STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395707	A. Building B. Wing	04/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clarion Healthcare and Rehabilitation Center	999 Heidrick Street Clarion, PA 16214

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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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48496 Based on observation, review of clinical records and facility policy, and resident and staff interviews, it was determined that the facility failed to allow residents the right to make choices about aspects of his or her life in the facility that are significant to the resident for one of 20 residents reviewed (Resident R17). Findings include: Resident R17's clinical record revealed an admitted [DATE], with diagnoses that included diabetes (condition of improper blood sugar control), anxiety (a condition that causes a person to be nervous, uneasy, or worried about something or someone), and Crohn's disease (a chronic inflammation of the digestive tract that leads to abdominal pain and severe diarrhea). Review of facility policy entitled Resident Rights dated 1/2/24, revealed Federal and state laws guarantee certain rights to all residents . These rights include the residents right to, self-determination. Review of Resident R17's Minimum Data Set (MDS- periodic assessment of resident care needs) assessment dated [DATE], indicated that Resident R17 had a Brief Interview for Mental Status (BIMS-tool used to assess cognitive status) of 15 (a score from 13 to 15 indicates intact cognition, or mental status). Review of Resident R17's care plans revealed a care plan focus for activities with interventions that included encourage resident out of room for activities. Further review of care plans revealed a care plan focus for depression with interventions that included involve resident in making his/her own schedule of activities. Review of Resident R17's MDS Section F 0500 dated 8/16/23, indicated that participating in religious services or practices, attending favorite activities, and doing things with a group of people is very important to Resident R17. During an interview with Resident R17 on 4/9/24, at 12:00 p.m. resident shared that he/she wanted to be out of bed for meals including breakfast and that he/she would like to be up in his/her wheelchair to eat. He/she also shared that he/she wants to attend bible study, and other activities but staff does not always have him/her up to attend on a regular basis. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 4/9/24, at 12:00 p.m. revealed Resident R17 was laying in his/her bed dressed in his/her pajamas. Further observations at 2:10 p.m. revealed resident was laying in his/her bed and remained dressed in his/her pajamas, and at 2:13 p.m. resident was observed being assisted by staff getting ready for the day. Observation on 4/10/24, at 10:00 a.m. revealed Resident R17 was laying in his/her bed dressed in his/her pajamas, further observations at 11:34 a.m. revealed resident was laying in his/her bed and remained dressed in his/her pajamas, with further observations on 4/10/24, revealed that at 12:30 p.m. resident was up in his/her wheelchair appropriately dressed. Observation on 4/10/24, at 12:37 p.m. revealed Resident R17 was being assisted to the dining room for lunch when a staff member approached Resident R17 with his/her lunch tray. At the time of observation, Resident R17 was observed being taken back to his/her room to eat his/her lunch. During an interview with Resident R17 on 4/10/24, at 12:45 p.m. he/she shared that he/she was eating in her room because the staff told him/her that lunch was done in the dining room. He/she shared that she eats in the dining room for lunch. Observation on 4/10/24, at 12:55 p.m. of the seating chart in the dining room revealed Resident R17's name on the seating chart posted on the wall in the dining room. Observation on 4/11/24, at 9:35 a.m. Resident R17 was laying in his/her bed dressed in his/her pajamas, further observation on 4/11/24, at 10:35 a.m. revealed resident was up in his/her wheelchair. Interview with Resident R17 on 4/11/24, at 10:40 a.m. revealed he/she shared that he/she wanted to be at a resident council meeting that was scheduled at 10:00 a.m. but he/she had just got out of bed. He/she shared that not getting out of bed in a timely manner happens often. During an interview on 4/12/24, at 11:25 a.m. the Nursing Home Administrator and the Director of Nursing confirmed that residents have the right to be out of bed for meals and activities. They also confirmed that it is not appropriate for staff to not get a resident out of bed per the resident's wishes. 28 Pa. Code 201.29 (a) Resident rights 28 Pa. Code 201.18 (b)(1)(3) Management 28 Pa. Code 211.12(d)(1)(5) Nursing services

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 40177 Based on review of facility policy, observations, and staff interview, it was determined that the facility failed to maintain privacy of confidential information during medication administration for one of three resident units (Unit C). Findings include: Review of a facility policy entitled Confidentiality of Information and Personal Privacy dated 1/2/24, indicated The facility will safeguard the personal privacy and confidentiality of all Resident personal and medical records. Observation on 4/9/24, between 3:50 p.m. and 4:20 p.m. revealed Licensed Practical Nurse (LPN) Employee E1 performing resident medication administration to Residents R5, R10, R26, R28, R45, R47, and R60. The medication cart was parked in the hallway against the wall with the computer screen unlocked and open, sitting on top of the medication cart facing into the hallway with resident information accessible to anyone passing by in the corridor. On each occasion, the LPN proceeded into the resident's room to administer medication where the medication cart / computer screen was out of his/her view and did not cover resident information that was on the computer screen accessible to anyone passing by. During an interview on 4/9/24, at 4:20 p.m. LPN Employee E1 confirmed that he/she left the medication cart unattended and out of his/ her view the computer open and resident information accessible to anyone passing by. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 211.5(b) Medical records 28 Pa. Code 211.12(d)(1)(5) Nursing services

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F 0600

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 48496

Based on review of facility policy and documentation and clinical record, and resident and staff interviews, it was determined that the facility failed to ensure that one of 20 residents reviewed was free of neglect during care. (Resident R8)

Findings include:

Review of facility policy entitled, Identifying Types of Abuse, dated 1/2/24, revealed that Neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Neglect occurs when the facility is aware of, or should have been aware of, goods or services that a resident requires but the facility fails to provide them, and this has resulted in (or may result in) physical harm, pain, mental anguish, or emotional distress. Neglect includes cases where the facility's indifference to or disregard for resident care, comfort, or safety results in (or could have resulted in) physical harm, pain, mental anguish, or emotional distress.

Review of facility policy entitled, Safe Lifting and Movement of Residents dated 1/2/24, revealed that Resident safety, dignity, comfort, and medical condition will be incorporated into goals and decisions regarding the safe lifting and moving of residents.

Review of Resident R8's clinical record revealed an admitted [DATE], with diagnoses that included multiple sclerosis (a disease where the body's immune system attacks the nerves which can cause vision problems, muscle weakness, numbness, feeling tired, difficulty thinking and bowel and bladder dysfunction), dementia (a disease that affects short term memory and the ability to think logically), and chronic obstructive pulmonary disease (when your lungs do not have adequate air flow).

Review of Resident R8's Quarterly Minimum Data Set (MDS - an assessment tool used to facilitate the management of care) assessment dated [DATE], revealed under section GG 0170 E, that Resident R8 is dependent on staff for transfers from chair to bed.

Review of Resident R8's Kardex (an easy reference of resident care needs for the nursing assistants to reference), revealed under transferring that Resident R8 transfers with mechanical lift (Sara lift-type of mechanical lift) and required two staff members.

Review of Resident R8's Task (section of the clinical record where nursing assistants document in the resident record for care provided), documentation under transfer support provided revealed the resident was a two person physical assist.

Review of Resident R8's revision of care plan dated 4/1/24, for transfers revealed that Resident R8 transfers with a mechanical lift (Sara lift) and two staff.

Review of Resident R8's active physician orders as of 4/7/24, revealed an order for a Sara lift for all transfers.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of information submitted by facility dated 4/8/24, and interview with the Nursing Home Administrator and Director of Nursing revealed that Resident R8 was transferred from his/her wheelchair with the Sara lift to his/her bed with assist of one staff member resulting in Resident R8 being lowered to the floor. Review of facility's investigation revealed that NA Employee E3 confirmed on 4/7/24, he/she transferred Resident R8 with the Sara lift without the two staff members as required. NA Employee E3's statement revealed that he/she transferred Resident R8 using the Sara lift without another staff member. NA Employee E3 had Resident R8 sitting on the edge of the bed with the Sara lift still attached to Resident R8 when Resident R8 started to slide off the bed. NA Employee E3 grabbed Resident R8 under the arms and lowered Resident R8 to the floor. Review of documentation submitted by the facility dated 4/8/24, revealed that the facility initiated an investigation, regarding resident neglect on 4/8/24. The investigation revealed that NA Employee E3 was suspended pending investigation. During an interview on 4/12/24, at 11:45 a.m. the Nursing Home Administrator and Director of Nursing confirmed that NA Employee E3 did not get another staff member to assist in the transfer of Resident R8 that required assist of two staff with transfers. They also confirmed that all mechanical lifts must have two staff when in use with a resident. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 201.18(e)(1) Management 28 Pa. Code 211.12(c) Nursing services 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40177 Based on review of rights of medication administration, facility policy, observation, and staff interview, it was determined that the facility failed to provide nursing services consistent with professional standards of practice for medication administration during observation of one of three resident units (Unit C). Findings include: Review of Eight Rights of Medication Administration published by [NAME] (a prominent medical publisher that provides essential health information for practitioners, faculty, residents, students and healthcare institutions) on 5/28/2011, rights of medication administration include: Right Patient, Right Medication (includes checking label and checking physician order), Right Dose (includes checking order), Right Route, Right Time, Right Documentation (after administration), Right Reason, and Right Response. Review of facility policy entitled Administering Medications dated 1/2/24, indicated The individual administering the medication checked the label THREE (3) times to verify the right resident, right medication, right dosage, right time, and right method (route) of administration before giving the medication. and The individual administering the medication initials the resident's MAR (medication administration record) on the appropriate line after giving each medication and before administering the next ones. Observation of medication administration pass on 4/9/24, at approximately 3:50 p.m. revealed Licensed Practical Nurse (LPN) Employee E1 logged onto his/her computer located on the top of the medication cart bringing up a list of residents names. The LPN proceeded to obtain medications for Resident R60 that included Buspar (medication to treat anxiety) 15 mg, Gabapentin (medication to treat seizures and/or pain) 100 mg, and Tylenol Extra Strength 500mg, he/she then proceeded to the unit lounge and administer Resident R60's medication. Upon returning to the medication cart, LPN Employee E1 proceeded to obtain medications for Resident R5 that included Duoneb (solution administered via nebulizer for individual with lung disease), he/she then proceeded to Resident R5's room and administer Resident R5's medication. Upon returning to the medication cart, LPN Employee E1 proceeded to move the medication cart down the hallway and then obtained medications for Resident R45 that included Potassium 10 meq (milliequivalent), he/she then proceeded to Resident R45's room and administered Resident R45's medication. Upon returning to the medication cart, LPN Employee E1 was going to proceed to the next resident. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview, the surveyor asked LPN Employee E1 if he/she normally completes their medication pass without looking at the resident's MAR and without signing for administration after each resident. LPN Employee E1 stated he/she is always on this hall so they know what the residents get. When asked what they do if there were medication changes, LPN Employee E1 stated he/she gets report and they would find out that way. When asked what they would do if they were not informed of changes in report, LPN Employee E1 stated he/she knows some residents have routine changes, so he/she would look at their MARs first. LPN Employee E1 stated the last place he/she worked he/she was taught to save time he/she could give all the medications and then when he/she was done he/she could go back and sign the MAR and if he/she noticed anything was missed he/she could then go back and give it. LPN Employee E1 then stated if it would make the surveyor feel better he/she would look at their MAR and sign off for medication administration like he/she should. During interview on 4/9/24, at approximately 4:00 p.m. LPN Employee E1 confirmed he/she did not reference the MAR record for Residents R60, R5, and R28 prior to administering the medication nor did he/she document the administration of the medications after each resident. 28 Pa. Code 211.12(c)(d)(1)(5) Nursing services. 28 Pa. Code 211.9 (a)(1) Pharmacy services

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40177 Based on review of facility policy and clinical records, observations, and staff interview, it was determined that the facility failed to maintain proper care of respiratory equipment for one of two residents reviewed for respiratory services (Resident R22). Findings include: Review of the facility policy entitled Departmental (Respiratory Therapy) - Prevention of Infection dated 1/2/24, indicated to Wash filters from oxygen concentrators every seven days with soap and water. Rinse and squeeze dry. Resident R22's clinical record revealed an admitted [DATE], with diagnoses that included Diabetes, High Blood Pressure, and Alzheimer's Disease (brain disorder that destroys memory and thinking skills and eventually, the ability to carry out simple tasks). Resident R22's physician's order dated 7/12/23, revealed that oxygen was ordered at two liters per minute for shortness of breath via nasal cannula (tubing that enters into the nostrils to administer oxygen) every shift. Observations on 4/9/24, at 11:21 a.m. and on 4/10/24, at 9:38 a.m. revealed that Resident R22's oxygen concentrator had two filters, one on each side of the concentrator, that contained a gray dusty substance. During an interview on 4/10/23, at 9:56 a.m. Registered Nurse Employee E2 confirmed that the oxygen concentrator filters contained a gray dusty substance and are to be cleaned on a weekly basis. 28 Pa. Code 211.12(d)(1)(5) Nursing services

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47356 Based on a review of facility policy and closed clinical records, and staff interview, it was determined that the facility failed to implement procedures to promote accurate and safe disposition of controlled medication records for one of three closed records reviewed (Resident CR68). Findings include: Review of the facility policy, entitled Disposal of Medications and Medication related Supplies, dated 1/02/24, indicated, Schedule II-V medications remaining in the facility after a resident has been discharged , or the order discontinued, are disposed of in the facility by two licensed nurses or a licensed nurse and a licensed pharmacist as directed by state laws, regulations, and/or the DEA. Review of Resident CR68's closed clinical record revealed admission to the facility on [DATE]. Resident CR68 ceased to breathe on 2/18/24. Review of Resident CR68's closed clinical record revealed a lack of evidence that two licensed nurses were present and signed on 2/18/24, when 12.5 milliliters of Morphine (a controlled schedule II drug used for pain management and to help with breathing) and 29.75 milliliters of Lorazepam (a controlled schedule IV drug used for anxiety) were transferred to a Federally approved waste container. During an interview on 4/12/24, at 12:40 p.m. the Director of Nursing confirmed that the disposition of medications documentation lacked evidence that two licensed nurses were present and signed on 2/18/24, when 12.5 milliliters of Morphine and 29.75 milliliters of Lorazepam for Resident CR68 were transferred to a Federally approved waste container and that two licensed nurses should always be present and sign when disposing of a controlled drug. 28 Pa. Code 211.9(a)(1)Pharmacy services 28 Pa. Code 211.9(j.1)(3) Pharmacy services 28 Pa. Code 211.12(d)(3) Nursing services

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 40177 Based on review of facility policy and clinical records, and staff interview, it was determined that the facility failed to provide evidence that non-pharmacological interventions (interventions attempted to calm a resident other than medication) were attempted prior to administration of a PRN (as needed) psychotropic (affecting the mind) medication for two of six residents reviewed for unnecessary medications (Residents R39 and R60). Findings include: Review of a facility policy entitled Psychotropic Medication Use dated 1/2/24, indicated that Non-pharmacological approaches are used (unless contraindicated) to minimize the need for medications, permit the lowest possible dose, and allow for discontinuation of medications when possible. Resident R39's clinical record revealed an admitted [DATE], with diagnoses that included dementia (brain disorder that affects memory, thinking, and social abilities), anxiety, and depression. Resident R39's clinical record revealed a physician's order dated 1/12/24, that identified to administer Haldol (medication to treat mental/mood disorders) injection 1 milligram (mg) intramuscular (IM) times one for agitation, combativeness, and anxiety. Resident R39's Medication Administration Record (MAR) for January 2024 revealed that the Haldol was administered on 1/12/24, at 2:41 p.m. Review of the January 2024 MAR and clinical record progress notes revealed that there was no evidence that non-pharmacological interventions were attempted prior to the administration of the Haldol. Resident R39's clinical record revealed a physician's order dated 4/6/24, that identified to administer Lorazepam (medication to treat anxiety) 0.5 mg by mouth every 12 hours PRN for anxiety / agitation for 14-days. Resident R39's MAR for April 2024 revealed that the Lorazepam was used twice between 4/6/24, and 4/20/24. Review of April 2024 MAR and clinical record progress notes revealed that there was no evidence that non-pharmacological interventions were attempted prior to the administration of the PRN Lorazepam two of the two times the Lorazepam was utilized in April 2024. Resident R60's clinical record revealed an admitted [DATE], with diagnoses that included dementia, anxiety, and depression. Resident R60's clinical record revealed a physician's order dated 10/21/23, that identified to administer Vistaril (medication to treat anxiety) 25 mg by mouth every 6 hours PRN for anxiety / agitation. A physician's order dated 10/27/23, identified to administer Vistaril 25 mg by mouth every 6 hours PRN for restlessness. A physician's order dated 12/21/23, identified to administer Vistaril 25 --mg po every 8 hours PRN for anxiety / agitation. A physician's order dated 1/25/24, identified to administer Vistaril 25 mg po every 6 hours PRN for restlessness. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident R60's MAR for October 2023 revealed that the Vistaril was used 12 times between 10/21/23, and 10/31/23. Review of October 2023 MAR and clinical record progress notes revealed that there was no evidence that non-pharmacological interventions were attempted prior to the administration of the PRN Vistaril nine of the 12 times the Vistaril was utilized in October 2023. Resident R60's MAR for November 2023 revealed that the Vistaril was used eight times between 11/1/23, and 11/16/23. Review of November 2023 MAR and clinical record progress notes revealed that there was no evidence that non-pharmacological interventions were attempted prior to the administration of the PRN Vistaril five of the eight times the Vistaril was utilized in November 2023. Resident R60's MAR for December 2023 revealed that the Vistaril was used four times between 12/21/23, and 12/31/23. Review of December 2023 MAR and clinical record progress notes revealed that there was no evidence that non-pharmacological interventions were attempted prior to the administration of the PRN Vistaril two of the four time the Vistaril was utilized in December 2023. Resident R60's MAR for January 2024 revealed that the Vistaril was used seven times between 1/1/24, and 1/4/24, and 1/25/24, and 1/31/24. Review of January 2024 MAR and clinical record progress notes revealed that there was no evidence that non-pharmacological interventions were attempted prior to the administration of the PRN Vistaril five of the seven times the Vistaril was utilized in January 2024. Resident R60's MAR for February 2024 revealed that the Vistaril was used five times between 2/1/24, and 2/29/24. Review of the February 2024 MAR and clinical record progress notes revealed that there was no evidence that non-pharmacological interventions were attempted prior to the administration of the PRN Vistaril five of the five times the Vistaril was utilized in February 2024. Resident R60's MAR for March 2024 revealed that the Vistaril was used four times between 3/1/24, and 3/17/24. Review of the March 2024 MAR and clinical record progress notes revealed that there was no evidence that non-pharmacological interventions were attempted prior to the administration of the PRN Vistaril four of the four times the Vistaril was utilized in March 2024. During an interview on 4/11/24, at 2:08 p.m. the Director of Nursing confirmed that there was no evidence of non-pharmacological interventions being attempted prior to the administration of the PRN Haldol and the PRN Lorazepam administered for Resident R39 and for the PRN Vistaril administered for Resident R60. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services 28 Pa. Code 201.18(b)(1)(3) Management

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395707	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/12/2024
NAME OF PROVIDER OR SUPPLIER: Clarion Healthcare and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 999 Heidrick Street Clarion, PA 16214	

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 48496 Based on review of a facility policy, observations, and staff interview, it was determined that the facility failed to ensure that food was stored in accordance with standards for food safety in one of two refrigerators reviewed (first floor pantry). Findings include: Review of a facility policy entitled Food Receiving and Storage dated 1/2/24, indicated Beverages are dated when open and discarded after twenty-four (24) hours. Observation on 4/11/24, at approximately 1:35 p.m. revealed a refrigerator in the pantry used for residents on the first floor with two open containers of Imperial Butter Pecan 2.0 Cal Med Pass (a supplement that helps increased calorie intake) with no open date. During an interview on 4/11/24, at the time of observation with Registered Nurse Employee E2, he/she confirmed that the two open containers of Imperial 2.0 Cal Med Pass in the refrigerator should have been dated when opened. He/she also confirmed that the Imperial 2.0 Cal Med Pass should have been discarded due to no open date. 28 Pa. Code 201.14(a) Responsibility of licensee