STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375385	A. Building B. Wing	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkland Manor Living Center	922 West Parkland Avenue Prague, OK 74864

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 46582 Based on record review and interview, the facility failed to ensure accurate coding of a MDS assessment for an indwelling catheter for one (#5) of 12 residents whose MDS assessments were reviewed. The administrator identified 21 residents who resided in the facility. Findings: Res #5 had diagnoses which included cerebral infarction and hypertensive heart disease with heart failure. An annual MDS assessment, dated 01/22/24, documented the resident was cognitively intact, required maximum assistance with toileting, and had an indwelling catheter. A physician order, dated 02/26/24, documented to discontinue the foley catheter. A quarterly MDS assessment, dated 04/18/24, documented the resident was cognitively intact, dependent with toileting, and had an indwelling catheter. Res #5's records were reviewed and did not document an order for an indwelling catheter during the review period of the quarterly assessment. On 05/29/24 at 1:55 p.m., the DON stated Res #5's indwelling catheter was discontinued in February. They stated the MDS assessment was documented in error.

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities 46582 Based on record review and interview, the facility failed to ensure accuracy of a level I PASARR assessment for three (#8, 10, and #13) of three residents reviewed for PASARR assessments. The administrator identified 21 residents who resided in the facility. Findings: 1. Res #10 had a level I PASARR screen, dated 04/27/23, which documented a primary diagnosis of hypertensive heart disease and chronic kidney disease with heart failure and a secondary diagnosis of hemiparesis and hemiplegia. The level I PASARR screen documented the resident had no diagnoses of a serious mental illness. A medical diagnosis report, dated 05/01/23, documented Res #10 had admission diagnoses which included schizoaffective disorder- bipolar type, delusional disorders, and brief psychotic disorders. On 05/29/24 at 2:00 p.m., the DON was shown the level I PASSAR form and Res #10's admission diagnoses. The DON was asked if these diagnoses had been reported to the OHCA to see if a level II PASSAR was required. On 05/29/24 at 2:15 p.m., the DON stated the level I PASSAR form was not completed correctly. They stated there was no documentation the OHCA had been notified of the serious mental illness diagnoses. 43023 2. Res #8 was admitted to the facility with diagnosis of bipolar disorder. A PASARR Level I, dated 10/28/21, documented the resident did not have a mental health diagnosis. 3. Res #13 was admitted to the facility with diagnoses of schizoaffective disorder and major depressive disorder. A PASARR Level I, dated 10/25/22, documented the resident did not have a mental health diagnosis. On 05/29/22 at 1:55 p.m., the DON reported the PASARs were not filled out correctly and the OHCA was not notified.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 43023 Based on record review and interview, the facility failed to ensure care plans were developed/implemented for four (#9, 19, 11, and #13,) of 14 residents sampled for care plans. The Administrator reported 21 residents resided in the facility. Findings: 1. Res #9 admitted to the facility with diagnoses of bipolar disorder, major depressive disorder, and anxiety disorder. A care plan revised on 02/09/24, documented AIMS (abnormal involuntary movement scale) completed quarterly and PRN. A review of the resident's record documented the last AIMS was completed on 01/27/24. On 05/30/24 at 11:47 a.m., the DON reported the AIMS assessment should have been completed quarterly. 2. Res #19 was admitted to the facility with diagnoses of displaced intertrochanteric fracture of right femur and displaced fracture of base of neck of left femur. A care plan revised on 04/10/24 documented pressure censor applied to alert staff when movement is detected. A care plan revised on 04/14/24 documented assure security mat in placed at all times. On 05/30/24 at 11:37 a.m., the DON was asked about the security mat and pressure censor that is documented on the resident's care plan. She stated the pressure censor should be on his bed and the security mat was used to keep the cool air off the resident since he is in the low bed. On 05/30/24 at 11:39 a.m., the DON and this surveyor went to the resident's room to check for the pressure censor and security mat. Neither one was observed in place. The DON was asked if the care plan was being followed and she reported no it is not. 3. Res #11 was admitted to the facility with diagnoses of bipolar disorder, major depressive disorder, and anxiety. A care plan, dated 04/24/24, contained no documentation of bipolar disorder. On 05/30/24 at 11:45 a.m., the DON reported the resident's diagnosis of bipolar disorder should have been care planned. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. Res #13 was admitted to the facility with diagnoses of schizoaffective disorder and major depressive disorder. A care planned revised on 05/22/24 contained no documentation of schizoaffective disorder. On 05/30/24 at 11:46 a.m., the DON reported the resident diagnosis of schizoaffective disorder should have been care planned.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 43023 Based on observation, record review, and interview, the facility failed to ensure physician's orders were followed for leg rest to wheelchair and pressure offload boots when out of bed for one (#19) of one resident sampled for physician's orders. The Administrator reported 21 residents resided in the facility. Findings: Res #19 was admitted with diagnoses of displaced intertrochanteric fracture of right femur, displaced fracture of base of neck of left femur, and history of falling. A physician's order, dated 5/23/24, documented add elevating leg rests to w/c d/t edema when out of bed and pressure off load boots when out of bed. On 05/29/24 at 8:38 a.m., Res #19 was observed up in w/c in dining room. The resident's legs were not elevated, and no pressure offload boots were observed. On 05/30/24 at 10:41 a.m., the resident was observed up in w/c in lobby, legs were not elevated, and no offload boots were in place. On 05/30/24 at 11:40 a.m., the resident's leg rest were observed sitting on the resident's bedside table in room and offload boots were observed under the resident's bed. The DON was asked if the staff are following physician's order and she reported no they are not.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 43023 Based on record review and interview, the facility failed to ensure the residents were free from accident hazards fro one (#8) for two residents sampled for accidents. The administrator reported 21 residents resided in the facility. Findings: On 05/29/24 at 9:55 a.m., Res #8 reported one person uses lift to transfers her most times. A monthly summary, dated 4/2/24, documented mechanical lift with 2 person assist. On 05/29/24 at 1:07 p.m., CNA #1 was asked how the resident is transferred. CNA #1 reported with the mechanical lift. CNA #1 was asked how many people transfer resident and he reported usually 2 but I can do it by myself. CNA #1 was asked if he transferred the resident by himself yesterday morning and he reported yes. On 05/29/24 at 2:03 p.m., the DON reported the mechanical lift should be used by 2 staff members with all transfers.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 46582 Based on observation, record review, and interview, the facility failed to ensure medications were administered separately and PEG tube placement was verified prior to the administration of medications for one (#17) of one resident reviewed for tube feedings. The DON identified one resident who received medications via PEG tube. Findings: An Administering Medications through an Enteral Tube policy, revised November 2018, read in parts, .Verify placement of feeding tube: if you suspect improper tube positioning, do not administer feeding or medications. Notify the charge nurse or physician .Administer each medication separately and flush between medications .If administering more than one medication, flush with 15 mL warm water (or prescribed amount) between medications . Res #17 had diagnoses which included dementia, cerebral infarction, and gastrostomy. A quarterly assessment, dated 04/27/24, documented Res #17 was severely cognitively impaired, had no swallowing concerns, and received 25% or less proportion of total calories through parenteral or tube feeding. A care plan, revised 05/06/24, documented medication administration through peg tube until further notice. On 05/30/24 at 7:15 a.m., LPN #1 was observed to access Res #17's PEG tube. LPN #1 did not check residual or verify placement of the PEG tube prior to administering 30 mLs of water. LPN #1 then administered 12 routine medications that had been mixed all together in one 30 mL medication cup. On 05/30/24 at 7:20 a.m., LPN #1 was asked how they ensured the PEG tube was in the correct place prior to medication administration and if all the medications should have been given mixed together. LPN #1 stated they had checked residual earlier in the shift but should have checked again using auscultation prior to instilling any water or medications through the PEG tube. LPN #1 stated sometimes they administered each medication separately but felt administering them all at once was appropriate also. On 05/30/24 at 1:32 p.m., the DON was made aware of the medication administration observations. The DON stated the nurse should have verified correct placement of the PEG tube prior to instilling anything through it. They stated auscultation with air should have been used for placement verification. The DON stated each of the 12 medications should have been administered separately per policy.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 46582 Based on observation, record review, and interview, the facility failed to ensure medications were administered according to physician orders for two (#1 and #5) of six residents who were observed for medication administration. The administrator identified 21 residents who resided in the facility. Findings: A Medication Administration policy, undated, read in parts, .Ensure that the six rights of medication administration are followed: Right resident, Right drug, Right dosage, Right route, Right time, Right documentation .Compare medication source (bubble pack, vial, etc.) with MAR to verify resident name, medication name, form, dose, route, and time . 1. Resident #5 had diagnoses which included type II diabetes mellitus. A physician order, dated 10/02/23, documented Humalog insulin - inject 6 units subcutaneously before meals for type II diabetes mellitus. On 05/29/24 at 12:05 p.m., LPN #2 was observed to administer Novolog insulin 6 units subcutaneously per injection to Res #5. On 05/30/24 at 1:39 p.m., the DON was made aware of the medication administration observations with LPN #2. The DON stated LPN #2 had administered the wrong type of insulin to Res #5. They stated Humalog insulin should have been administered per physician order instead of Novolog because they are not the same insulin. 2. Resident #1 had diagnoses which included chronic pain. A physician order, dated 03/11/24, documented hydrocodone-acetaminophen oral tablet 7.5/325 mg - give one tablet by mouth every 4 hours as needed for pain. On 05/30/24 at 7:50 a.m., CMA #1 was observed to administer hydrocodone-acetaminophen 5/325 mg one tablet by mouth to Res #1. On 05/30/24 at 8:52 a.m., CMA #1 was asked to compare Res #1's MAR with the medication that had been administered. CMA #1 stated the resident was administered the wrong strength of medication. CMA #1 stated Res #1 had received 5/325 mg of the hydrocodone-acetaminophen, but they should have received 7. 5/325 mg per physician order. On 05/30/24 at 1:50 p.m., the DON was made aware of the medication administration observations with CMA #1. The DON stated Res #1 had received the wrong strength of medication. They stated CMA #1 should have verified the physician order with the medication prior to administration.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46582 Based on record review and interview, the facility failed to ensure the consulting pharmacist identified irregularities and/or clinically significant risks which may result or be associated with psychotropic medications for two (#1 and #15) of five residents reviewed for unnecessary medications. The administrator identified 21 residents who resided in the facility. Findings: A Tapering Medications and Gradual Dose Reduction policy, revised July 2022, read in parts, .Residents who use psychotropic medications shall receive gradual dose reductions and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs .Within the first year after a resident is admitted on a psychotropic medication or after the resident has been started on a psychotropic medication, the staff and practitioner shall attempt and GDR in two separate quarters (with at least one month between the attempts) , 1. Res #1 was admitted [DATE] with diagnoses which included schizoaffective disorder, paranoid personality disorder, and anxiety. A physician order, dated 03/11/24, documented lorazepam 0.5 mg one tablet every four hours as needed for anxiety. A MAR, dated May 2024, documented Res #1 had received lorazepam 0.5 mg once daily on 29 occasions. Monthly medication regimen review reports were reviewed for March 2024 and April 2024. No recommendations were documented that lorazepam should be limited to 14 days unless the physician documented in the medical record the rationale for extending beyond 14 days and indicated the duration for the prn order. On 05/30/24 at 12:05 p.m., the DON stated PRN psychotropic medications should have a 14 day stop date. They stated having not realized Res #1 had received lorazepam since admission. The DON stated this medication should have been discontinued after 14 days and reordered only after the physician had assessed the resident. The DON stated the consulting pharmacist had missed this in the monthly medication reviews. 2. Res #15 was admitted [DATE] with diagnoses which included dementia, anxiety, and major depressive disorder. A physician order, dated 08/08/23, documented mirtazapine 15 mg by mouth at bedtime for antidepressant. A physician order, dated 08/08/23, documented olanzapine 10 mg by mouth at bedtime for anxiety. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A physician order, dated 08/08/23, documented quetiapine 12.5 mg by mouth at bedtime for depression/anxiety. A physician order, dated 08/08/23, documented buspirone 10 mg by mouth two times daily for anxiety. A physician order, dated 08/09/23, documented paroxetine 40 mg by mouth one time a day for depression/anxiety. Monthly medication regimen review reports were reviewed for August 2023 through April 2024. No recommendations for a GDR of the psychotropic medications were documented by the consulting pharmacist during this time frame. No attempts of a GDR or physician's rationale as to why a GDR was not appropriate were documented in the medical record since Res #15 was admitted to the facility. On 05/30/24 at 12:00 p.m., the DON stated no attempt of a GDR had been completed or attempted for Res #15 since admission. They stated the consulting pharmacist had not documented a recommendation of a GDR during the monthly reviews. The DON stated the physician had not documented rationale for the ongoing need for the psychotropic medications per policy.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46582 Based on record review and interview, the facility failed to ensure a. a PRN psychotropic medication was limited to 14 days for two (#1 and #17); b. a GDR (gradual dose reduction) was attempted for one (#15); and c. routine/PRN psychotropic medications were not received unless for a specific diagnosis for two (#15 and #17) of five residents reviewed for unnecessary medications. The administrator identified 21 residents who resided in the facility. Findings: A Tapering Medications and Gradual Dose Reduction policy, revised July 2022, read in parts, .Residents who use psychotropic medications shall receive gradual dose reductions and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs .Within the first year after a resident is admitted on a psychotropic medication or after the resident has been started on a psychotropic medication, the staff and practitioner shall attempt and GDR in two separate quarters (with at least one month between the attempts) , 1. Res #1 was admitted [DATE] with diagnoses which included schizoaffective disorder, paranoid personality disorder, and anxiety. A physician order, dated 03/11/24, documented lorazepam 0.5 mg one tablet every four hours as needed for anxiety. A MAR, dated May 2024, documented Res #1 had received lorazepam 0.5 mg once daily on 29 occasions. On 05/30/24 at 12:05 p.m., the DON stated PRN psychotropic medications should have a 14 day stop date. They stated having not realized Res #1 had received lorazepam since admission. The DON stated this medication should have been discontinued after 14 days and reordered only after the physician had assessed the resident. 2. Res #15 was admitted [DATE] with diagnoses which included dementia, anxiety, and major depressive disorder. A physician order, dated 08/08/23, documented mirtazapine 15 mg by mouth at bedtime for antidepressant. A physician order, dated 08/08/23, documented olanzapine 10 mg by mouth at bedtime for anxiety. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A physician order, dated 08/08/23, documented quetiapine 12.5 mg by mouth at bedtime for depression/anxiety. A physician order, dated 08/08/23, documented buspirone 10 mg by mouth two times daily for anxiety. A physician order, dated 08/09/23, documented paroxetine 40 mg by mouth one time a day for depression/anxiety. Monthly medication regimen review reports were reviewed for August 2023 through April 2024. No recommendations for a GDR of the psychotropic medications were documented by the consulting pharmacist during this time frame. No attempts of a GDR or physician's rationale as to why a GDR was not appropriate were documented in the medical record since Res #15 was admitted to the facility. On 05/30/24 at 12:00 p.m., the DON stated no attempt of a GDR had been completed or attempted for Res #15 since admission. They stated the consulting pharmacist had not documented a recommendation of a GDR during the monthly reviews. The DON stated the physician had not documented rationale for the ongoing need for the psychotropic medications per policy. On 05/31/24 at 9:38 a.m., the DON stated anxiety was not an appropriate diagnosis for the use of olanzapine. 43023 3. Res #17 was admitted to the facility with diagnoses of dementia and anxiety. A physician's order, dated 04/08/24, documented Olanzapine 5mg give 1 tablet every 4 hours as needed for agitation. A physician's order, dated 05/06/24, documented Olanzapine 10mg 1 tablet by mouth twice a day for anxiety. On 05/31/24 at 9:35 a.m., the DON reported dementia and anxiety are not an appropriate diagnosis for Seroquel and Olanzapine. The DON reported the PRN Olanzapine should have had a 14 day stop date.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 46582 Based on observation, record review, and interview, the facility failed to ensure the medication error rate was less than 5%. A total of 31 opportunities were observed with two errors. The total medication error rate was 6. 45%. The administrator identified 21 residents who received medications in the facility. Findings: 1. Resident #5 had diagnoses which included type II diabetes mellitus. A physician order, dated 10/02/23, documented Humalog insulin - inject 6 units subcutaneously before meals for type II diabetes mellitus. 2. Resident #1 had diagnoses which included chronic pain. A physician order, dated 03/11/24, documented hydrocodone-acetaminophen oral tablet 7.5/325 mg - give one tablet by mouth every 4 hours as needed for pain. On 05/29/24 at 12:05 p.m., LPN #2 was observed to administer Novolog insulin 6 units subcutaneously per injection to Res #5. LPN #2 stated the resident received this insulin due to the before meals physician order. On 05/30/24 at 7:50 a.m., CMA #1 was observed to administer hydrocodone-acetaminophen 5/325 mg one tablet by mouth to Res #1. On 05/30/24 at 8:52 a.m., CMA #1 was asked to compare Res #1's MAR with the medication that had been administered. CMA #1 stated the resident was administered the wrong strength of medication. CMA #1 stated Res #1 had received 5/325 mg of the hydrocodone-acetaminophen, but they should have received 7. 5/325 mg. On 05/30/24 at 1:39 p.m., the DON was made aware of the medication administration observations with LPN #2. The DON stated LPN #2 had administered the wrong type of insulin to Res #5. They stated Humalog insulin should have been administered instead of Novolog because they are not the same insulin. On 05/30/24 at 1:50 p.m., the DON was made aware of the medication administration observations with CMA #1. The DON stated Res #1 had received the wrong strength of medication. They stated CMA #1 should have verified the MAR with the medication prior to administration. The DON was informed of the medication error rate of 6.45%.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43023 Based on observation and interview, the facility failed to ensure the removal of expired/use by date medications/supplies from the medication storage room, medication cart, and treatment cart. The administrator reported 21 residents resided in the facility. Findings: On [DATE] 09:30 AM Review of the medication cart 1 bottle of house stock ibuprofen, sue by date [DATE] 1 card of vitamin C 500mg--, 7 pills, use by date [DATE] 1 card Probiotic 3 with 6 capsules, use by date [DATE] 1 card Metoprolol 25mg with 12 pills, use by date [DATE] 1 card Clonidine 0.1mg with 28 tablets, use by date [DATE] 1 card Loratadine 10mg with 20 tablets, use by date [DATE] 1 card Senna 8.6mg with 56 pills, use by date [DATE] 1 card Aspirin 81mg with 11 pills, use by date [DATE] 1 card Ibuprofen 800mg with 12 pills, use by date [DATE] 1 card Vitamin D3 2000IU with 25 tablets, use by date [DATE]. On [DATE] 09:48 AM CMA #1 reported medications should have been removed from the cart. On [DATE] 09:53 AM Review of the medication/storage room with CMA #1. 2 injections of Hepatitis B Vaccine with a use by date of [DATE] 1 vial Tubersol 5TU/0.1ml with a use by date of [DATE] 2 Bottles of Miralax Powder with a use by date of [DATE] 1 card of Clonidine 0.1mg with 31 tablets with a use by date of [DATE] 1 card of Acetaminophen 500mg with 30 tablets with a use by date of [DATE] (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375385	A. Building B. Wing	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkland Manor Living Center	922 West Parkland Avenue Prague, OK 74864

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] 10:05 AM CMA #1 reported all medications should have been removed from the med room. [DATE] 10:06 AM Review of the treatment cart with LPN #2 2 pair 7 ,d+[DATE] sterile latex gloves with an expiration date of ,d+[DATE] 2 bottles Novolog 100u/ml with an open date of [DATE] 1 Humalog Kwickpen with an open date of [DATE] [DATE] 10:15 a.m., LPN #2 reported these items should have been removed from the cart already. 46582 Resident #5 had diagnoses which included type II diabetes mellitus. A physician order, dated [DATE], documented Humalog insulin - inject 6 units subcutaneously before meals for type II diabetes mellitus. On [DATE] at 12:05 p.m., LPN #2 was observed administering medication. LPN #2 obtained a box containing a vial of Novolog insulin from the medication cart. The box was dated [DATE]. LPN #2 obtained 6 units of insulin from the vial and administered the insulin subcutaneously to Res #5. On [DATE] at 12:10 p.m., LPN #2 was asked what the date on the insulin box indicated. LPN #2 stated the date indicated when the vial was first opened for use. They stated they did not know how long the insulin could be used after the open date. LPN #2 stated they thought the insulin could be administered up until the expiration date on the insulin vial itself. On [DATE] at 1:39 p.m., the DON was made aware of the medication administration observation. The DON stated the insulin should not have been administered. They stated the vial should have been disposed of after 30 days from the opening date on the box.