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	175303	A. BUILDING _____ B. WING _____	11/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARSONS PRESBYTERIAN MANOR	3501 DIRR AVENUE PARSONS, KS 67357

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey and Complaint Investigation #s KS135232 and #KS135070. The 2567 was electronically sent to the facility on 12/04/18.	F 000		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of	F 655		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 655	Continued From page 1 this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: The facility reported a census of 37 residents, with 14 residents sampled for review. Based on observation, interview and record review, the facility failed to ensure the development and implementation of a base line care plan that included the instructions to provide effective and person-centered care that meet professional standards of quality of care within 48 hours of admission for 1 resident (#30). Findings included: - Review of the physician's orders, dated 11/6/18, for resident #30 included diagnoses of urinary tract infection, dizziness and giddiness, hypothyroidism (condition characterized by decreased activity of the thyroid gland), dementia (progressive mental disorder characterized by failing memory, confusion) without behavioral disturbances, tachycardia (rapid heart rate), HTN (hypertension-high blood pressure), and personal history of malignancy (cancer) of large intestines (bowel).	F 655		

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The admission MDS, dated 6/26/18, documented the resident admitted to the facility 6/19/18, with a BIMS (brief interview for mental status) score of 99 indicating the resident was not able to complete the interview; required extensive assistance of staff for for bed mobility, transfer, locomotion, dressing, toilet use, personal hygiene, and walking did not occur; balance was not steady during transition, the resident was only able to stabilize with staff assistance; had 1 fall a month and one fall 2-6 months prior to admission; had 2 non-injury falls since admission; received 4 days of antibiotics during the look back period; and received OT (occupational therapy) for 227 minutes over 4 days, and PT (physical therapy) for 276 minutes over 5 days of look back period

The baseline care plan, dated 6/30/18, documented the resident admitted 6/19/18. The facility staff completed the residents baseline care plan 11 days after admission, which exceeded the 48-hour time frame, as required.

On 11/27/18 at 10:38 AM, direct care staff I stated the care guide in the electronic medical record provides guidance for individual resident care. He/she was not aware of the availability of a baseline care plan that provided instructions to provide individualized care for new admissions prior to the completion of the comprehensive care plan.

On 11/28/18 at 4:58 PM, direct care staff K stated new residents have a baseline care plan that advised the staff of the resident needs; the baseline care plan was in a book at the nurses' station; and updated with new interventions are needed.

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On 11/27/18 at 2:09 PM, administrative nursing staff G stated the admission nurse was responsible to initiate a baseline care plan within 48 hours of admission which advised the staff of the identified risks of the resident.

On 11/28/18 at 2:13 PM, licensed nursing staff D, reported the admitting nurse should develop a baseline care plan that included the instructions to provide individualized, person-centered care. Staff D confirmed he/she completed the resident's baseline care plan on 6/30/18; because the admitting nurse failed to complete the baseline care plan had not been completed within 48 hours, as required.

On 11/28/18 at 11:08 AM, administrative nursing staff B confirmed the resident's baseline care plan dated 6/30/18, completed 11 days after admission on 6/19/18; staff should complete the resident's baseline care plan as part of the initial screening on admission and no later than 48 hours after admission, as required.

The facility care plan policy, dated 1/2018, documented staff are to complete a baseline care plan no later than 48 hours after admission to meet identified resident needs until the overall comprehensive plan was developed, as required in the RAI (Resident Assessment Manual) guidelines.

The facility failed to ensure staff developed and implemented a base line care plan which included the instructions to staff to provide effective and person-centered care that meet professional standards of quality of care within 48 hours of admission for the resident.

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F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: The facility reported a census of 37 residents with 14 selected for review. Based on observation, record review, and interview, the facility failed to review and revise the residents care plan for 2 (#25 and #30) of 3 residents reviewed for falls, to prevent further falls. Findings included:	F 657		

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- Resident #25's, signed physician orders, dated 11/6/18, documented the resident admitted on 10/4/18, with the following diagnoses including; history of falling, dementia with behavior disturbance (progressive mental disorder characterized by failing memory, confusion).

The admission MDS (minimum data set), dated 10/11/18, revealed the resident had a BIMS (brief interview for mental status) score of 7, indicating severely impaired cognition. The resident with disorganized thinking, the behavior continuous, and does not fluctuate. The resident with verbal behavioral symptoms directed toward others, other behavioral symptoms not directed toward others, and behavior of this type occurred 1-3 days. The resident also had wandering, which occurred 4-6 days and placed the resident at considerable risk of getting to a potentially dangerous place. The resident required extensive staff assistance for transfers, locomotion, and toileting. The residents balance was not steady but able to stabilize without staff assistance, and mobility per wheelchair and walker.

The CAA (care area assessment), dated 10/17/18, for ADL's (activities of daily living) documented the resident required extensive staff assistance with bed mobility, transfers, dressing, toileting and bathing for safety. Self care deficit was due to weakness, unsteadiness, history of fall, and cognitive impairment with poor safety awareness. Resident does attempt to maintain his/her independence and, would perform self ADL tasks, transfer himself/herself, and walk without waiting for staff assistance. The resident was ambulating without use of any assistive device, staff provides supervision for safety. At

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this time resident was up ambulating on his/her own without waiting for staff assistance.

The CAA's for falls, identified the resident was ambulatory with episodes of unsteadiness. Supervision to limited assistance is given during transfers and ambulation for safety and redirection. Upon admission the resident was receiving extensive assistance with transfers/ambulation. The resident was at risk for falls due to unsteadiness, history of multiple falls, impulsiveness, getting up and wandering, weakness, cognitive impairment and poor safety awareness. Staff provide close monitoring and would assist resident when he/she attempted to walk unsupervised.

The Fall Assessment, dated 10/4/18, with a score of 20, a score of 10 or more, represents high risk

The base line care plan, dated 10/4/18, identified the resident was able to verbalize wants and needs, speech was clear, and oriented to self only. The resident was a fall risk due to a history of falls, an intervention in place was a low bed, and the resident was full weight bearing.

The comprehensive care plan dated on 10/25/18, for history of falls due to unsteady balance, weakness and a history of falls, documented the following interventions:
--The resident with a shuffling gait and unsteady balance when walked.
--Assist to keep the resident's bed in a position which was easy for the resident to get in and out of. Initiated 10/25/18.
--Monitor and assist the resident to wear non-skid shoes/socks. Initiated 10/25/18.
--Assist the resident in keeping his/her room

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uncluttered with a clear path to ambulate.
--Offer and assist the resident with toileting routinely.
--The resident to have non-skid strips in his/her bathroom for traction. Initiated 10/19/18.
--The resident to have a touch pad call light placed next to his/her arm in an attempt to alert staff when he/she gets out of bed. Initiated 10/19/18.
--Skid-proof strips on both sides of the resident's bed. Initiated 11/10/18.
--The resident required supervision with all transfers and ambulation. Please assist the resident to his/her destination when found ambulating. Initiated 11/10/18.
--Keep the resident in view during high risk times. Initiated 11/19/19.
--The resident would be placed in a straight back chair when staff are not assisting him/her to walk or with ADL's. Initiated 11/20/18.
--Staff to assist resident to toilet 30-45 min after meal. Initiated 11/27/18.

The resident's care plan lacked an intervention for the fall on 10/23/18.

The interdisciplinary note, dated 10/23/18 at 9:47 AM, documented at 7:00 AM, this nurse observed the resident on his/her knees at bedside. The resident was not in any distress, and denied any pain or hitting his/her head. The resident was a high fall risk. The resident's door to his/her room was almost completely shut. Staff informed to keep the resident's door open enough to do walk by checks whenever staff pass by.
The intervention was written in the nurses note however staff failed to review and revise the care plan for on 10/23/18.

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On 11/27/18 at 4:34 PM, the resident sat in his/her wheelchair by the nurses station. At 4:35 PM, resident #29 assisted the resident to a standing position, in front of the wheelchair. The resident stood for a few minutes and then the licensed nursing staff E stepped out of the nurses area, and assisted the resident to sit, and then brought the resident in to sit with him/her for 1:1. The resident speaking softly and in word salad, was pleasantly confused.

On 11/27/18 at 4:42 PM, licensed nursing staff E stated the resident was usually 1:1 on his/her shift. If staff E did not have the resident with him/her then another staff member would be with the resident. Resident #29 would assist the resident to stand at times.

On 11/27/18 at 4:43 PM, the resident required 1:1 by the administrative nursing staff B.

On 11/28/18 at 9:00 AM, the resident sat in his/her wheelchair in the dining room with direct care staff P beside him/her, and the resident was watching television.

On 11/28/18 at 10:19 AM, the resident sat in a wheelchair by the door of the quality assurance staff F. The resident not within arms length of the staff member. On 10:26 AM, the resident sat in his/her wheelchair in the same place without staff beside him/her.

On 11/27/18 at 1:05 PM, direct care staff H stated the nurse would let the staff know of any new interventions for residents, the care tracker for new interventions, and staff read new messages to update interventions.

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On 11/28/18 at 1:24 PM, direct care staff P stated the nurse would send messages on KIOSK any new interventions and the staff communicate interventions during the huddle.

On 11/27/18 at 9:49 AM, licensed nursing staff D stated he/she would check to see if the current care plan, and what interventions were in place. Staff can not use the same interventions twice. Update the care plan with a new intervention. Staff D would communicate a new intervention verbally and on the message system on electronic smart chart.

On 11/27/18 at 2:09 PM, administrative nursing staff G stated the nurses initiate an immediate intervention for the resident after a fall. The most recent care plan has the interventions noted as of that date.

On 11/28/18 at 2:01 PM, licensed administrative nursing staff D stated he/she was the nurse working on the day the resident fell. He/she remembered this fall and inputting the note in the computer. The nurse was unable to locate an intervention for the resident's fall on 10/23/18.

On 11/29/18 at 9:08 AM, administrative nursing staff B stated he/she was not aware of the care plan not being done for the resident for the fall on 10/23/18. The nurses are to complete an investigation, and update the residents care plan.

The facility policy for care plans, dated 1/18, advised the person centered plan of care would be reviewed and revised quarterly if need, annually, and when a significant changes occur.

The facility failed to review and revise the care

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F 657	Continued From page 10 plan with an intervention for a fall on 10/23/18, to prevent further falls for this resident. - This deficient practice of failure to review and revise the plan of care also affected resident #30, related to appropriate new interventions to prevent further falls on 6/20/18 at 6:00 PM, 6/27/18 at 5:00 PM, and 11/7/18 at 4:40 PM, for this resident with repeated falls.	F 657		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility reported a census of 37 residents with 14 residents sampled with 3 residents selected for review for falls. Based on observation, record review and interview the facility failed to determine the root cause of falls and develop appropriate interventions to prevent further falls for 3 (#25, #87, and #30) of the 3 residents reviewed. Findings included: - Resident #87's, signed physician orders, dated 11/15/18, documented the resident readmitted on 11/15/18, with the following diagnoses including; agitation and/or flight of ideas, and dementia	F 689		

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without behavioral disturbances (a progressive mental disorder characterized by failing memory, confusion), restlessness, and agitation.

The admission MDS (minimum data set), dated 11/7/18, revealed the resident had short/long term memory issues, and moderately impaired decision making. The resident had inattention and disorganized thinking, the behavior present and fluctuated. The resident required extensive staff assistance for transfers, locomotion, and toileting. The resident's balance was not steady, with functional imitation in range of motion to the upper extremity on 1 side, and a walker and wheelchair for mobility. The resident with 1 non-injury fall and 1 injury fall.

The baseline care plan, dated 11/2/18, documented safety concerns were due to the resident was a fall risk, and to have a low bed. On 11/3/18 after the 1st fall, ensure the resident was dressed in appropriate bedtime attire, including non-skid socks as preferred by the resident, and ensure a touch pad call light was placed toward the middle of the bed. Furthermore, the resident required 1 staff physical assistance with transferring, toileting and dressing. The resident required limited staff assistance for ambulation and locomotion on the unit.

The fall risk assessment tool, dated 11/2/18, with a score of 29. A score of 13 and over, indicated the resident was a high fall risk.

The admission nursing screening, dated 11/2/18, at 12:42 PM, advised on admission the resident was able to transfer with 2 staff assistance, full weight bearing, and for mobility a wheelchair only which the resident propelled. The resident

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oriented times 1 (to himself/herself), and his/her comprehension was unable to understand.

The progress interdisciplinary note, dated 11/3/18 at 12:30 AM, documented at 9:55 PM, the resident was lying on the floor on his/her right side in front of the resident's closet with his/her feet toward the doorway, and his/her knees slightly bent. The resident was awake, alert and talking with clear speech. The resident continued to be alert and oriented only to person with confusion and disorientation to time and place as he/she was upon arrival to the facility at 1:00 PM. The resident was unclothed except for a top and socks. The resident observed with a steady flow of blood from the left back of his/her head, steady flow of blood. Applied a cold wet compress and cleaned occipital area to determine where injury was on resident head was and observed 2 cm (centimeter) laceration to the left occipital region. The EMS (emergency medical services) arrived 9:50 PM, and the resident transferred to the hospital. The resident returned from the hospital on 11/3/18 at 3:29 AM, with 5 staples to the back of his/her head. A call light pad was placed on the resident's chest and the resident was instructed to press the pad if he/she needed anything. The note lacked information regarding the determination of the root cause analysis of the fall.

The hospital CT of the head, dated 11/2/18, Identified no acute intracranial hemorrhage or mass effect.

The interdisciplinary note, dated 11/5/18 at 4:18 PM, documented at approximately 3:00 PM, heard noise outside of nurses station. The resident was found laying on his/her left side in

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the hall close to the fish tanks. The resident's name called multiple times, but he/she did not respond. A sternal rub was done, but did not elicit much of a response from the resident. The only response was blinking of his/her eyes. The resident assisted up to a wheelchair and into his/her room. EMS called and arrived to transfer the resident to the hospital for evaluation and transport right back to the facility without injury.

The facility investigation, dated 11/5/18, documented the incident, in which staff found the resident, the notification of the durable power of attorney, and the resident's transfer to the hospital for evaluation. The investigation lacked a root cause analysis of the resident's fall.

Observation, on 11/27/18 at 2:06 PM, the resident rested quietly in bed with his/her eyes closed. The bed in the lowest position, the floor with carpeting, non skid strips on the left side of the bed, and in the bathroom. The touch pad call light lying on the upper left side of the scoop mattress. A wheel chair placed beside the bed facing the foot of the bed.

On 11/27/18 at 3:33 PM, direct care staff L placed the resident's tennis shoes on, and placed a gait belt around the resident. The resident stood with staff assistance of 1 and the use of a walker, then took a couple of steps and transferred to the wheel chair.

On 11/27/18 at 4:24 PM, the resident propelled to his/her room via wheelchair by direct care staff M. Direct care staff placed the gait belt on the resident, and the resident assisted to transfer to the toilet. Staff left the resident in the bathroom alone, and closed the door to the bathroom, and

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	175303	A. BUILDING _____ B. WING _____	11/29/2018

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waited outside of the door. Staff M stated he/she was was only prn (as needed), and did not know if this was the resident's normal routine, due to he/she usually worked the other hall. Within 5 minutes the resident called out to the staff member he/she was done. Staff M assisted the resident to then transfer back into his/her wheelchair.

On 11/28/18 at 9:44 AM, direct care staff N stood by the resident's bed. The bed was in the low position, the pad call light was above the resident's left shoulder. The staff stated he/she had just assisted the resident to lay down.

Interview, on 11/27/18 at 3:28 PM, direct care staff K stated the resident required limited 1 staff assist, and usually will turn the call light on when using the bathroom. The resident's routine was to turn his/her call light on, go to the bathroom, and then eat supper. Then after supper, the resident, would toilet, and go to bed. The resident does try to transfer himself/herself. After a resident fall, the nurse would inform us of what the intervention is so the resident would not fall again.

On 11/28/18 at 11:40 AM, direct care staff O stated the resident was a fall risk, he/she was good about turning his/her light on in the bathroom. Staff check on the resident frequently. The nurse would let us know of any interventions for falls. Interventions are also placed on the KIOSK (CNA [certified nurses aide] electronic documentation) also.

On 11/28/18 at 11:41 AM, direct care staff I stated the resident was a fall risk, required limited staff assistance for transfers, would use his/her call light. The CNA's have a meeting with the on

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coming shift and with the off going shift of CNA's. The CNA's let us know the fall intervention if a resident had a fall. There was also a message alert on the KIOSK and the nurse would literally come and tell the CNA's of any new interventions.

On 11/27/18 at 4:32 PM, licensed nursing staff E stated he/she followed the facility fall protocol if a resident had a fall. Make sure bed was in the lowest position to the floor, then he/she would go to the computer, go to matrix care smart chart, pull up a incident tracking form, and then choose a new incident and complete the form, do a fall risk assessment, and a pain and skin assessment. Staff E would update the care plan. Communicate verbally to the staff and pass along during report with the next nurse. The investigation flagged incident goes to QA (quality assurance) and which was then reviewed during a stand up meeting every morning.

On11/27/18 at 9:49 AM, licensed nursing staff D stated he/she would follow the fall protocol. Update the resident's care plan with an immediate intervention. He/she would obtain witness statements, and complete the incident report. Then the QA nurse, administrative nursing staff F, reviews the information. He/she would check to see if current care plans in place, add a new intervention, and relay the new intervention verbally and on the message system on the computer.

On 11/28/18 at 2:01 AM, licensed nursing staff D stated he/she recalled the first time the resident had a fall he/she had to go to the ER (emergency room) and returned with staples to his/her scalp, and multiple bruises. Furthermore, the staff did a lot of 1:1 with the resident.

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On 11/29/18 at 11:30 AM, administrative nursing staff B stated the QA nurse was new and we have identified the lack of a through investigation during QA. The investigations are not through.

The facility policy for occurrence report check list, dated 5/16/18, documented the involves residents or visitors. A supervisor, licensed nurse or designee completes the Occurrence Report Checklist from direct observation or by report and subsequent investigation, as needed. A formal investigation will be recorded, as needed on the Investigation Report Form.

The facility failed to ensure a through investigation to determine root cause of the fall completed for this resident to prevent the resident from further falls.

- The deficient practice of failure to determine root cause analysis of the resident's falls to develop appropriate interventions and prevent accidents also affected resident #25 related to the facility's failure to thoroughly investigate 8 of 8 unwitnessed, non-injury falls in 8 weeks on the following dates: 10/19/18 at 4:00 AM, 10/19/18 at 7:13 AM, 10/23/18 at 7:00 AM, 11/10/18 at 12:20 PM, 11/10/18 at 11:30 PM, 11/19/18 st 12:50 PM, 11/20/18 at 5:10 PM, and 11/28/18 at 12:08 AM.

- This deficient practice of failure to provide adequate supervision and/or assistive devices also affected resident #30. The facility failed to do a root cause analysis to determine the cause and contributing factors associated with the resident's

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F 689	Continued From page 17 falls on 6/20/18 at 6:00 PM, 6/26/18 at 5:00 PM, 9/6/18 at 7:30 AM, 10/3/18 5:20 PM, and 11/7/18 at 4:40 PM, to provide appropriate interventions to prevent further falls.	F 689		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: The facility reported a census of 37 residents. Based on observation, record review, and interview, the facility failed to monitor expiration dates and labeling of open dates to ensure safe	F 761		

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storage of medications.

Findings included:

- On 11/26/18 at 10:12 am, initial inspection of the medication room refrigerator, with direct care staff H, revealed:

1.) A Humalog insulin pen for resident #8, with no open date and no instructions on the pen for administration.

2.) A Lantus insulin pen for resident #85, with no open date and no instructions on the pen for administration.

3.) Two Humalog insulin pens and a Tresiba insulin pen for resident #34, with no open date.

Interview, on 11/27/18 at 10:00 am, with Licensed Nursing staff C, stated the insulin pens should have been dated when the nurse opened them.

Interview, on 11/27/18 at 1:55 pm, with Administrative Nursing staff B, verified the above concerns and stated the nurses should have dated the pens when they opened them.

The facility policy for storage medication, dated 3/09, identified the medications and biologicals are stored safely, securely, and properly following manufacturer ' s recommendations or those of the supplier.

The facility failed to properly label opening dates and to monitor expiration dates, to ensure the safe storage and use of these medications.