool to guide care), dated 2/16/2024, indicated Resident 52 had a Brief Interview for Mental Status (BIMS) score of 7, which indicated the Resident 52 had severe cognitive impairment. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 5/14/24, at 11:20 a.m., with Registered Nurse (RN) 1, RN 1 stated, Resident 52 eloped and left the faciity on a wheelchair unattended. RN 1 stated the facility found out because while one of the facility's nurses was driving, she saw Resident 52 in the street and called to inform the facility of the resident's location. RN 1 stated the facility was not using WanderGuard for the high elopement risk residents (WanderGuard system is a technology that protect residents who are at risk for elopement. The residents wear a bracelet, and when the resident approaches a monitored door, the system alerts the staff). During an interview with Licensed Vocational Nurse (LVN) 1, on 05/14/24 at 11:38 a.m., LVN 1 stated, earlier that morning, Resident 52 was sitting in a wheelchair in the activities room with the other residents but was moved out of the room because of disruptive behavior. Resident 52 was then brought beside LVN 1 around 10:00 a.m. to 10:15 a.m. from the activities room. LVN 1 stated, she was supposed to monitor Resident 52, but was distracted and forgot about Resident 52 when she went to another resident's room. After that, LVN 1 received a phone call from LVN 3 at 11:15 a.m., who told LVN 1 Resident 52 was seen outside of the facility. LVN 1 stated LVN 3 brought the resident back to the facility. LVN 1 acknowledged, the risks to Resident 52 being outside of the facility unattended was the possibilities of getting hit by a car, getting kidnapped, falling, and sustaining injuries and death. During an interview with LVN 2, on 5/14/24 at 11:50 a.m., LVN 2 stated she received a phone call from LVN 4, who stated, she saw Resident 52 in the sidewalk of an intersection. LVN 2 stated, she drove her car and LVN 3 came with her, to look for the resident. LVN 2 stated, they saw Resident 52 in the sidewalk of an intersection, sitting in a wheelchair. During an interview with LVN 3, on 5/14/24 at 12:39 p.m., LVN 3 stated he rode with LVN 2's car to look for Resident 52. LVN 3 stated they had to drive past 3 to 4 long street blocks, before they found Resident 52 in the sidewalk of an intersection. LVN 3 stated, it took him around seven to ten minutes to wheel Resident 52 in a wheelchair back to the facility. A review of Resident 52's SBAR, dated 5/12/24 at 9:22 p.m., indicated, Resident 52 attempted to leave the facility on 5/12/24 (SBAR, Situation, Background, Assessment, and Recommendation is a structured communication framework that can help teams share information about the condition of a resident). A review of Resident 52's Wandering Risk Scale Assessment, dated 04/26/24, and Elopement Risk Assessment, dated 5/14/24, indicated Resident 52 had a score of 11, which indicated Resident 52 had a high risk to wander. Review of Resident 52's Care Plan for Elopement, initiated on 11/17/23 and revised on 5/14/24, indicated, Resident 52 was considered at risk for elopement. The care plan indicated, the approaches to minimize recurrence/risk of elopement included: to use WanderGuard system to alert staff of exit seeking behaviors and to check for proper functioning of the audible alarm system as needed. A review of Resident 52's physician order, dated 5/14/24, indicated, Resident 52 had an active order effective on 11/16/23 for, no wheelchair to the resident due to high risk of elopement. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an observation on 5/14/2024, at 1:00 p.m., in Station 2 hallway, Resident 52 was alone, unsupervised and was wheeling himself with a wheelchair. Resident 52 was alone in the hallway and was not being monitored by staff. During a concurrent interview and record review, on 5/14/24, at 12:07 p.m., with the Receptionist (Rec), the facility's, Binder for Elopement Risk Residents, was reviewed. Rec confirmed Resident 52 was not in the binder. Rec stated she was informed Resident 52 was an elopement risk. Review of Resident 52's Departmental Notes revealed Resident 52 was last seen in the facility on 5/14/24 at 10:15 a.m. and was found in the side street of the intersection at 11:14 a.m. The note also indicated, Resident 52 wheeled himself out of laundry/kitchen exit door. During an interview with ADM, on 5/14/24, at 6:53 p.m., ADM stated the facility exit alarms were not activated at nights and will start activating them starting the night of 5/14/24. ADM stated the WanderGuard system of the facility needed maintenance. During an interview with Maintenance Assistant (MA), on 5/15/24, at 9:46 a.m., MA stated he worked in the facility for [AGE] years. MA stated the laundry/kitchen exit door's alarm should be activated all the time but the alarm had not been activated since he worked in the facility. MA stated if the alarm was not activated, anyone from inside the building could go out of the facility without triggering the alarm. MA stated the facility just started to activate the door's alarm on the night of 5/14/24. During an interview with Director of Nursing (DON), on 5/14/24, at 11:57 a.m., DON stated the facility was aware Resident 52 had a history of elopement, and Resident 52 was a high risk for elopement. DON stated the intervention to prevent elopement was not placing a wheelchair beside the resident. DON stated, the CNAs were doing visual checks on Resident 52 every two hours but could not provide documentation. DON stated she was not aware of the existence of the Binder for Elopement Risk Residents that was kept in the Rec's desk in the lobby. DON stated, Resident 52's elopement care plan interventions should have been followed and Resident 52 should have had a WanderGuard. During a review of the facility's policy and procedure (P&P) titled, wandering and elopement, revised 2019, the P&P indicated, .the facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents . 1. If identified as at risk for wandering, elopement, or other safety issues, the resident's care plan will include strategies and interventions to maintain the resident's safety . 2. Review of Resident 43's Facesheet indicated, Resident 43 had diagnoses of epilepsy (a brain condition that causes recurring seizures) and paraplegia (the inability to voluntarily move the lower parts of the body). Review of Resident 43's MDS, dated [DATE], indicated Resident 43's BIMS score was 13 (meaning he was cognitively intact). The MDS indicated, Resident 43 used a wheelchair for mobility. MDS indicated Resident 43 needed maximal assistance during surface-to-surface transfer (such as when transferring between bed and chair or wheelchair). Resident 43's MDS indicated a need for ADL (activities for daily living) support with at least one person providing physical assist. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident 43's, Physician's Progress Notes, dated 4/10/24, indicated, Resident 43 had a history of psychogenic seizures and was a high risk for fall (psychogenic seizures are seizure attacks that resemble epilepsy-related seizures that are due to underlying psychological distress). Review of Resident 43's, Fall Risk Assessment, dated 4/6/24, revealed Resident 43 had a score of 17, which meant the resident was a high risk for falling. During an interview on 5/13/24, at 2:15 p.m., with Resident 43, Resident 43 stated there were times when the facility staff did not know he had seizures in his room because staff did not check on him. Resident 43 stated, he fell from his wheelchair a few times when he had seizures. Resident 43 stated he felt sad because it seemed like the staff did not care about him. Review of Resident 43's Departmental Notes, revealed Resident 43 had 11 seizure episodes from 3/3/24 through 5/8/24. During an interview on 5/14/24, at 9:35 a.m., with CNA 2, CNA 2 stated, she monitored Resident 43 every 15-30 minutes because the resident had a history of having frequent seizures. CNA 2 stated she did not document monitoring Resident 43. During an observation on 5/14/24, at 9:20 a.m., in Station 1 hallway, facility staff did not check on Resident 43 for 50 minutes. During an interview on 5/14/24, at 9:20 a.m., with LVN 2, LVN 2 stated, Resident 43 should be monitored every 15 to 30 minutes due to the history of frequent seizures. LVN 2 acknowledged it was not acceptable for Resident 43 not to be checked by the staff for 50 minutes. LVN 2 further stated, Resident 43 could sustain serious injuries from a seizure and fall. During an interview on 5/15/24, at 11:27 a.m., with Director of Nursing (DON), DON stated, Resident 43 should be monitored at least every 15 minutes due to frequent seizure activities. DON stated staff not checking on Resident 43 for 50 minutes was not acceptable. During a review of the facility's P&P titled, Emergency Procedure-Seizure Management, Revised 2018, the P&P indicated, Personnel will assist in safety measures for a resident who is having a seizure .

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 44771 Based on interview and record review, the facility failed to ensure there was Registered Nurse (RN) coverage eight hours a day, seven days a week, when an RN was not on duty for eight of 12 days sampled. This failure has the potential to endanger the health and safety of residents while presenting a threat to residents from reaching their highest practicable level of well-being. Findings: During a concurrent interview and record review, on 5/17/2024, at 11:20 a.m., with Payroll (PAYROLL), payroll data was reviewed from Q1/2023 (January - March) until Q1/2024 (January - March). A random sample of dates were chosen for review for each quarter. Payroll confirmed there was no RN scheduled for the following dates: 1. For the month of July 2023: 7/10/23, 7/12/23, 7/13/23 2. For the month of August 2023: 8/24/23, 8/25/23, 8/28/23 3. For the month of October 2023: 10/27/23, 10/30/23 During an interview on 5/17/24, at 11:59 a.m., with Director of Nursing (DON), DON stated there has be an RN in the facility eight hours a day.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 39291 Based on interview and record review, the facility failed to ensure a system of records for controlled drugs (medications regulated by the government due to high risk for potential abuse and dependence) for disposition were followed and maintained when three Controlled Drug Logbook (CDL) pages of the Narcotics Destruction Log (NDL) were not consistently completed with date of Director of Nursing Services (DNS) receipt of controlled medications, no co-signatures by the licensed nurse and DNS upon exchange of controlled medications, and no page number. The failure to complete three CDL pages listing a total of 43 medications had the potential to prevent accurate accounting of controlled medications and prompt identification of loss, extent of loss, or potential diversion of controlled medications. Findings: During a concurrent interview and record review on 5/16/24 at 8:44 a.m., with the Director of Nursing (DON), at the DON's office, the Narcotics Destruction Log (NDL) binder was reviewed. The pages in the NDL were titled Controlled Drug Logbook (CDL). The three CDL pages contained a total listing of 43 medications with the lot number of the first listed medication on the CDL pages as follows: 608016C (15 medications listed on the page), 4010082 (14 medications listed on the page), and 606609N (14 medications listed on the page). The CDL pages were printed forms with rows for each medication and labeled columns with spaces for data entry. The top portion of each of the CDL pages indicated, All discontinued controlled drugs are to stay in the locked medication cart until picked up by the Director of Nursing Services. Director of Nursing Services will go to each nurses station and pick up all discontinued controlled drugs from each medication cart. D/C'd [discontinued] controlled drugs will be counted and logged by the license nurse and co-signed by the DNS at the time of exchange. DNS will log the date of destruction when destroying controlled drugs with the pharmacy. Both the DNS and pharmacy will sign when destroyed. *Note: Log must have a page number listed on each page. The reviewed CDL pages had no entries in the first columns labeled Date. There was an arrow pointing from column one to a handwritten note at the bottom of the page which indicated, is the Date when DON receives the medication from the nurses. There were no co-signatures by the licensed nurse and DNS for exchange of the controlled medications for destruction (column eight). The reviewed CDL pages had no page number. The DON stated the CDL pages were missing information for the date column, staff co-signatures (column eight), and page numeration. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/16/24 at 3:14 p.m., with the DON, the DON stated there was no policy yet on the CDL records utilized for controlled drugs for disposition. DON stated the facility follows instructions written on the CDL record for the process. DON stated it was important to maintain consistent narcotic logs for disposition to prevent diversion and avoid discrepancies with narcotics.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46487 Based on interview and record review, the facility failed to ensure three of 18 sampled residents (Residents 33, 23, and 28) residents were free from unnecessary psychotropic drugs (medications that are capable of affecting the mind, emotions, and behavior) when: 1. Resident 33's PRN (pro re nata [a Latin phrase], meaning as needed, or as necessary) order for Olanzapine (an anti-psychotic medication used to treat mental disorders) had no end date. 2. Resident 23 had no rationale for continued use of PRN Ativan beyond 14 days (Ativan is a psychotropic medication used to treat anxiety). 3. Resident 28 had no rationale for continued use of PRN Ativan beyond 14 days. These failures had the potential to not promote or maintain Resident 33's highest practicable mental, physical, and psychosocial well-being. Findings: 1. Review of Resident 33's History and Physical (H&P), dated 4/16/24, indicated past medical history of Diabetes Type II and Dementia (impaired memory and thinking abilities). The H&P also included an Assessment/Plan, that indicated, Agitation - was given Olanzapine . Review of Resident 33's Order Summary Report (OSR), dated 04/01/24 - 05/31/24, indicated, Olanzapine Oral Tablet 5 MG . Give 1 tablet by mouth every 8 hours as needed for agitation . The OSR indicated, Communication Method - Prescriber Written, with Order Status that indicated Active, and Start Date of 4/3/24. The OSR End Date was blank [no end date indicated]. Review of the facility's Policy and Procedures (P&P), titled, Antipsychotic Medication Use, revision dated 12/2016, the P&P indicated, .PRN orders for antipsychotic medications will not be renewed beyond 14 days unless the healthcare practitioner has evaluated the resident for the appropriateness of that medication . 2. A review of Resident 23's clinical record indicated diagnoses of dementia and anxiety (a type of mental health condition). Review of resident 23's Quarterly Minimum Data Set (MDS- an assessment screening tool to guide care), dated 2/9/24, under Section C, indicated Resident 1's short- and long-term memory was impaired, and had moderately impaired decision-making capacity (decisions poor, cues/supervision required). Review of Resident 23's physician order dated 5/14/24, indicated, the physician prescribed Ativan 0.5 milligram (mg, a unit of measurement) by mouth every 8 hours PRN for anxiety with a start date of 4/29/24. There was no stop date for the PRN Ativan. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 5/15/24 at 10:22 a.m., with Registered Nurse (RN) 1, Resident 23's Physician's Order , dated May 2024, was reviewed. RN 1 acknowledged Resident 23's PRN Ativan did not have a stop date and should have a duration of 14 days. 3. A review of Resident 28's clinical record indicated diagnoses of dementia and anxiety. Review of resident 28's Quarterly MDS, dated [DATE], under Section C, indicated Resident 1's short- and long-term memory was impaired, and had moderately impaired decision-making capacity (decisions poor, cues/supervision required). Review of Resident 28's physician order dated 5/14/24, indicated, the physician prescribed Ativan 1 mg. by mouth every 6 hours as needed for anxiety with a start date of 3/13/24. There was no intended duration of Ativan. During a concurrent interview and record review on 5/15/24 at 10:22 a.m., with RN 1, Resident 28's Physician's Order, dated May 2024, was reviewed. RN 1 acknowledged Resident 28's PRN Ativan did not have a stop date and should have a duration of 14 days. During an interview on 5/15/24 at 11:27 a.m., with Director of Nursing (DON), stated physician's orders of PRN psychotropic medications should have a duration of 14 days, and the licensed nurses should remind the physician to reevaluate if it was appropriate to extend the PRN psychotropic medications. During an interview on 5/17/24 at 12:34 p.m., with the Pharmacy Consultant (PC), the PC acknowledged PRN orders of psychotropic medications were limited to 14 days duration, then should have been reevaluated by the physician for the indication for continued use beyond the 14 days. Review of the facility's Policy and Procedures (P&P), titled, Psychotropic Medication Use, undated, the P&P indicated, .15. PRN orders for psychotropic medications will not be renewed beyond 14 days unless the healthcare practitioner has evaluated the resident for the appropriateness of that medication .

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 39291 Based on observation, interview, and record review, the facility failed to ensure medications were dated and stored under proper temperature controls in the medication refrigerator for one of two medication rooms (a locked room used to store medications and supplies) when: 1. Medication refrigerator temperatures were not monitored daily for nine days out of 31 days in May 2024. 2. Two multiple dose vials of Tuberculin Purified Protein Derivative (PPD, a test used to detect tuberculosis (an illness that affects the lungs), were not labeled with the date the vials were opened. These failures had the potential to result in resident use of ineffective medications. Findings: 1. During a concurrent interview and record review on 5/13/24 at 2:09 PM, with the Infection Preventionist (IP), the Temperature Log, for the medication refrigerator was reviewed. The Temperature Log indicated, Medication Fridge Temperature Acceptable Range: 36 F - 46 F. The IP stated there were no refrigerator temperature records documented on the following days in May 2024: May 1, 3, 5, 6, 7, 8, 9, 10, 11. During an interview on 5/13/24 at 2:10 p.m., IP stated it was important to monitor medication refrigerator temperature to ensure the medications don't get bad. Review of the facility's Policy and Procedures (P&P) titled, Policy and Procedure On Medication Room & Refrigerator Temperatures dated 5/2023, indicated, .It shall be this facility's policy to store all drugs in secured locations and/or locked compartments under proper temperature controls . 5. Refrigerator inside the medication room used for storage of drugs and biologicals should be monitored daily for proper temperature (36-46 degrees Fahrenheit) . Review of the facility's Policy and Procedures (P&P) titled, Medication Storage in the Facility, revised January 2018, the P&P indicated, .L. All medications are maintained within the temperature ranges noted in the United States Pharmacopeia (USP) and by the Centers for Disease Control (CDC) . 3) Refrigerated 36 F to 46 F (2 C to 8 C) with a thermometer to allow temperature monitoring . 2. During a concurrent observation and interview on 5/13/24 at 2:24 PM, with the IP, the medication refrigerator in the medication room next to the Pine Tree nursing station had two multiple dose vials of tuberculin PPD: one of diluted Aplisol, and one of Mantoux Tubersol. Both vials contained liquid and were stored inside an unsealed original manufacturer's box with the vial stoppers uncovered. There was no date on either the manufacturers' box or the vials to indicate when the vials were first accessed/opened. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056471	A. Building B. Wing	05/17/2024

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/13/24 at 2:26 p.m., with the IP, the IP stated the two opened multiple dose vials of Tuberculin PPD tests had no dates when they were initially used. IP stated the vials should be discarded 28 days after they were opened. Review of the facility's Policy and Procedures (P&P), titled, Medication Storage in the Facility, revised January 2018, the P&P indicated, .D. When the original seal of a manufacturer's container or vial is initially broken, the container or vial will be dated. 1) The nurse shall place a date opened sticker on the medication and enter the date opened and the new date of expiration (NOTE: the best stickers to affix contain both a date opened and expiration notation line). The expiration date of the vial or container will be [30] days unless the manufacturer recommends another date or regulations/guidelines require different dating . Review of the U.S. Food and Drug Administration's (FDA) package insert for Aplisol (Tuberculin Purified Protein Derivative, Diluted Stabilized Solution), dated 11/2013, indicated, .How supplied - Tuberculin PPD-Aplisol . multiple dose vial . Storage . Vials in use more than 30 days should be discarded due to possible oxidation and degradation which may affect potency . Review of the U.S. Food and Drug Administration's (FDA) package insert for Tuberculin Purified Protein Derivative (Mantoux) Tubersol Rx only, undated, indicated, . How supplied Tubersol Tuberculin Purified Protein Derivative (Mantoux) . is supplied in: .multi-dose vial (10 tests) . A vial of TUBERSOL which has been entered and in use for 30 days should be discarded .