STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345159	A. BUILDING _____ B. WING _____	C 11/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN NURSING CENTER INC	1410 EAST GASTON ST LINCOLNTON, NC 28092

(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 No deficiencies cited as a result of complaint investigation on 11/10/11. Event ID # QSPB11.	F 000	*This Plan of Correction is the center's credible allegation of compliance.*	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to properly position a resident's feet for one (1) of one (1) sampled residents observed for positioning. (Resident # 57.) The findings are: Resident # 57 had diagnoses which included peripheral vascular disease. Review of the annual MDS (Minimum Data Set) dated 8/22/11 assessed the resident severely impaired in cognition, being extensive to totally dependent on staff for ADL (Activities of Daily Living) and impaired in mobility on one side of the lower extremities. Review of the Care Area Assessment Summary dated 08/30/11 revealed the resident had impaired mobility and generalized weakness. A care plan was developed that included assisting	F 309	*Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* Resident #57 feet is properly positioned on a padded foot board. The Staff Development Coordinator (SDC) and the Unit Managers (UM) will conduct an audit of the current resident population to identify residents with improper feet positioning while in wheelchair. The SDC will re-educate the direct care-givers on the importance of proper positioning of residents feet while up in wheel chair. This in-service will be incorporated into the new employee orientation for direct care staff. The UM and or SDC will monitor five residents 2x weekly for 4 weeks then weekly x 4 weeks then monthly to ensure ongoing compliance with feet positioning while up in wheelchair. Data results will be analyzed and reviewed at the centers monthly Performance Improvement Meeting (PI) for three months with a subsequent plan of correction as needed.	12/8/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Allen Phillips — TITLE: Executive Director — (X6) DATE: 12/7/11

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 309	Continued From page 1 the resident with mobility and referring to therapy as needed. Observations on 11/07/11 at 4:40 PM revealed resident sitting in her w/c (wheelchair) in the dining room. The resident's feet were hanging off of the w/c foot rests. Observations on 11/08/11 at 9:00 AM revealed the resident sitting out in the hallway. The resident's feet were not on resting on the foot rest platform but were hanging off the foot rest. Observations on 11/08/11 at 11:20 AM and at 12:35 PM revealed Resident # 57 sitting in her w/c in the dining room. Both feet were hanging off of the foot rest with the lower calf area pressed against the foot rest platform. Observations on 11/09/11 at 8:45 AM revealed NA (Nursing Assistant) # 1 brought the resident from the dining room into the resident's room after breakfast. NA # 1 placed the resident by the window and left the room. The resident's right foot hung off of the foot rest platform and the lower calf area just above the ankle was pressed against the foot rest platform. Observations on 11/09/11 at 11:00 AM revealed Resident # 57 sitting in her room in her w/c with both feet hanging off the foot rest platform and both lower calves just above the ankle were pressed against foot rest platform. On 11/09/11 at 11:20 AM, NA # 1 was questioned regarding the resident's positioning. NA # 1 stated she did not know what to do with the resident's feet because Resident # 57 could not	F 309		

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F 309	Continued From page 2 bend her knees and that the resident usually sat with her lower legs up against the foot rests. At this time NA # 1 proceeded to turn the foot rest up and away from resident. Observations at this time revealed a pitting indentation in the both of resident's lower legs just above the ankle. During an interview on 11/09/11 at 12:00 PM, LN # 5 stated she was unaware of the resident's feet not being positioned properly on the foot rests. During an interview on 11/09/11 at 12:10 PM the rehabilitation manager stated he was unaware until this morning that Resident # 57 needed a different type of leg rest. He further stated the resident had been screened on 08/03/11 for wheelchair mobility/leg rests and OT (occupational therapy) had evaluated and placed bilateral foot rests on the resident's chair at that time. During an interview on 11/09/11 4:50 PM LN # 4 stated her expectations were that staff would reposition a resident as needed and/or refer them to therapy as needed. During an interview on 11/09/11 at 5 PM the DON (Director of Nurses) stated her expectations were that staff would reposition a resident's feet onto the foot rest as needed. The DON further stated if a resident's feet would not stay on the foot rest that staff would report it to any nurse and or make a referral to therapy for a consult.	F 309	*This Plan of Correction is the center's credible allegation of compliance.*	
F 312 SS=E	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to	F 312	*Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	

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F 312	Continued From page 3 maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview the facility failed to provide grooming and nail care for four (4) of five (5) dependent residents. (Residents # 57, # 129, # 1 and # 68.) The findings are: 1. Resident # 57 had diagnoses which included dementia. Review of the most recent annual Minimum Data Set (MDS) dated 8/22/11 assessed Resident # 57 as severely impaired in cognition and needing extensive to total assistance from staff for ADL (activities of daily living) which included personal hygiene. The resident was assessed as having no behavioral problems. Review if the plan of care updated 8/30/11 documented the resident would receive assistance as needed for personal hygiene and included interventions to provide nail care daily. Observations on 11/07/11 at 4:40 PM revealed Resident # 57 sitting in her w/c (wheelchair) in the dining room. The resident's fingernails had dark brown debris underneath and were approximately 1/8 inch long. The resident could not to answer questions appropriately. Observations on 11/08/11 at 9:00 AM revealed the resident sitting out in hallway in her w/c. Her	F 312	Resident #57, #129, #1, and #68 is receiving grooming and nail care daily and on an as needed basis. The Staff Development Coordinator (SDC) and the Unit Managers (UM) will conduct an audit of the current resident population to identify residents who are in need of nail care and grooming. The SDC will re-educate the direct care-givers on the importance of providing appropriate grooming and nail care daily and on an as needed basis. This in-service will be incorporated into the new employee orientation for direct care staff. The UM and or SDC will monitor five residents 2x weekly for 4 weeks then weekly x 4 weeks then monthly to ensure ongoing compliance in providing nail care and grooming. Data results will be analyzed and reviewed at the centers monthly Performance Improvement Meeting (PI) for three months with a subsequent plan of correction as needed.	12/8/11

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F 312	Continued From page 4 fingernails were still long and dirty. Observations on 11/08/11 at 11:20 AM revealed Resident # 57 sitting in the dining room in her w/c with fingernails unchanged. Observations on 11/08/11 at 12:35 PM revealed the resident sitting at the dining room table with fingernails still dirty. The resident was eating yogurt with a spoon initially but subsequently inserted her fingers into the yogurt and licked her licked fingers. Observations on 11/09/11 at 08:35 AM revealed Resident # 57 in the dining room with the breakfast tray in front of resident. Most of the food had been eaten and the resident's fingernails were still long and dirty. The resident's hair had not been combed and her eyes were matted. NA #1 (Nursing Assistant) was was observed 11/09/11 at 8:45 AM taking Resident # 57 into her room. The NA left the resident sitting in her w/c by the window and left the room. The resident's eyes were still matted, hair still not combed and fingernails still long and dirty. Observations on 11/09/11 at 11:00 AM revealed the resident in her room sitting in her w/c. The resident's eyes were still matted, hair still not combed and fingernails were still dirty. NA #1 was observed taking Resident # 57 into the dining room on 11/09/11 at 12 noon. The resident's eyes were still matted, hair not combed and fingernails were still long and dirty.	F 312		

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F 312	Continued From page 5 During an interview on 11/09/11 at 1:45 PM, NA # 1 stated that resident usually get their nails cleaned with showers. NA # 1 stated that Resident # 57 received her shower Monday (11/07/11) but nail care was not done. NA #1 stated she had so many other things to take care of that she had not provided nail care for Resident # 57. NA # 1 stated she had not combed the resident's hair because she could not find a brush or comb. NA # 1 stated she had not washed the resident's hands or done nail chair before taking the resident into the dining room and had not washed the resident's face because she was not the one who got the resident out of bed this morning. NA # 1 stated she not noticed Resident # 57's fingernails being dirty. LN (License Nurse) # 4 accompanied the surveyor to the resident's room on 11/09/11 at 1:50 PM and concurred the resident's nails were dirty and in need of trimming. During an interview on 11/09/11 at 1:55 PM, LN # 4 stated her expectations were that nail care was to be done every day and not just shower days because some residents eat with their hands. The unit manager further stated each resident's hair should be combed every morning along with having their faces washed. During an interview on 11/09/11 at 2:25 PM the DON (Director of Nurses) stated it was her expectations that residents would get their hair combed, faces washed and nails cleaned with morning care. The DON further stated all staff/shifts were responsible to ensure resident's were well groomed.	F 312		

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F 312	Continued From page 6 2. Resident # 129 had diagnoses which included rheumatoid arthritis. A significant change assessment MDS (Minimum Data Set) dated 03/28/11 and assessed the resident as being cognitively intact with no behavioral problems. Resident # 129 was assessed as needing extensive assistance in ADL (Activities of Daily Living) and independent with eating. Review of the resident's care plan updated 9/12/11 revealed the resident would receive assistance as needed in ADL and included anticipation of resident's needs and to assist as necessary. Observations on 11/08/11 at 11:08 AM revealed Resident # 129 in bed, alert, oriented and answered questions appropriately. The resident's fingernails were long, extended over the ends of the resident's fingers and turned downward over the resident's fingertips. A large amount of brown debris was noted underneath the resident's fingernails. The resident stated the facility trimmed her nails "occasionally" and that they needed trimming now. The resident did not know when her nails were last trimmed. Observations on 11/08/11 at 11:50 AM revealed Resident # 129 sitting up in bed eating lunch, feeding herself a few bites. The resident's fingernails were still long and dirty. Observations on 11/09/11 at 08:25 AM revealed Resident # 129 sitting up in bed. The resident's fingernails were still long and dirty. Observations on 11/09/11 at 12:10 PM revealed Resident # 129 sitting up in bed eating lunch. The	F 312		

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F 312	Continued From page 7 resident's fingernails were still long and dirty. During an interview on 11/09/11 at 1:45 PM, NA (Nursing Assistant) # 1 stated nail care was usually done with showers but she did not know when Resident # 129's showers were done. NA # 1 further stated she had so many other things to take care of that she had not done nail care for Resident # 129 and had not noticed the resident's nails being dirty. LN (License Nurse) # 4 accompanied the surveyor to the resident's room on 11/09/11 at 1:52 PM and concurred the resident's nails were dirty and in need of trimming. During an interview on 11/09/11 at 1:55 PM, LN # 4 stated her expectations were that nail care was to be done every day and not just shower days because some residents eat with their hands. The unit manager further stated each resident's hair should be combed every morning along with having their faces washed. During an interview on 11/09/11 at 2:25 PM the DON (Director of Nurses) stated it was her expectations that residents would get their hair combed, faces washed and nails cleaned with morning care. The DON further stated all staff/shifts were responsible to ensure residents were well groomed. 3. Resident # 1 was admitted to the facility on 05/10/11 with a diagnosis of dementia. A review of the most recent quarterly Minimum Data Set (MDS) assessment dated 10/14/11 revealed	F 312		

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Resident # 1 had severely impaired cognition and required extensive assistance with activities of daily living which included personal hygiene. The MDS further revealed the resident was independent with feeding and no behavioral problems.

A review of Resident # 1's care plan updated on 10/17/11 revealed the resident required extensive to total assistance with activities of daily living including personal hygiene, and to provide adaptive devices for meals as needed.

A review of the facility's 'Shower Schedule' revealed Resident # 1 had her showers on Tuesdays and Fridays.

Observations on 11/08/11 at 9:00 AM revealed Resident # 1 sitting in her wheelchair in the main dining room. The resident's fingernails had dark brown debris underneath them. Resident # 1 was observed feeding herself with the use of her fingers with the debris under her fingernails. The resident was observed scooping her food to her mouth with her fingers and licking her fingers.

Observations on 11/09/11 at 9:24 AM revealed Resident # 1 in her room with debris underneath her fingernails.

Observations on 11/09/11 at 12:15 PM revealed Resident # 1 was observed in the main dining room, eating her meal with dark brown debris underneath her fingernails. The resident was observed using her fingers while feeding herself.

An observation with the Restorative Aide on 11/09/11 at 2:29 PM agreed Resident # 1's

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F 312	Continued From page 9 fingernails had debris underneath them. An interview with Nursing Aide (NA) # 2 on 11/09/11 at 2:33 PM revealed she did not notice Resident # 1's fingernails having debris underneath them. NA # 2 reported she did not pay attention to her fingernails during her personal hygiene care. NA # 2 stated she usually cleaned the resident's fingernails during her shower days, but should have cleaned Resident # 1's fingernails during personal hygiene care and as needed. An interview with License Nurse (LN) # 4 on 11/09/11 at 2:40 PM revealed the expectation was when the nursing staff noticed any debris underneath the residents' fingernails, the staff should hand wash and provide fingernail care to the residents. LN # 4 expected the nursing staff to be observant and clean the residents' fingernails as needed. LN # 4 further revealed Resident # 1 should have not had to eat with her fingernails dirty. An interview with Director of Nursing (DON) on 11/09/11 at 2:25 PM revealed her expectations was that the residents would get their fingernails cleaned with morning care and as needed. The DON further stated all staff was responsible to ensure residents were well groomed and clean. 4. Resident # 68 was admitted to the facility on 04/09/08 with diagnoses that included Alzheimer's dementia and diabetes. A review of the most recent annual Minimum Data Set (MDS) assessment dated 10/13/11 revealed Resident # 68 had short and long-term memory problems and had moderately impaired decision-making	F 312		

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skills. The MDS further revealed the resident required extensive to total assistance with activities of daily living with no behavioral problems.

A review of Resident # 68's care plan updated on 10/13/11 revealed the resident required extensive to total assistance with activities of daily living including personal hygiene.

A review of the facility's 'Shower Schedule' revealed Resident # 68 had his showers on Mondays and Wednesdays.

Observations of Resident # 68 on 11/08/11 at 12:45 PM and 11/09/11 at 10:10 AM revealed all of the resident's fingernails being a half inch long.

An interview with Licensed Nurse (LN) # 6 on 11/09/11 at 3:52 PM revealed Resident # 68's fingernails should have been trimmed as needed. LN # 6 reported Resident # 68 did not resist personal hygiene care. LN # 6 stated a license nurse would trim the resident's fingernails if informed by the nursing assistants. LN # 6 further revealed she was not informed by the nursing assistants that Resident # 68's fingernails needed to be trimmed.

An interview with Nursing Assistant (NA) # 3 on 11/10/11 at 10:18 AM revealed she had not noticed his fingernails being long. NA # 3 reported she should have reported the long fingernails to the license nurse, and the fingernails would have been trimmed.

An interview with NA # 4 on 11/10/11 at 10:34 AM revealed she did not inform the license nurse of

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F 312	Continued From page 11 Resident # 68's long fingernails because she did not notice the fingernails were long. NA # 4 report she cleaned his hands and nails and did not know how long the fingernails had to be to inform the license nurse about them. NA # 4 further revealed she would not trim Resident # 68's fingernails because he was a diabetic. An interview with License Nurse (LN) # 4 on 11/09/11 at 2:40 PM revealed the expectation was when the nursing staff noticed long fingernails, the fingernails should be trimmed. LN # 4 expected the nursing staff to be observant and trim the residents' fingernails, and agreed Resident # 68's fingernails were long. Resident # 68 agreed for his fingernails to be trimmed when asked by LN # 4 to trim his fingernails. An interview with Director of Nursing (DON) on 11/09/11 at 2:25 PM revealed her expectations was that the residents would get their fingernails trimmed as needed. The DON further stated all staff was responsible to ensure residents were well groomed and clean. An interview with Licensed Nurse (LN) # 5 on 11/10/11 at 2:49 PM revealed her expectations were that the nursing assistants informed her when the residents' fingernails needed to be trimmed.	F 312		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug	F 431	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	

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F 431	Continued From page 12 records are in order and that an account of all controlled drugs is maintained and periodically reconciled. 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. 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. 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: Based on observation, pharmacy policy review, and staff interview, the facility failed to discard three (3) expired bottles of over the counter medication, failed to discard three (3) expired vials of insulin, failed to label two (2) open vials of insulin, failed to store one (1) bottle of Miacilin nasal spray in an upright position according to	F 431	Resident #17 bottle of Novolog was discarded. The (3) bottles of expired vials of insulin, the 2 open vials of unlabeled insulin, and the Micalcin nasal spray was discarded. The Staff Development Coordinator (SDC) and the Unit Managers (UM) will conduct an audit of the four medication carts to ensure proper labeling and storage of medication per facility policy. The SDC will re-educate the Licensed Nurse on the facility policy for labeling and storage of medications with an emphasis on expiration dates. This in-service will be incorporated into the new employee orientation for Licensed Nurses. The UM and or SDC will monitor four medication carts 2x weekly for 4 weeks then weekly x 4 weeks then monthly to ensure ongoing compliance with proper labeling, storage, and expiration dates of medications. Data results will be analyzed and reviewed at the centers monthly Performance Improvement Meeting (PI) for three months with a subsequent plan of correction as needed.	12/8/11

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	345159	A. BUILDING _____ B. WING _____	C 11/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 431	Continued From page 13 manufacturer's recommendations, and failed to refrigerate nine (9)unopened vials of insulin in four (4) of four (4) medication carts. The findings are: 1. Review of undated pharmacy guidelines entitled Medications With Special Expiration Date Requirements revealed that insulins should be discarded 28-30 days after opening. The pharmacy guidelines indicated the date of opening should be documented on the container/vial. Review of facility policy dated 12/11/2004 entitled Storage of Medications read in part to remove and dispose of outdated medications. Inspection of the 100 Hall medication cart on 11/09/2011 at 11:42 AM. revealed a partially used bottle of Aspirin 325mg (milligrams) with an expiration date of 10/2011 which was available for use. Also, on the medication cart was a partially used bottle of Novolog insulin labeled for Resident # 17 with a date opened sticker of 10/09/2011. Interview with Licensed Nurse (LN) # 1 at the time revealed the Aspirin and Insulin should have been discarded. 2. Review of undated pharmacy guidelines entitled Medications With Special Expiration Date Requirements revealed that insulins should be discarded 28-30 days after opening. The pharmacy guidelines indicated the date of opening should be documented on the container/vial. Review of facility policy dated 12/11/2004 entitled Storage of Medications read in part to remove and dispose of outdated medications.	F 431		

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F 431	Continued From page 14 Inspection of the 200 Hall medication cart on 11/9/2011 at 10:30 AM. revealed a partially used bottle of Multivitamin with Iron with an expiration date of 10/2011 which was available for use. Interview with LN # 2 at the time revealed the Multivitamin with Iron should have been discarded. On 11/10/2011 at 8:38 AM an interview with LN # 3, the Staff Development Coordinator, about expiration dates of insulin revealed the facility policy is to discard all insulin 28 (twenty-eight)days after opening. She stated the nurses were re-inserviced again on 11/09/2011. She further stated the Novolog insulin should have been discarded 28 days after opening. On 11/10/2011 at 1:27 PM the Director of Nursing (DON) and Administrator were asked about the process for making sure expired medications are not available for use on the medication carts. The DON stated all nurses are expected to check expiration dates on medications before giving them to make sure medications aren't expired and that she periodically asked the LN Unit coordinators to check for expired medications. She was unable to state how often the medications are checked. She stated she doesn't have anyone assigned to check carts for expired medications on a regular basis such as weekly or monthly but that someone from the pharmacy checks for expired medications on a quarterly basis. She also stated the Central Supply clerk checks expiration dates on over the counter (OTC) medications in the stock room. The DON stated the facility doesn't have a written policy on expiration dates of insulin after the date they're	F 431		

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F 431	Continued From page 15 opened. . She stated the facility policy is to label multidose vials with the date it was opened. She further stated the night nurse put the insulin, which was received on 11/8/2011, on the medication cart instead of in the refrigerator. The DON stated the nurses will be inserviced on the requirement for storing insulin in the refrigerator until it is opened and on removing expired medications from the medication carts.. The DON stated she wasn't aware that Micalcin nasal spray had to be stored upright. 3. Review of undated pharmacy guidelines entitled Medications With Special Expiration Date Requirements revealed that insulins should be discarded 28-30 days after opening. The pharmacy guidelines indicated the date of opening should be documented on the container/vial. Review of facility policy dated 12/11/04 entitled Storage of Medications read in part to remove and dispose of outdated medications. On 11/9/11 at 10:15 AM an observation of the 300 hall medication cart revealed the following medications in active stock for resident use: 1 open 10ml multidose vial of Novolog insulin. The vial was labeled as opened 9/24/11 and the pharmacy product label indicated to discard in 28 days. 1 open 10ml multidose vial of Lantus insulin. No date was indicated to specify when the vial was opened. 1 open 10ml multidose vial of Humalog insulin. No date was indicated to specify when the vial was opened.	F 431		

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F 431	Continued From page 16 LN # 6 was interviewed at the time of the observation and stated that all insulins should be dated when opened and discarded 28 days after opening. LN # 6 stated that all nurses are responsible for checking medication expiration dates prior to medication administration. LN # 6 removed the insulin vials from active stock. 4. Review of undated pharmacy guidelines entitled Medications With Special Expiration Date Requirements revealed that insulins should be discarded 28-30 days after opening. The pharmacy guidelines indicated the date of opening should be documented on the container/vial. Pharmacy guidelines indicated to store Miacilin nasal spray in upright position. Review of facility policy dated 12/11/04 entitled Storage of Medications read in part to remove and dispose of outdated medications. On 11/9/11 at 10:20 AM an observation of the 400 hall medication cart revealed the following medications in active stock for resident use: 1 open over the counter bottle of multivitamin with iron, with manufacturer expiration date 10/2011. 1 open 10ml multidose vial of Novolin 70/30 insulin. The vial was labeled as opened 10/7/11 and the pharmacy product label indicated to discard in 28 days. 1 unopened 10ml multidose vial of Novolin 70/30 insulin. The pharmacy product label indicated to refrigerate until opened. 2 unopened multidose vials of Novolog insulin. The pharmacy product label indicated to refrigerate until opened. 6 unopened multidose vials of Lantus insulin. The pharmacy product label indicated to refrigerate	F 431		

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F 431	Continued From page 17 until opened. 1 unopened bottle of Miacilin nasal spray stored in medication cart on its side. The pharmacy product label indicated to store in upright position. LN # 5 was interviewed at the time of the observation and stated that insulins are dated when opened and discarded 28 days after opening. LN # 5 stated expiration dates should be checked before all medication administration. LN # 5 stated she was unsure of storage requirements for unopened vials of insulin or the Miacilin nasal spray. LN # 5 removed the expired medications and unopened vials of insulin from active stock. The nasal spray was stored in an upright position. On 11/10/11 at 1:27 PM interview with Director of Nursing (DON) stated facility policy was to refrigerate unopened vials of insulin for storage until ready for use. DON stated vials were dated when opened and discarded 28 days after opening. DON stated she expected licensed nurses to check expiration dates on all medications before medication administration and follow pharmacy guidelines and recommendations for labeling and storage.	F 431		