STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225242	A. Building B. Wing	02/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westborough Healthcare	8 Colonial Drive Westborough, MA 01581

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, and interviews, the facility failed to maintain proper sanitation and food handling practices to prevent the outbreak of foodborne illness in the main facility kitchen.Specifically, the facility failed to ensure that the minimum wash temperature necessary was maintained per manufacturer's guidelines for the dish machine utilized for cleaning and sanitizing dishware for resident use in the main facility kitchen, when the low temperature dish machine was operating at registered temperatures below acceptable ranges of 120 degrees Fahrenheit (F) for the wash cycle. Findings include:Review of The Food Safe Pal, Dishwashing Temperature Guidelines, dated 10/29/2024, retrieved from https://foodsafepal.com/dishwashing-temperature-guidelines/ indicated the following:-Ensuring that the wash and rinse water of your dishwasher reach a certain minimum temperature is just as important as cooking food to the proper minimum internal temperature.-Just as bacteria and other pathogens can survive on food that's not cooked to its minimum internal temperature, they can also survive on dishes and utensils that aren't washed and rinsed at the proper temperatures.-The minimum wash and rinse temperature depends on the type and whether it uses heat or chemicals to sanitize.-Those that rely on heat are called high-temperature dishwashers, while those that rely on chemicals are called low-temperature dishwashers.-For dishwashers that use chemicals to sanitize, the wash and rinse cycles should reach at least 120 Fahrenheit [F} (49 Celsius [C]).-Dishwashers that rely on chemicals to sanitize should reach a minimum of 120 F (49 C). Review of the temperature log provided by the Food Service Director (FSD) for February 2026, indicated for Low Temperature Dish Machine Temperature Log:-Wash Temperature: 120 degrees F-Rinse Temperature: 120 degrees F-If levels are out of acceptable range, do not wash dishes and notify supervisor. On 2/19/26 from 11:30 A.M. through 12:15 P.M., the surveyor and the FSD observed the following during a walkthrough of the kitchen: -Dish machine was in operation and running.-Dietary Aide #1 was pre-rinsing and loading dirty dishware and meal trays into the dish racks to be washed.-Dish machine wash temperature fluctuated and did not reach above 120 degrees F.-Dish machine wash temperature was observed at 80 degrees FDuring an interview at the time, Dietary Aide #1 was unable to verbalize the temperature reading on the dishwashing machine. The FSD said that washing and rinsing dishes at 80 degrees F was an acceptable temperature because the dishwashing machine had chemical sanitizer in the water. -The FSD provided a chemical testing strip, (test strips for sanitizing solutions - used to measure the concentration of active sanitizing agents, ensuring effective sanitation in various settings), tested the water using the test strip, and demonstrated to the surveyor the test strip matched corresponding testing parameter, and informed the surveyor that the sanitizer was at an acceptable level. -The FSD said there was no concern with the dishwashing temperature remaining at 80 degrees F. -Dietary Aide #1 continued to wash dishes while the machine temperature remained at 80 degrees F. On 2/19/26 at 1:00 P.M., the FSD and the Administrator reported to the surveyor that a Pilot (something that controlled the temperature of the dishwasher) had shut down, and that the pilot light had been corrected, and therefore the temperature of the dishwashing machine was working. During an interview on 2/19/26 at 1:43 P.M., the Administrator said the dishwashing machine was operating at (continued on next page)

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.

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	an acceptable temperature (80 degrees F) because there was an acceptable level of sanitizer in the dishwashing machine. During a follow-up observation and interview on 2/19/26 at 4:15 P.M., the surveyor and the FSD observed the following: -Dish machine was in operation and running.-Dietary Aide #1 was pre-rinsing and loading dirty dishware and meal trays into the dish racks to be washed.-Dish machine wash temperature was observed at 100 degrees F.During an interview at the time, the FSD said the facility will continue to monitor the Pilot to ensure proper functioning of the dish washing machine. Dietary Aide #1 continued to wash dishes while the machine temperature was at 100 degrees F. At time of survey exit, no further evidence was provided to the survey team that the low temperature dishwashing machine met the minimum required temperature of 120 degrees F.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observations, record reviews, and interviews, the facility failed to adhere to infection control standards of practice to prevent contamination and the spread of infections for two Residents (#9 and #38) out of a total sample of 21 residents, and also failed to clean and sanitize hands before and after removing resident meal trays on one unit (2nd Floor) out of three units observed.Specifically, 1.For Resident #9 and Resident #38, the facility failed to ensure that appropriate Personal Protective Equipment (PPE: items such as gowns and gloves worn to prevent the spread of infection) was worn as required for the Resident on Enhanced Barrier Precautions (EBP), and that hand hygiene was performed before donning (putting on) PPE and during provision of activities of daily living (ADL - washing, bathing and grooming) care, placing both Residents at increased risk of contamination and the spread of infections.2. For the 2nd Floor unit, the facility failed to ensure staff performed appropriate hand hygiene between handling meal trays being passed in multiple resident rooms. Findings include: Review of the facility policy titled Infection Control Guidelines for Nursing Procedures, revised in July 2024 indicated:-Standard precautions are the minimum infection prevention practices that apply to all resident care, regardless of suspected or confirmed infection status of the resident, in any setting where health care is delivered. These practices are designed to both protect (Direct Health Care Personnel) DHCP and prevent DHCP from spreading infections among residents. Standard precautions include:-Hand hygiene-Use of PPE-Transmission-Based Precautions (TBP) will be used whenever measures more stringent than Standard Precautions are needed to prevent the spread of infection. Transmission Based Precautions will be initiated when there is reason to believe that a resident has a communicable infectious disease. Transmission Based Precautions may include Enhanced Barrier Precautions.-Enhanced Barrier Precautions (EBP) are infection control intervention designed to reduce transmission of multi-drug-resistant organisms (MDROs).-Use of gowns and gloves during high-contact resident care activities that may provide opportunities for transmission of MDROs via staff hands and clothing. Example of high contact resident activities are dressing, bathing, showering, transferring, changing linen, personal hygiene, toileting/brief change. Review of CDC Guideline for Frequently Asked Questions (FAQs) about Enhanced Barrier Precautions in Nursing Homes, revised 6/28/24, retrieved from https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/faqs.html indicated: -Enhanced Barrier Precautions are an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes. -Enhanced Barrier Precautions involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices). -Enhanced Barrier Precautions expand the use of gowns and gloves beyond anticipated blood and body fluid exposures. They focus on use of gowns and gloves during high-contact resident care activities that have been demonstrated to result in transfer of MDROs to hands and clothing of healthcare personnel, even if blood and body fluid exposure is not anticipated. -Enhanced Barrier Precautions are recommended for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices). -Standard Precautions still apply while using Enhanced Barrier Precautions. For example, if splashes and sprays are anticipated during the high-contact care activity, face protection should be used in addition to the gown and gloves. 1a. Resident #9 was admitted to the facility in May 2023 with diagnoses including Unspecified Dementia. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #9's February 2026 Physician's orders indicated:-Maintain Enhanced Barrier Precautions due to wounds every shift, start 5/5/25.-Enhanced Barrier Precaution every shift, start 8/8/25. On 2/19/26 at 7:45 A.M., the surveyor observed the following:-Signage posted at Resident #9's door indicated that the Resident was on EBP.-EBP signage indicated that anyone entering the room should clean their hands when entering or exiting the room and staff must wear gloves and a gown for high contact care activities. -CNA #3 entered Resident #9's room and pulled the curtain.-CNA #3 was not observed to wear a gown.-CNA #3 washed and dressed Resident #9.-CNA #3 exited Resident #9's room, without washing or sanitizing her hands.-CNA #3 returned to Resident #9's room with CNA #4.-CNA #3 and CNA #4 were observed transferring Resident #9 with a hydraulic lift from the Resident's bed to his/her chair.-CNA #5 entered Resident #9's room, removed the hydraulic lift and brought the lift to another resident's room. CNA #5 was not observed disinfecting the hydraulic lift before removing the equipment from Resident #9's room. 1b. Resident #38 was admitted to the facility in April 2025 with diagnoses including Moderate Protein-calorie Malnutrition and Gastrostomy Status. Review of Resident #38's February 2026 Physician's orders indicated:-Enhanced Barrier Precautions related to G-Tube and wounds, start 12/30/25. On 2/19/26 at 9:34 A.M., the surveyor observed the following:-Signage posted at Resident #38's door indicated the Resident was on EBP.-EBP signage indicated that anyone entering the room should clean their hands when entering or exiting the room and staff must wear gloves and a gown for high contact care activities.-CNA #6 entered Resident #38's room and pulled the curtain.-CNA #6 was not observed to wear a gown.-CNA #6 washed and dressed Resident #38.-CNA #6 exited Resident #38's room, without washing or sanitizing her hands. During an interview on 2/19/26 at 9:38 A.M., CNA #6 said she forgot to wear a gown. During an interview on 2/19/26 at 9:42 A.M., CNA #3 said she was not aware that Resident #9 was on precautions. CNA #3 said she did not observe the precautions sign at the Resident's door. CNA #3 said she should have worn a gown before providing ADL care to Resident #9, but she did not. During an interview on 2/19/26 at 9:59 A.M., CNA #4 said she was not aware Resident #9 was on precautions. CNA #4 said she did not observe the precautions sign at the Resident's door. CNA #4 said she should have worn a gown before assisting CNA #3 to transfer Resident #9 with the hydraulic lift, but she did not. During an interview on 2/19/26 at 10:03 A.M., CNA #5 said she was not aware Resident #9 was on precautions. CNA #5 said she did not observe the precautions sign at the door and should have disinfected the hydraulic lift before removing the lift out of Resident #9's room but she did not. During an interview on 2/25/26 at 2:00 P.M., the Director of Nursing (DON) said it was her expectation for staff to adhere to the infection prevention protocols when EBP signage is displayed at a Resident's door. 2. Review of the facility policy titled Handwashing/Hand Hygiene dated 4/2018 and last revised 7/2024 indicated: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-All staff shall be trained and regularly in-serviced on the importance of hand hygiene in prevention of the transmission of healthcare-associated infections -Use an alcohol-based hand rub at least 62% alcohol; or alternatively soap and water for the following situations: -Before and after entering isolation precaution settings -Before and after assisting a resident with meals On 2/19/26 at 7:49 A.M. through 8:30 A.M., the surveyor observed the following on the 2nd Floor unit: -CNA #7 entered a resident room with a meal tray and set it up for the resident and then exited the room. CNA #7 was then observed going directly to the meal tray cart and taking another tray from the cart without performing hand hygiene. -CNA #7 entered a second resident room with a meal tray, set up the resident's meal tray and exited the room. CNA #7 went directly to the tray cart and took another tray from the cart without performing hand hygiene. -CNA #7 entered a third resident room, set up the meal tray for the resident and then exited the room. CNA #7 went directly to the meal cart and took another meal tray from the cart and entered a fourth resident room. CNA #7 set up the resident's meal tray and exited the room without performing hand hygiene. -CNA #7 moved the meal tray cart to another section of the unit, took a meal tray from the cart and delivered the tray to a resident room. CNA #7 exited the room and did not perform hand hygiene. CNA #7 went directly to the meal cart, took another tray from the cart and entered a resident room with contact precautions signs outside the room. CNA #7 set up the tray for the resident and did not perform hand hygiene when exiting the room before going to take another meal tray from the cart. During an interview on 2/19/26 at 8:15 A.M., with Nurse #3 translating for CNA #7, CNA #7 said she should be performing hand hygiene between every meal tray passed, but she was not. During an interview on 2/19/26 at 8:54 A.M., the Assistant Director of Nurses (ADON) who was also serving as the Infection Preventionist (IP) for the facility said the staff should be performing hand hygiene between every resident meal tray passed to decrease the risk for the spread of infection.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, and interviews, the facility failed to provide appropriate access to the call light for one Resident (#16) out of a total sample of 21 residents.Specifically, for Resident #16, the facility staff failed to place the Resident's call light within his/her reach placing the Resident at risk for unmet needs. Findings include:Review of the facility policy titled Answering call lights, established 4/2018 revised 1/2024, included but was not limited to:-The purpose of this procedure is to respond to the resident's requests and needs-When the resident is in bed provide the call light within easy reach of the resident.-Answer the resident's call as soon as possible Resident #16 was admitted to the facility in January 2023 with diagnoses including Bell's Palsy, insomnia unspecified, anxiety disorder, Major Depressive Disorder, and Unspecified Dementia. Review of the Resident's Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #16:-was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15 possible points. -has adequate hearing and vision-has clear speech-could understand others and could make himself/herself understood. On 2/18/26 at 8:14 A.M., the surveyor observed Resident #16 lying in bed and the Resident's call bell hanging on the wall on the far side of the bedside chair. During an interview at the time, the Resident said that he/she didn't have a call bell to call for staff. When the surveyor asked how he/she would get assistance from staff, the Resident said he/she would just get out of bed and go into the hallway and ask for help. On 2/18/26 at 3:45 P.M., the surveyor observed Resident #16 lying in bed. There was a bedside chair observed on the left side of the Resident's bed and on the far side of the chair the Resident's call bell was attached to the wall beyond his/her reach. When the surveyor asked, the Resident said that he/she was not aware of any call bell, and if he/she needed someone he/she would just go into the hallway and call for help. On 2/19/26 at 9:39 A.M., the surveyor observed Resident #16 lying in bed and the call bell was clipped to the wall, on the other side of a chair that was placed beside the Resident's bed. The call bell was observed beyond the Resident's reach. During an interview at the time, Resident #16 said that he/she never had a call bell. On 2/19/26 at 9:41 A.M., the surveyor and Nurse #2 observed Resident #16 lying in bed and the call bell hanging on the wall on the far side of the Resident's bedside chair. During an interview at the time, Nurse #2 said the call bell should always be accessible to the Resident and not hooked on the wall beyond the Resident's reach. Nurse #2 unhooked the call bell from the wall and made the call bell accessible to Resident #16. During an interview on 2/19/26 at 11:15 A.M., the Director of Nursing (DON) said that call bells should always be accessible to the Residents.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to inform one Resident (#5) out of a total sample size of 21 residents in advance of the risks and benefits of treatments prior to implementation of treatment.Specifically for Resident #5 the facility failed to obtain signed informed consent for the use of two psychotropic medications prior to administration of the medications to the Resident. Findings include:Review of the Facility policy titled Psychotropic Medication, dated 4/2018 last revised 7/2023, indicated:-a written informed consent from the resident (or legally authorized individual in the case of resident incompetence) is required for administration of psychotropic medication. Resident #5 was admitted to the facility in July 2025 with diagnoses including Anxiety Disorder, Alcoholic Liver Disease, Chronic Kidney Disease Stage 4. Review of Resident #5's Minimum Data Sets (MDS) assessment dated [DATE] indicated:-taking anti-anxiety and antidepressant medications.-was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) exam score of 15 out of a possible 15. Review of Resident #5's Psychotropic Medication Care Plan initiated 7/29/25 and revised 8/20/25 indicated:-Resident is taking psychotropic medications-Interventions included: discuss with MD, family re (regarding) ongoing need for use of medication.-Review behaviors/interventions and alternate therapies attempted and their effectiveness as per facility policy, initiated 7/29/25. Review of Resident #5's February 2025 Physician's orders indicated the Resident had orders for the following medications:-Sertraline HCL (hydrochloride) oral tablet (Antidepressant medication) 100 mg (milligrams) (Sertraline HCL), give 2 tablets by mouth one time a day for depression, 2 TABS = 200 mg, start date 11/23/25.-Trazodone HCL oral tablet (Antidepressant medication) 50 mg (Trazadone HCL), give 2 tablets by mouth at bedtime for anxiety and insomnia, start date 11/22/25. Review of Resident #5's Medication Administration Records (MAR) for November 2025, December 2025, January 2026 and February 2026 indicated the Sertraline HCL and Trazodone were administered as ordered by the Provider. Review of Resident #5's medical record failed to indicate evidence that the Resident or Resident's Representative had signed a written informed consent for the Trazodone or the Sertraline medications. The facility was unable to provide any evidence a signed informed consent was completed for Resident #5 prior to administration of Sertraline and Trazodone. During an interview on 2/25/26 at 7:44 A.M., Nurse #4 said when a resident gets an order for a new psychotropic medication, a signed written consent was obtained from the resident or the resident's health care proxy, prior to administering the medication. Nurse #4 said consent should always be obtained prior to administering any new psychotropic medications. Nurse #4 was unable to find evidence a written signed consent for Resident #5's Sertraline and Trazodone had been completed but she said one should have been obtained prior to administering the medications. During an interview on 2/25/26 at 8:00 A.M., the Director of Nursing (DON) said written signed consent for psychotropic medications should be obtained prior to administering any new psychotropic medications. The DON said Resident #5 should have signed informed written consents prior to administering the Trazodone and Sertraline, but she had no evidence consent was obtained prior to administration of the medications.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide independent activities of choice to meet the mental and psychosocial needs of one Resident (#13), out of a total sample of 21 residents.Specifically, for Resident #13, the facility failed to ensure the Resident was provided with preferred television access in his/her bedroom, after the Resident requested assistance to access television programming, resulting in negative psychosocial outcome of increased anxiety and depressed mood of the Resident. Findings include:Review of the Facility Assessment, last revised 2/5/26, indicated:- The facility adjusts its activities to accommodate all residents, ensuring everyone has access to meaningful and enjoyable programs.- The facility inquires about each resident's hobbies, interest, and the activities they enjoyed at home and tailors programs to their preferences. Review of the facility's policy titled Residents Rights, revised January 2024, indicated that the residents have a right to:-a dignified existence.-be supported by the facility in exercising his or her rights.-communication with and access to people and services, both inside and outside the facility.-equal access to quality care, regardless of source of payment. Resident #13 was admitted to the facility in September 2016 with diagnoses including Tracheostomy, Gastrostomy, Anxiety, Insomnia, Depression, and Post Traumatic Stress Disorder (PTSD). Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #13:-was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of a possible 15-reported stable mood with no symptoms of depression. Review of the Activity Assessment, dated 12/10/25, indicated the following for Resident #13:-Preference for self-directed activities.-preferred 1:1 room activity-Types of entertainment in the Resident's room - TV, Phone, Radio, and other reading materials. Review of Resident #13's Activity Care Plan, last revised 12/11/25, indicated:-Goal was for the Resident to express satisfaction with type of activities and level of activity per preferred daily routine.-Resident preferred to spend his/her leisure time in his/her room and does not attend activities regularly.-Resident was mostly reserved and did not participate in groups. Review of Resident #13's Psychosocial Well-Being Care Plan, last revised on 6/30/35, indicated:-has potential for alteration in psychosocial well-being/coping mechanisms related to diagnoses of depression, anxiety, PTSD, failure to thrive, initiated 3/15/20.-interventions include direct problems to those who can address them and honor Resident preferences and choices. During an interview on 2/20/26 at 7:03 A.M., Resident #13 said that television was his/her only source of entertainment and activity and that he/she preferred to watch cable news programing and movies in his/her room. The Resident further said there were no movies, news, or other TV channels available. Resident #13 said he/she reported the issue several times to staff members, including maintenance, for the past twenty-five days that he/she was unable to watch channels on the television, but no one had assisted him/her. Resident #13 said the lack of response had been giving [him/her] a lot of anxiety and it was destroying [his/her] mental health. Resident #13 also said he/she had been told that the facility was in the process of obtaining satellite services but that had not yet occurred. The Resident demonstrated to the surveyor on the television set in his/her room that the channels available were TURBO and Golf Channel, and all other channels were nonfunctional and showed static. During an interview on 2/20/26 at 8:15 A.M., the Administrator said he was aware of Resident #13's inability to obtain TV channels. The Administrator said the Ombudsman had reported Resident #13's concern to him about two weeks ago. The Administrator said he did not follow up with the Resident because the facility was in the process of acquiring satellite television. During an interview on 2/20/26 at 9:27 A.M., the Ombudsman said Resident #13 made her aware of his/her inability to watch TV and/or watch movies when she visited the Resident on 1/29/26, which was interfering with his/her mental health. The Ombudsman said she presented Resident #13's concerns to the Administrator on 1/29/26. During an interview on 2/20/26 at 10:44 A.M., the Administrator said he did not follow up with Resident #13 (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	after the Ombudsman informed him of the Resident's concern. The Administrator said he should have followed up with Resident #13 and offered a resolution, but he did not.

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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 - Few	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. Based on observation, and interviews, the facility failed to ensure that drugs and biologicals were stored in accordance with State and Federal laws in one (2nd Floor) of two medication storage rooms reviewed. Specifically, the facility failed to ensure multi-dose vial medications were dated once opened according to manufacturer's guidelines in the 2nd Floor medication storage room. Findings include:Review of the facility policy titled Storage of Medications, established 4/2018, revised 1/2024, included but was not limited to:-the facility shall store drugs and biologicals in a safe, secure, and orderly manner.-the facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs will be destroyed. On 2/19/26 at 9:56 A.M., the surveyor and Nurse #1 observed the 2nd Floor medication storage room. The surveyor observed two multi-dose vials of medication opened with no open or expiration date indicated. The medications observed were:-Tuberculin, Purified Protein Derivative Diluted/Aplisol 5TU (Tuberculin Units) for intradermal test, 1 ML (milliliter) (10 tests), Once entered, vial should be discarded after 30 days.Review of the Tuberculin, Purified Protein Derivative Diluted/Aplisol package insert indicated that the multi-dose vial should be dated when opened and discarded after 30 days.-Insulin Lispro 10 ML multi-dose vial, 100 units per ML.Review of the Insulin Lispro package insert indicated that the multi-dose vial once opened should be discarded after 28 days. During an interview on 2/19/26 at 10:00 A.M., Nurse #1 said she did not know when the two vials of medication had been opened. Nurse #1 said that the multi-dose vials of Tuberculin serum and Insulin Lispro should have been labeled when they were opened but the two vials had not been labeled. Nurse #1 said that once opened the vials would be good for 30 days but since she couldn't tell when these two vials had been opened, she would have to discard them. During an interview on 2/19/26 at 11:15 A.M., the Director of Nursing (DON) said all multi-dose medication vials should be labeled with an open date indicating when they were first opened.