

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455815	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/03/2026
NAME OF PROVIDER OR SUPPLIER Fallbrook Rehabilitation and Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 10851 Crescent Moon Dr. Houston, TX 77064	
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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures for 2 (Resident #27 and Resident #40) out of 8 residents reviewed for reporting. -The facility failed to report to the State Survey Agency (SSA) Immediately, but not later than 24 hours when Resident #27 had an unwitnessed fall on 05/03/2026. -The facility failed to report to the State Survey Agency (SSA) Immediately, but not later than 24 hours when Resident #40 reported neglect after she waited 4 hours to be repositioned in bed on 06/28/2026 and EMS (Emergency Medical Services) were contacted. --The staff failed to report to the Administrator immediately when Resident#27 had an unwitnessed fall on 05/03/2026, was moved CNA X prior to being assessed on 05/03//2026, went unassessed until 05/05/2026, and observed with a bruise to the left eye 05/05/2026. -The staff failed to report to the Administrator immediately when Resident #40 reported neglect after she waited 4 hours to be repositioned in bed on 06/28/2026 and EMS (Emergency Medical Services) were contacted. This failure could place residents at risk of not having complaints and concerns reported resulting in ongoing abuse, neglect, and exploitation. Findings included: Resident #27Record review of Resident #27's face sheet revealed a [AGE] year-old male who admitted into the facility on [DATE], readmission date on 04/24/2026, with a principal diagnosis of acute myocardial infarction (death of heart muscle tissue due to a sudden blockage of blood flow in a coronary artery). Record review of Resident #27's MDS, dated [DATE], revealed the resident had a BIMS score of 2 indicating residents' cognition was severely impaired. Record review of progress note dated 05/05/2026 read in part, Resident #27 noted with left eye, below the lower lid, left hand and above the eyebrow bruised areas, assessment completed, no swelling or pain. NP and RP notified today. Record review of Resident #27's progress noted dated 05/05/2026 read in part, NP visited and ordered to transfer Resident #27 to the hospital for further evaluation. CT scan of head, maxillofacial and the left hand. Record review of Resident #27's undated care plan, revealed:Focus: [Resident #27] is at risk for falls. Goal: [Resident #27] will remain free from serious injury related to falls.Interventions: Ensure that the resident is wearing appropriate footwear when ambulating or mobilizing in wheelchair.Will continue to monitor closely for any delayed symptoms or changes in condition.Redirect resident back to nurse (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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to maintain an effective pest control program so that the facility was free of pests for 2 of 2 hallways (Halls 100 and 200), 1 of 26 rooms (room [ROOM NUMBER]), and the kitchen reviewed for pest. The facility had live flies in areas of the facility including Hall 100, Hall 200, and room [ROOM NUMBER].-The facility failed to ensure the kitchen was free of pest when a fly was observed to land on uncovered bread prepared for the lunch meal service on 07/01/2026. This failure could place residents at risk for foodborne illness, disease, decreased health, safety and decreased quality of life. Findings included: Record review of Resident #3's Face Sheet dated 07/03/2026 revealed, a [AGE] year-old female who was admitted to the facility on [DATE] with principal diagnoses of chronic respiratory failure with hypoxia (a condition when the lungs are long-term unable to properly transfer oxygen into the bloodstream, causing dangerously low blood oxygen) with secondary diagnosis of end state renal disease(ESRD most severe stage of chronic kidney disease with a decrease in function with inability to filter blood and remove waste). Record review of Resident #3's quarterly MDS assessment dated [DATE] revealed in section C a BIMS score of 13 indicating she was cognitively intact. In section I Resident#3 was triggered for active pulmonary diagnosis of respiratory failure, and ESRD. Record review of Resident #3's undated Care Plan with last review/revised date 04/28/2026 that read in part. Focus: Resident#3 is on Enhanced Barrier Precautions for dialysis port Gown and Gloves required for HIGH-CONTACT Resident Care Activities. Goal: The resident will remain free from infection through the review date. Intervention: Monitor/document/report PRN any s/sx of infection: Fever; Redness; Drainage or swelling around wounds or catheter sites; Cough, respiratory symptoms; Dysuria(pain, burning, or discomfort during urination), hematuria(the presence of red blood cells in the urine), flank pain and foul smelling urine. Monitor/document/report PRN abnormal laboratory values (e.g., white blood cell count and differential, serum protein, serum albumin, and cultures). Monitor/document/report to MD s/sx of delirium: Changes in behavior, Altered mental status, Wide variation in cognitive function throughout the day, Communication decline, Disorientation, Periods of lethargy, Restlessness and agitation, Altered sleep cycle. The resident is at risk for contracting infections due to impaired immune status. Keep the environment clean and people with infection away. Use UNIVERSAL PRECAUTIONS as appropriate. Focus: Resident#3 is on oxygen therapy r/t Respiratory failure and asthma OXYGEN: at 3 LPM per Nasal Cannula continuously - Monitor every shift related to CHRONIC RESPIRATORY FAILURE WITH HYPOXIA. Goal: Resident#3 will have no s/sx of poor oxygen absorption through the review date. Interventions: Administer Oxygen as ordered. In an observation on 06/30/2026 at 09:36am, there was 1 fly observed flying in the room of Resident#3. The fly was observed to land on the head of Resident#3 who swatted the fly, the fly was observed to exit the room in the hallway. In an interview on 06/30/2026 at 9:37am, Resident#3 said that the facility has an issue with flies. She said that that flies were always in the room, but she had not told anyone about the flies. In an observation of hall 200 on 06/30/2026 at 9:40am, there was 1 fly in the hallway passing by the room of Resident#36 who seated in the door of her room. In an interview on 06/30/2026 at 9:41am, Resident#36 said that flies were always in the facility and her room. She said that that she had not told anyone about the flies. In an observation of hall 100 on 06/30/2026 at 9:58am, there were approximately 3 flies flying in the hallway. Observation on 07/01/2026 at 11:39 a.m. of the Dietary Manager to prepare bread for the lunch meal service, leave the bread uncovered, a fly to landed on the bread, the Dietary Manager used her hand to swat the fly away, discard the bread, (continued on next page)		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention for 1 of 3 residents (Resident #27) reviewed for notification of changes. The Weekend Supervisor failed to notify the physician and RP when Resident #27 had an unwitnessed fall on 05/03/2026. These failures could place residents at risk of delay in treatment, worsening of conditions, hospitalization, and responsible party not being informed in care decisions. Findings include: Record review of Resident #27's face sheet revealed a [AGE] year-old male who admitted into the facility on [DATE], readmission date on 04/24/2026, with a principal diagnosis of acute myocardial infarction (death of heart muscle tissue due to a sudden blockage of blood flow in a coronary artery). Record review of Resident #27's MDS, dated [DATE], revealed the residents had a BIMS score of 2 indicating residents' cognition was severely impaired. Record review of progress note dated 05/05/2026 documented by RN-C read in part, Resident #27 noted with left eye, below the lower lid, left hand and above the eyebrow bruised areas, assessment completed, no swelling or pain. NP and RP notified today. Record review of Resident #27's progress noted dated 05/05/2026 documented by RN-C read in part, NP visited and ordered to transfer Resident #27 to the hospital for further evaluation. CT scan of head, maxillofacial and the left hand. Record review of Resident #27's hospital discharge records dated 05/06/2026 revealed no fractures and normal CT scans. Record review of Resident #27's undated care plan, revealed: Focus: [Resident #27] is at risk for falls. Goal: [Resident #27] will remain free from serious injury related to falls. Interventions: Ensure that the resident is wearing appropriate footwear when ambulating or mobilizing in wheelchair. Provider notified of incident, As part of the post fall intervention plan, a review of the patients' psychotropic medications have been initiated to evaluate potential effects on balance and fall risk. Will continue to monitor closely for any delayed symptoms or changes in condition. Redirect resident back to nurse station when seen wandering to prevent any fall occurrence. Initiate a scheduled toileting program with increased frequency for every 2 hours and as needed to reduce urgency and unassisted bathroom attempts. In an interview with CNA-X on 07/01/2026 at 9:34 a.m., she stated Resident #27 had an unwitnessed fall during her shift on 05/03/2026, and she reported the fall to the weekend supervisor. She did not know if the Weekend Supervisor reported the incident to the Administrator or DON. She said that she had been trained on abuse and neglect, and all allegations should be reported to the Administrator immediately. She said that she did not report it to the Administrator. She did not answer when asked why she did not report it immediately to the Administrator. In an interview with CMA-Q on 07/01/2026 at 10:45 a.m., she stated Resident #27 had an unwitnessed fall and he was observed on the floor, she stated she notified the weekend supervisor. She did not know if the Weekend Supervisor reported the incident to the Administrator or DON. She said that she had been trained on abuse and neglect, and all allegations should be reported to the Administrator immediately. She said that she did not report it to the Administrator. In an interview with the DON on 07/01/2026 at 12:05 p.m., he stated he was not sure exactly how many days later he learned about Resident #27's fall but he knows it was days later after the fall occurred. He stated Resident #27 was observed with a bruise on his face and that led the facility to start an investigation. He said that staff are trained to report allegations of abuse and neglect to the (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455815	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/03/2026
NAME OF PROVIDER OR SUPPLIER Fallbrook Rehabilitation and Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 10851 Crescent Moon Dr. Houston, TX 77064	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administrator immediately. He said that staff failed to reported Resident #27's unwitnessed fall to the Administrator on 05/03/2026. In an interview with the Weekend supervisor on 07/02/2026 at 12:56 p.m., he stated Resident #27 did not have a fall on his shift and denied that anyone had ever notified him that the resident had a fall. He said that he was trained to report allegations of abuse and neglect to the Administrator immediately. He said that if staff had notified him of Resident #27's fall he would have reported it to the Administrator immediately. In a phone interview with NP-W on 07/02/2026 at 1:29 p.m., he stated he was informed Resident #27 had a fall on 05/05/2026 when the resident was observed with bruising. He stated they were trying to determine what happened so ultimately the resident was sent out to the hospital. He stated the resident did not have any fractures and he was readmitted back to the facility. He stated he should have been contacted on the day of the fall, and his recommendation would have been to send the resident out to hospital that day. Record review of facility policy, Notification of changes dated 12/05/2025 read in part, .Compliance Guidelines: The facility must inform the resident, consult with the resident's physician and/or notify the resident's family member or legal representative when there is a change requiring such notification.1. Accident. S. resulting in injury b. Potential to require physician intervention. 2. Significant change in the resident's physical, mental, or psychological condition.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that resident received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan and resident choice for 1 of 3 residents (Resident #27) reviewed for falls. The facility failed to ensure Resident #27 was assessed after an unwitnessed fall. This failure placed residents at risk of delay in care, worsening of injuries. Findings included: Record review of Resident #27's face sheet revealed a [AGE] year-old male who admitted into the facility on [DATE], readmission date on 04/24/2026, with a principal diagnosis of acute myocardial infarction (death of heart muscle tissue due to a sudden blockage of blood flow in a coronary artery). Record review of Resident #27's MDS, dated [DATE], revealed the resident had a BIMS score of 2 indicating residents' cognition was severely impaired. Record review of progress note dated 05/05/2026 read in part, Resident #27 noted with left eye, below the lower lid, left hand and above the eyebrow bruised areas, assessment completed, no swelling or pain. NP and RP notified today. Record review of Resident #27's progress noted dated 05/05/2026 read in part, NP visited and ordered to transfer Resident #27 to the hospital for further evaluation. CT scan of head, maxillofacial and the left hand. Record review of Resident #27's undated care plan, revealed: Focus: [Resident #27] is at risk for falls. Goal: [Resident #27] will remain free from serious injury related to falls. Interventions: Ensure that the resident is wearing appropriate footwear when ambulating or mobilizing in wheelchair. Will continue to monitor closely for any delayed symptoms or changes in condition. Redirect resident back to nurse station when seen wandering to prevent any fall occurrence. Initiate a scheduled toileting program with increased frequency for every 2 hours and as needed to reduce urgency and unassisted bathroom attempts. In an interview with the Administrator on 07/01/2026 at 9:04 a.m., he stated Resident #27 had an unwitnessed fall on 05/03/2026 but he did not learn about the fall until 05/05/2026 or 05/06/2026. He stated the weekend supervisor did not report the fall and there was no documentation that the fall occurred. He stated the resident was assessed when he learned about the fall and the physician and family was contacted. He stated the resident was sent out to the hospital and returned to the facility the following day. He stated the residents test results came back normal. He stated he interviewed the weekend supervisor, and he denied that anyone had informed him that the resident had a fall. He stated he spoke to other staff members during his investigation, and they reported that the weekend supervisor was informed that the resident had a fall. In an interview with CNA-X on 07/01/2026 at 9:34 a.m., she stated Resident #27 had an unwitnessed fall during her shift on 05/03/2026 and it was reported to the weekend supervisor. She stated the resident was observed on the floor in his room. She stated she did not observe any marks or bruises on the resident, and he was not complaining of any pain. She stated when the incident reported to the Weekend supervisor, he did not do anything. She stated he did not assess the resident; he remained sitting at the nurse's station. She stated the weekend nurse informed her to put the resident back in bed. She stated she picked the resident up and put him back in bed. She stated that she knew that the resident should have been assessed by the nurse prior to being moved but because the weekend supervisor gave her directive to pick him up, so she did what she was told. She stated she should have called for another nurse or contacted administration instead of moving the resident. She stated she did not report the incident to anyone else. In a phone interview with Family member of Resident #27 on 07/01/2026 at 9:56 a.m., she said she learned the resident had a fall on 05/03/2026 after reviewing electronic monitoring of the resident's room. She stated the facility did not notify her until 05/05/2026 which was the day the (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident was sent out to the hospital. She stated she no longer had to video surveillance because she did not have a [NAME] card at the time of the incident. She stated she did not see anyone assess the resident, but she did see the aid pick the resident up off the floor after walking by him to fix the bed. She stated the nurse could be heard in the video stating, Not today, Resident #27, Not today Resident #27. In an interview with CMA-Q on 07/01/2026 at 10:45 a.m., she stated Resident #27 had an unwitnessed fall and he was observed on the floor, she stated she notified the weekend supervisor. She stated the weekend supervisor did not do anything when she informed him that the resident was on the floor; she stated he remained sitting at the nurse's station. She stated she the CNA assigned to the resident went to check on the resident and she did not know what happened afterwards because the resident was not assigned to her so she went on to complete her duties. She did not know if the Weekend Supervisor reported the incident to the Administrator or DON. She said that she had been trained on abuse and neglect, and all allegations should be reported to the Administrator immediately. She said that she did not report it to the Administrator. In an interview with the DON on 07/01/2026 at 12:05 p.m., he stated he was not sure exactly how many days later he learned about Resident #27's fall but he knows it was days later after the fall occurred. He stated Resident #27 was observed with a bruise on his face and that led the facility to start an investigation. He stated through the investigation they learned that Resident #27 had a fall. He stated the Weekend supervisor was working the day the resident had the fall and it was not reported to anyone or documented. In an interview with the Weekend supervisor on 07/02/2026 at 12:56 p.m., he stated Resident #27 did not have a fall on his shift and denied that anyone had ever notified him that the resident had a fall. He said that he was trained to report allegations of abuse and neglect to the Administrator immediately. He said that if staff had notified him of Resident #27's fall he would have reported it to the Administrator immediately. In a telephone interview with NP-W on 07/02/2026 at 1:29pm, he stated he was informed Resident #27 had a fall on 05/05/2026 when the resident was observed with bruising. He stated they were trying to determine what happened so ultimately the resident was sent out to the hospital. He stated the resident did not have any fractures and he was readmitted back to the facility. He stated he should have been contacted on the day of the fall, and his recommendation would have been to send the resident out to hospital that day. Interview/Observation with Resident #27 on 07/02/2026 at 8:02am with Resident #27, he was observed sitting in bed with bed in lowest position, call light in reach, and fall matt in place. Resident #27 stated he did not remember having a fall and asked Surveyor if he had a fall. He stated the staff treated him good and stated the staff were not rude to him. He stated he felt safe at the facility. Record review of the facility's dated revised 08/01/2025 policy titled Fall Risk Assessment revealed, It is the policy of this facility to provide an environment that is free from accident hazards over which the facility has control and provides supervision and assistive devices to each resident to prevent avoidable accidents. 1. The risk assessment will be completed by the nurse or designee. when a significant change in identified. Record review of the facility's dated 05/06/2026 in- service training: Responding to Resident Falls-No Resident Left Unattended revealed: 1. Immediate Priorities When a fall occurs-Safety first- The resident must never be left alone on the floor for any reason Stay with the resident until a licensed nurse arrives and completes an assessment Call for help immediately-use the call light, radio, or nearest staff member. 2. What staff must do. Notify the nurse right away-A licensed nurse must assess the resident before any movement or transfer. 3. What staff Must Not Do: Do not attempt to life or move the resident before the nurse assesses them Do not leave the resident to go get help. Call out, use your radio, or send another staff member. Do not allow the resident to get up on their own.		

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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, interview, and record review the facility failed to ensure drugs and biologicals used in the facility were labeled in accordance with currently accepted professional principles, for 1 (100-hall med cart) of 4 med carts reviewed for medication storage. The 100-hall nursing medication cart had an insulin pen labeled for Resident #1 and was not labeled with an open date. This deficient practice could place residents at risk of not receiving expired medications and or the intended therapeutic benefit of their medications, resulting in a decline in health status. Findings included: In an observation on 7/01/2026 at 2:00 p.m., with the ADON, the 100-hall nursing medication cart assigned to RNA revealed an insulin pen with 180 units/ml for Resident #1 without open date information available. In an interview on 07/02/2026 at 10:32 a.m., the DON stated he has been working for 1 year 8 months in the facility. He stated he has 15 years of Nursing Experience. DON stated they have a pharmacy requisition binder with pharmacy receipts, if they get an insulin, he will have to go through the binder to see when it was delivered and that they store it for up to 60 days. He stated they have a delivery log and a record of medication delivery. DON stated that nurses are obligated to check on expiration dates before administering medication. He stated that nurse managers take time to go through the cart. He also stated the DON, the ADON and pharmacy, including nurses on the floor frequently check the medication cart. DON stated that ADON checks medications cart to ensure what is not supposed to be in the cart is removed. He stated that the medication is frequently reordered and doesn't have to run out. He stated that if a medication is running low, 3-5 days before, if there is refill, the pharmacy will send it or if refills are needed the doctor will send another prescription as needed. DON stated that if the medication is expired, they are supposed to take it out and put it in the destruction box. He stated that new insulin pens are kept in medication storage room and refrigerated insulins are in the refrigerator. He stated that residents' names are already on the insulin pen as it comes from the pharmacy, the nurse will just add the date once it is open. DON stated that sometimes the label on the insulin pen can fall off and they are supposed to put it back on it and make sure it is secure. He stated that there is always a label on the insulin pen and that you cannot write the resident name on the pen, you just put an open date on it. He stated that the insulin pen is supposed to last for 30 days once it is open. DON stated that his expectation is to have an open date on the insulin pen. He stated that if the pen is given with no date on it, it could be expired and they cannot give insulin with no date on it. DON stated that the risk of giving expired medications to patients has a wide range of reactions and that it would be based on patients' immune system and allergies. He stated if an Insulin pen has no date, it must be discarded and the doctor must be notified. In an interview on 07/02/2026 at 11:04 a.m., with ADON, she stated she has been working in the facility since May 2026, full time, ADON for 2 years and LVN for 17 years. She stated Insulin is supposed to have patients name and an open date. She stated that some insulin pens in the storage box or E-kit don't have orders labeled. Insulin pens coming directly from the pharmacy have a label on them. ADON stated that medications in the E-kit are for emergencies if the medication that was ordered is running late, didn't come or is run out. She stated that nurses will hand write the name of the resident on the insulin pen if the pen comes from the E-kit and they must also write the open date. ADON stated if there is no date on an insulin pen, the nurse must remove it from the medication cart and discard it. She stated the risk of giving the medicine with no open date is that the medication can be expired and it can cause complications like death, some type of changes and other complications. (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ADON stated that nurses need to go by the policy, be prudent nurses and be more alert and communicate. She stated that the pharmacy comes every 2 weeks to refill the E-kit, the box is good until 07/6/2026. She stated that they check medication carts every day but beginning of the month is the main day to check all the carts. ADON stated checking medications carts for expired medications is everybody's job; nurses, ADON and medication aids. She stated that only medications that are supposed to be given are on the cart. She stated that all insulin pens must have a resident name and the open date. In an interview on 07/02/2026 at 11:34 a.m., with RN A, she stated she has been working at the facility for 1 year and has been an RN for 20 years. She stated that she did not open the insulin pen it. She used it. RN A stated it was her fault because she did not check for the expiration date on the insulin pen when she gave it in the morning. She stated the insulin pen was recently open because resident #1 get 22 units twice a day. She stated that if she finds an expired medication in the medication cart, she will notify ADON and she will tell her what to do. She stated that this was the first time this incident happened. RN A stated that the risk of giving expired medication is that the medicine will not be effective. She stated that ADON is the one supposed to be checking the medications carts for expired medications. She stated she is supposed to check the expiration date on the medications she is given but that ADON is supposed to check the whole cart for expired medications. Record review of facility's Administering Medications policy, revised April 2019, indicated that 12. The expiration/beyond use date on the medication label is checked prior to administering. When opening a multi-dose container, the date opened is recorded on the container. Vials and Ampules of injectable medications. b. The date opened and the initials of the first person to use the vial and recorded on multidose vials) on the vial label or an accessory label affixed to that purpose.		