STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345296	A. BUILDING _____ B. WING _____	C 07/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARGATE HEALTH AND REHAB CENTER	540 WAUGH STREET JEFFERSON, NC 28640

(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 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observations, interviews with staff and a resident, and medical record review, the facility failed to honor a known food allergy and preferences for two (2) of twenty-four (24) sampled residents (Residents #132 and #182). The findings are: 1. Resident #132 was admitted to the facility with diagnoses which included end stage Alzheimer's dementia. The resident's diet order since admission was pureed. A bright orange allergy sticker on the outside of the resident's medical record and monthly physician orders included all known allergies specific to Resident #132. Included as an allergy in both of these locations in the resident's medical record were iodine, mercury and seafood. Review of the tray card for Resident #132 revealed seafood was not listed as a dislike or food allergy. Review of the initial nutritional assessment as well as all dietary notes revealed no notation of the resident's allergy to seafood.	F 242	RECEIVED AUG 8 2011 BY: ABN 8/9/2011 Resident 132's tray was immediately corrected to show preferences/allergies. Acting Dietary Manager will thoroughly review current resident's chart so that food allergies are correctly entered into the tray card system. Upon new admissions, acting manager will thoroughly review information to see that allergies are entered into the system. Residents with allergies to specific items will not receive such items. Dietary Manager, two times weekly, will randomly audit trays of those with food allergies and provide a regularly updated food allergy list to dietary employees.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	L.N.H.A.	8-5-11

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 242	Continued From page 1 The facility preplanned spring/summer menus were reviewed and included six times when seafood was served during the four week menu cycle. Seafood items served included tuna, salmon and crab cakes. On 07/14/11 at 10:25 AM the second shift cook reported she was not aware of any residents allergic to seafood. The second shift cook stated when seafood is on the menu a prepared frozen puree fish is served to residents on a puree diet. On 07/14/11 at 11:05 AM the acting Food Service Director (FSD) stated Resident #132 was admitted well before she became acting FSD. The acting FSD stated the person in the position prior to her would have reviewed the medical record of Resident #132 and identified any food allergies. The acting FSD could not explain why seafood was not included as an allergy on the resident's tray card. 2. Resident #182 was admitted to the facility with chronic obstructive pulmonary disease and intractable pain. The latest Minimum Data Set dated 07/13/11 revealed the resident had moderate cognitive impairment. A Nutritional Assessment of Resident #182, completed on 07/07/11, revealed that the resident stated she had not had an appetite due to her pain. The resident's diet order specified a regular diet. A review of the resident's medical record also revealed that on 07/07/11 the acting Food Service Director (FSD) completed an initial nutritional interview that documented the food likes and dislikes of Resident #182. The dislikes included carrots and tomatoes, among many others.	F 242	Dietary Manager, two times weekly, will do random tray audits to eval for food likes/dislikes for three months. Monitoring tool implemented. Inservice staff on resident preferences, reading tray cards, etc. New tray card system in place to help address issues with capturing food dislikes correctly. All negative findings will be brought to the monthly C.Q.I. Meeting for three months. Will then reassess the need to continue monitoring.	8/9/2011

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F 242	Continued From page 2 On 07/12/11 at 1:58 PM Resident #182 was interviewed. She stated that when she was first admitted someone had interviewed her about her food likes and dislikes. She stated that about four times since then she had received items on her dislikes list including tomatoes and carrots. She stated that when this happened, she just set them aside and did not eat them. On 07/13/11 at 12:45 PM Resident #182 was observed sitting on her bed eating her lunch. The resident had received tomatoes on her tray which she had set aside. She stated she did not like tomatoes. A review of the tray card that came with her meal revealed she had received tomatoes as a substitute for her dislike of carrots. On 07/14/11 at 2:30 PM the acting FSD was interviewed. She stated she had interviewed Resident #182 on 07/07/11 and assessed her food likes and dislikes which she put in the computerized tray card program that day. She confirmed that Resident #182 did not like carrots and tomatoes, among many other items. She also stated that the computerized tray card program could not recognize an alternate food item as a dislike. She stated that for lunch on 07/13/11 the program recognized that Resident #182 did not like carrots and substituted tomatoes, but did not recognize that tomatoes were also a dislike of Resident #182.	F 242		8/9/2011
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality.	F 281		

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F 281	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to check placement of a gastrostomy tube prior to administering medications for one (1) of one (1) sampled residents with gastrostomy tubes observed during medication pass. (Resident #172). The findings are: Resident #172 was admitted to the facility with diagnoses including anemia, anxiety disorder, cerebrovascular accident (stroke), and malnutrition. On 07/13/11 at 9.20 AM Resident #172 was observed for medication administration. During the observation Licensed Nurse (LN) #1 cleansed her hands and poured four (4) ounces of Jevity 1.5 (a nutritional formula) in a cup. In a separate cup LN #1 mixed six to eight ounces of water with one packet each of Metamucil and Questran and added multiple crush medications scheduled to be administered at 9:00 AM. LN #1 entered Resident #172's room, donned gloves, opened the resident's gastrostomy tube, inserted a 60 milliliter (ml) syringe, and without verifying tube placement or checking residual flushed the tube with 30 milliliters (ml) of water. LN #1 proceeded to administer the Jevity 1.5 followed by the Metamucil, Questran, and crushed medications mixture via the gastrostomy tube. After all medications were administered LN #1 flushed Resident #172's gastrostomy tube with 30 mls of water and recapped the tube.	F 281	Feeding tube placement was checked for Resident #172 on 7-13-11. LN #1 was given a 1:1 inservice on checking tube placement. All nurses will be inserviced on checking feeding tube placement. Reminder will be placed on MAR of all residents with feeding tubes to check placement of tube prior to administration of meds/tube feeding.	8/9/2011

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F 281	Continued From page 4 During an interview, 07/13/11 at 9:40 AM, LN #1 confirmed she did not check tube placement or residual prior to flushing and administering fluids and medications via Resident #172's gastrostomy tube. LN #1 stated tube placement and residual should be checked prior to utilizing the gastrostomy tube for fluids or medications. LN #1 stated she usually checks Resident #172's tube but was "nervous" about being observed and forgot. During an interview, 07/13/11 at 10:40 AM, the facility Directory of Nursing (DON) stated the facility had no written policy regarding verification of gastrostomy tube placement or checking residual. The DON stated the facility followed nursing standards of practice and LN staff were responsible for checking tube placement and residual prior to utilizing the gastrostomy tube.	F 281	D.O.N. or designee will randomly 3-4 times weekly observe nurse checking for tube placement to ensure proper procedure is followed. Monitoring tool will be completed and turned in to D.O.N. weekly. Findings will be reviewed in monthly C.Q.I. Meeting for three months. At end of three months, team will determine need to continue monitoring.	
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, staff interviews, and medical record review, the facility failed to ensure that one (1) of one (1) resident with a swallowing problem was properly positioned during the administration of oral medications (Resident #19);	F 309	Resident #19 was monitored for signs and symptoms of aspiration. All nursing staff will be inserviced on proper positioning for residents with swallowing difficulty.	8/9/2011

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F 309	Continued From page 5 and the facility failed to ensure that one (1) or one (1) resident with visual impairment had adequate light in his room (Resident #6). The findings are: 1. Resident #19 was admitted to the facility with dementia and swallowing difficulty. The latest Minimum Data Set (MDS) dated 06/07/11 revealed the resident had short and long term memory problems and was severely impaired in cognitive skills for daily decision making. The MDS also revealed the resident required extensive assistance with activities of daily living including eating. Review of the medical record of Resident #19 revealed that the Speech Therapist had assessed the resident on 04/20/11 and recommended that the diet order be changed from thickened liquids of nectar consistency to honey consistency to increase swallowing safety. The current diet order for the resident included pureed diet, honey thickened liquids, and use of an adaptive cup for all liquids. Review of nursing notes revealed that since this change the resident was tolerating honey thickened liquids well with no choking episodes. Review of the care plan for Resident #19 revealed a problem entitled weight loss. Among others, interventions for this problem included: follow recommendations by the Speech Therapist; administer honey thickened liquids; use an adaptive nosey cup for all liquids; and only feed the resident when she was alert and in an upright position.	F 309	Residents with swallowing difficulty will be randomly monitored daily by D.O.N. or designee to ensure residents are properly positioned for medication administration. Monitoring tool will be completed and turned in to D.O.N. daily for review for three months. Findings will be Findings will be discussed in monthly C.Q.I. Meeting for three months. At end of three months, team will determine need to continue. 8/9/2011	

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F 309	Continued From page 6 On 07/13/11 at 4:23 PM Licensed Nurse (LN) #4 was observed to administer medications to Resident #19. The resident was in her room sitting in a gerichair at an angle of approximately 45 degrees. LN #4 administered oral medications which were crushed and mixed in applesauce. She also administered 90 cc of a honey thickened high protein supplement in an adaptive nosey cup. During this administration, the resident remained at an approximate angle of 45 degrees. She did not cough but some of the protein supplement ran out of the side of her mouth. On 07/14/11 at 3:36 PM the Speech Therapist was interviewed. She stated that when a resident with swallowing problems was assisted to eat or drink, the most important thing to do was to have them positioned upright as close to 90 degrees as possible. She stated that she expected staff to position Resident #19 as close to 90 degrees as possible for eating or drinking. On 07/14/11 at 3:53 PM LN #4 was interviewed. She stated she was aware that Resident #19 should have been positioned closer to 90 degrees but had overlooked it. On 07/14/11 at 4:45 PM the Director of Nursing (DON) was interviewed. She stated that residents with swallowing problems should be positioned upright for food or fluids, as close to 90 degrees as possible. She stated she expected staff to position Resident #19 as close to 90 degrees as possible to eat or drink thickened liquids. 2. Resident #6 was admitted to the facility with	F 309		

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F 309	Continued From page 7 diagnoses of dementia, aphasia, Parkinson's disease, and impaired vision. The latest Minimum Data Set (MDS) dated 05/11/11 revealed the resident had short and long term memory problems and was severely impaired in cognitive skills for daily decision making. The MDS also revealed that the resident required extensive to total assistance with activities of daily living. The MDS further revealed that the resident's vision was highly impaired. A review of the resident's current care plan, revised 06/22/11, revealed a problem entitled visual impairment with the notation "Resident has decreased visual acuity. Unable to determine (extent of impairment) but eyes follow objects." One intervention for this problem was to promote sensory awareness activities. On 07/11/11 at 3:30 PM Resident #6 was observed awake in his gerichair in his room. The window shade was closed, the lights were off, and the room was very dark. The resident's roommate, whose bed was closest to the door, was lying on his bed. On 07/12/11 at 11:05 AM Resident #6 was observed awake in his gerichair in his room. Again, the window shade was closed, the lights were off, and the room was very dark. A nursing assistant entered the room and turned on the lights. She stated that she guessed someone had gotten Resident #6's roommate up and out of the room but forgot to turn on the light for Resident #6. The nursing assistant left the window shade closed. On 07/12/11 at 3:00 PM Resident #6 and his	F 309	Room change for Resident #6 was made on 7-25-11. All residents will be assessed to ensure they have appropriate lighting for each resident. Residents will be monitored by nursing/activity staff to ensure rooms are adequately lit. Any issues will be discussed in the monthly C.Q.I. Meeting for three months. Team will discuss need to continue monitoring.	8/9/2011

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F 309	Continued From page 8	F 309		

roommate were both observed lying on their beds. The window shade was closed, the lights were off, and the room was very dark.

On 07/13/11 at 10.02 AM Resident #6 was observed awake in his gerichair in his room. The window shade was closed, the lights were off, and the room was very dark. The resident's roommate was lying on his bed near the door.

On 07/13/11 at 4:00 PM Resident #6 was again observed awake in his gerichair in his room. The window shade was closed, the lights were off, and the room was very dark. The resident's roommate was lying on his bed near the door.

On 07/14/11 at 10:25 AM Resident #6 was again observed awake in his gerichair in his room. Resident #6 was moaning. The window shade was closed, the lights were off, and the room was very dark. The resident's roommate was lying on his bed near the door.

At that time, Nursing Assistant (NA) #1 was interviewed. She stated Resident #6 was assigned to her care and she stated she had worked with him frequently. NA #1 stated that the resident's roommate always wanted the shade closed, the lights off, and the room dark, and that he complained if the lights were on for Resident #6. She stated that if the resident's roommate was out of the room, the staff turned on the lights for Resident #6, but that the roommate was in the room in the dark sleeping almost all the time. NA #1 stated that staff had tried leaving on the light on Resident #6's side of the room with the privacy curtain drawn between the residents, but that his roommate had still complained about the light

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F 309	Continued From page 9 being on then too. On 07/14/11 at 3:27 PM Licensed Nurse (LN) #1 was interviewed. She stated that the roommate of Resident #6 had always requested the lights off and window shade closed since being admitted. She stated Resident #6 was brought out to meals and activities so he was not in the dark all day long. She stated if his roommate was out of the room, which was not very often, staff turned on the light for Resident #6. She stated that Resident #6 did need sensory stimulation because of his visual acuity problem. On 07/14/11 at 4:00 PM the activities log was reviewed with the Activity Director. Documentation revealed Resident #6 was taken to out of room activities approximately four or more times a week, and an activity staff member visited with him in his room daily. She stated Resident #6 was taken out of the room for meals and was often placed in the hallway for sensory stimulation. The Activity Director stated that given the resident's visual impairment, sensory stimulation was good for the resident and was one of the goals of his care. On 07/14/11 at 4:53 PM the Director of Nursing (DON) was interviewed. She acknowledged that the lights were off in Resident #6's room "a lot", except when his roommate occasionally left the room. She stated that for Resident #6 to be in a darkened room so much of the time would make it difficult for him to see and decrease sensory stimulation. The DON stated she may to move one of the residents to accommodate the needs of Resident #6.	F 309		8/9/2011
F 312	483.25(a)(3) ADL CARE PROVIDED FOR	F 312		

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F 312 SS=D	Continued From page 10 DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and medical record review, the facility failed to provide nail care for one (1) of three (3) dependent residents (Resident #108). The findings are: Resident #108 was admitted to the facility with diagnoses of recent myocardial infarction, and weakness. The most recent Minimum Data Set dated 07/07/11 revealed the resident had moderate cognitive impairment and required limited to extensive assistance with activities of daily living, including limited assistance for personal hygiene. A review of the resident's care plan, revised 06/07/11, revealed the resident was considered at risk for skin breakdown. One intervention for this problem read: "Provide nail care as needed. Keep nails short, trimmed, and clean." On 07/11/11 at 2:50 PM Resident #108 was observed lying in her bed. Dark brown matter was observed beneath fingernails on both hands. On 07/12/11 at 10:19 AM Resident #108 was	F 312	Resident #108's nails were cleaned 7-12-11. All residents were assessed for appropriate nail care 7-12-11. Nursing staff has been inserviced on proper nail care.	8/9/2011

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F 312	Continued From page 11 again observed lying in her bed. Dark brown matter was again observed beneath fingernails on both hands. On 07/12/11 at 10:25 AM the Activities Assistant was observed in the resident's room trimming her nails. She stated she was trimming the resident's nails because the resident had been sick and in the hospital and missed the last nail care activity which was held every two weeks. She noted that her nails were dirty with dark matter beneath them and needed to be cleaned. She stated she would clean them. She stated that resident nails should be cleaned on shower days twice a week by the nursing assistants, but if they were dirty in between showers that would be a nursing assistant responsibility. On 07/12/11 at 10:38 AM Licensed Nurse (LN) #3 was interviewed. She stated she expected nursing assistants to assess nails for trimming and to clean them on shower days twice a week. She stated she expected nursing assistants to monitor nail cleanliness daily as part of morning care for dependent residents, and that Resident #108's nails should have been cleaned yesterday or today by nursing assistants. On 07/13/11 at 3:23 PM the Director of Nursing (DON) was interviewed. She stated she expected nails to be trimmed and cleaned as needed twice a week during showers and anytime they needed it in between shower days. She stated she expected nursing assistants to monitor nails daily as part of morning care for dependent residents. The DON added that nursing staff should have noticed and cleaned the dirty nails of Resident #108 while washing her hands before	F 312	8/9/2011 Residents will be randomly monitored by D.O.N. or designee daily to ensure proper nail care has been performed. Results will be documented on monitoring tool and turned in to D.O.N. for review daily for three months. Findings will be reviewed in monthly C.Q.I. Meeting for three months. At end of three months, team will discuss need to continue monitoring.	

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F 312	Continued From page 12 meals the last two days.	F 312		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to store thawed chicken in a safe manner. The findings are: During the initial tour of the facility kitchen on 07/11/11 at 11:30 AM fifteen pounds of thawed chicken was observed in a reach in refrigerator. There was no date on the chicken or the tray it was housed on to indicate when it was placed in refrigeration, what its intended use was or when it needed to be discarded. The acting Food Service Director (FSD) was present at the time of the observation and stated she could not determine when the chicken had been placed in refrigeration. The acting FSD checked the preplanned facility menus and determined chicken had last been served on 07/07/11. After brought to her attention the acting FSD discarded the fifteen pounds of thawed chicken. The acting	F 371	Thawed chicken was removed immediately. Inservice was held with all Dietary employees R/T the need to date foods when removed from freezer to refrigerator for thawing. Also, inservice held for all Dietary employees regarding dating and labeling leftovers and un-used foods. 8/9/2011	

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	345296	A. BUILDING _____ B. WING _____	C 07/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARGATE HEALTH AND REHAB CENTER	540 WAUGH STREET JEFFERSON, NC 28640

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F 371	Continued From page 13 FSD stated she was not aware of a policy for storing meat and that typically staff only pull the amount of meat needed a day or two prior to meal preparation to facilitate thawing. The acting FSD stated she could not explain why fifteen pounds of thawed chicken would have remained stored in refrigeration from the meal served 07/07/11.	F 371	Acting Dietary Manager, two times weekly, will randomly check freezers and coolers for unlabeled items for three months.. Monitoring tool implemented. All negative findings will be brought to the monthly C.Q.I. Meeting for three months. Will then re-assess the need to continue monitoring.	8/9/2011
F 431 SS=D	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 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	F 431	Expired insulins were discarded on 7-14-11. All med carts were checked for expired meds on 7-14-11. All nursing staff will be inserviced regarding proper insulin storage.	8/9/2011

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F 431	Continued From page 14 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 observations, manufacturer's package insert review, and staff interviews the facility failed to discard/remove expired insulin from one (1) of five (5) medication carts. The findings are: Storage instructions noted on the manufacturer's package insert, revised 3/2009, for Novolin R (regular) insulin stated, discarded 28 days after first use. A document titled "Medication Storage Monitoring Tool" utilized by the facility for verifying that medications on the medication carts were stored properly was provided by the facility. The document revealed from 07/10/11 to 07/14/11 Licensed Nursing (LN) staff, for the on coming and off going shifts, were signing that medications on the 200 Hall cart were stored properly. Documentation prior to 07/10/11 was not provided by the facility. Observations of the 200 Hall medication cart, 07/14/2011 at 3:45 PM, revealed two (2) ten milliliter (10 ml) vials of Novolin R Insulin opened more than 28 days and available for two residents with current physician's orders. The vials were dated 05/24/11 and 06/06/11 and no additional	F 431	All med carts will be checked daily by charge nurse for proper insulin storage. A monitoring tool will be completed by charge nurse daily and turned in weeky to D.O.N. Findings will be discussed at the monthly C.Q.I. Meeting for three months. At the end of three months, team will discuss need to continue monitoring.	8/9/2011

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F 431	Continued From page 15 vials of Novolin R Insulin were opened and available for the two residents. Further observations of the vials revealed pharmacy labels that read "Expires 28 days after opening. Check exp date." During an interview, 07/14/11 at 3.45 PM, the Director of Nursing (DON), present during the observations, confirmed that the Novolin R Insulin vials were opened 05/24/11 and 06/06/11. The DON stated the Insulins were expired and should have been discarded 28 days after opening. The interview further revealed the expired Insulins were prescribed to and available for residents with current physician's orders. The interview further revealed both residents were receiving Novolin R Insulin daily. The DON stated Licensed Nursing (LN) staff were responsible for checking their carts each shift, removing expired medications, and signing the "Medication Storage Monitoring Tool." The DON stated signatures noted from 07/10/11 to 07/14/11 on the monitoring tool indicted that the 200 Hall cart was checked. The DON stated expired medications should not have been available for use on the 200 Hall medication cart. During an interview, 07/14/11 at 4:30 PM, LN #1 identified her signature on the "Medication Storage Monitoring Tool" for 07/13/11. LN #1 stated her signature was to indicate that the 200 Hall medication cart was checked and free of expired medications. LN #1 reported Novolin R Insulin should be discarded 28 days after opening. LN #1 stated she should have recognized the expired Insulins and removed them from the cart.	F 431		8/9/2011

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F 431	Continued From page 16 During an interview, 07/14/11 at 4:35 PM, LN #2 identified her signature on the "Medication Storage Monitoring Tool" for 07/14/11. LN #2 stated her signature was an indication that the 200 Hall medication cart was checked and free from expired medications. LN #2 stated she should have recognized the expired Novolin R Insulins and removed them from the cart. Interview, 07/14/11 at 5:30 PM, with the facility Pharmacist revealed Novolin R Insulin should be discarded 28 days after opening. The Pharmacist stated Insulins used beyond their expiration dates may be degraded and/or less stable which could alter the desired effects of the medication. The Pharmacist stated expired Insulin should not be stored on the medication cart available for use. The interview further revealed pharmacy staff conduct random medication cart checks monthly to ensure proper medication storage. The Pharmacists stated the 200 Hall cart was last checked in June 2011.	F 431		