

Division of Licensing and Protection  
103 South Main Street, Ladd Hall  
Waterbury VT 05671-2306  
<http://www.dail.vermont.gov>  
Voice/TTY (802) 241-2345  
To Report Adult Abuse: (800) 564-1612  
Fax (802) 241-2358

February 3, 2011

Charlene Bedor, Administrator  
Redstone Villa  
7 Forest Hill Drive  
St Albans, VT 05478

Provider ID #:475055

Dear Ms.. Bedor:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **January 5, 2011.**

Follow-up may occur to verify that substantial compliance has been achieved and maintained.

Sincerely,



Pamela M. Cota, RN  
Licensing Chief

PC:jl

Enclosure



STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # <b>475055</b>	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: <b>1/5/2011</b>
NAME OF PROVIDER OR SUPPLIER <b>REDSTONE VILLA</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>7 FOREST HILL DRIVE ST ALBANS, VT</b>		RECEIVED Division of <b>JAN 2 4 11</b>
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES		Licensing and Protection
<b>F 515</b>	<p><b>483.75(1)(2) RETENTION OF RESIDENT CLINICAL RECORDS</b></p> <p>Clinical records must be retained for the period of time required by state law; or five years from the date of discharge when there is no requirement in State law; or, for a minor, three years after a resident reaches legal age under State law.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview the facility failed to retain a copy of the medical record for a five year period from date of discharge for 1 applicable resident (Resident #53). Findings include:</p> <p>During the investigation of a complaint related to the care and services provided to Resident #53, who was admitted to the facility on 10/29/10 and discharged on 11/3/10, both the facility Administrator and the DNS stated that they were unable to provide the surveyor with the resident's medical record for review as it could not be found.</p> <p><i>See next page for POC.</i></p>		

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

The above isolated deficiencies pose no actual harm to the residents

Redstone Villa, (the "Provider") submits this plan of correction, (POC), in accordance with specific regulatory requirements. It shall not be construed as an admission of any alleged deficiency cited.

The Provider submits this POC with the intention that it be inadmissible by any third party any civil or criminal action against the Provider or any employee, agent, officer, director or shareholder of the Provider. The Provider hereby reserves the right to challenge the findings, that are relied upon to adversely influence or serve as a basis, in any way, for the selection and / or imposition of future remedies, or for any increase in future remedies, whether any such remedies are imposed by the Centers for Medicare and Medicaid Services ("CMS"), the State of Vermont or any other entity.

Any changes to Provider Policy or Procedure should be considered to be subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and should be inadmissible in any proceedings on that basis.

F515

**1. How will corrective action be accomplished for those residents found to have been affected by the deficient practice?**

**Resident #53 was not harmed by this alleged deficient practice. Facility staff continue to search for missing medical record.**

**2. How will the facility identify other residents having the potential to be affected by the same deficient practice?**

**All residents with discharged medical records could be affected.**

**3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?**

**All Licensed Nursing staff and Medical records staff will be re-educated on protocol for storage of discharged medical records by 2/5/11. All open discharged medical records will be placed in designated cabinet for storage. Applicable staff with access to discharged medical records will sign when taking and returning these medical records.**

**4. How will the facility monitor its corrective actions to ensure that the deficient practice will not recur?**

**Audits by Administrator/Designee will be done with each discharge for proper storage of medical records for 3 months.**

**Results will be reviewed at Quarterly QA meeting.**

**5. Include dates when a corrective action will be completed.**

**Administrator/Designee will be responsible for monitoring to assure with compliance with POC and regulatory requirements by 2/5/11.**

F515 POC accepted 2/3/11 Btbwe RN/DMCotler

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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Licensing and

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PRINTED: 01/18/2011  
FORM APPROVED  
OMB NO. 0938-0391

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F 000	INITIAL COMMENTS	F 000		
F 272 SS=D	<p>An unannounced on-site recertification survey was conducted by the Division of Licensing and Protection on 1/3/11-1/5/11 in conjunction with a complaint investigation.</p> <p>483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS</p> <p>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following:                      Identification and demographic information;                      Customary routine;                      Cognitive patterns;                      Communication;                      Vision;                      Mood and behavior patterns;                      Psychosocial well-being;                      Physical functioning and structural problems;                      Continence;                      Disease diagnosis and health conditions;                      Dental and nutritional status;                      Skin conditions;                      Activity pursuit;                      Medications;                      Special treatments and procedures;                      Discharge potential;                      Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and                      Documentation of participation in assessment.</p>	F 272		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

*Challen Bede*

TITLE

*Administrator*

(X6) DATE

*1/26/2011*

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 272	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to complete an initial comprehensive assessment including the mood and behavior patterns, psychosocial and medication needs for 2 of 13 applicable residents (Residents #46 and #48). Findings include:</p> <p>Per record review, the MDS (Minimum Data Set) initial comprehensive assessments had not been completed for Residents #46 and #48, who had been admitted on 12/10/10 and 12/17/10, respectively. There was no assessment for the use of the following psychotropic medications that each of the resident's had received since their admission to the facility:</p> <p>Resident #48 had a physician order, dated 12/17/10, for; Geodon (an atypical antipsychotic) 80 mg PO (by mouth) BID (twice a day), Citalopram (antidepressant) 10 mg PO daily and Ativan (an anti-anxiety drug) 0.5 mg PO every 12 hours PRN (as needed).</p> <p>Resident #46 had physician orders, dated 12/10/10, for the use of lorazepam (anti-anxiety) 1 mg PO TID (three times a day) PRN.</p> <p>Although there was a diagnosis for the use of Ativan (lorazepam) for each of the residents, and for Citalopram for Resident #48, there was no indication for the use of Geodon for Resident #48. There was no assessment, for either resident, of mood and behaviors or psychosocial status, to assist in identifying the need for each of the medications and developing a plan of care to address those needs. This was confirmed by the DNS (Director of Nursing Services) during</p>	F 272	<ol style="list-style-type: none"> <li>How will corrective action be accomplished for those residents found to have been affected by the deficient practice? <b>MDS comprehensive assessments were completed for Residents #46 and #48.</b> Residents # 46 and #48 were not affected by this alleged deficient practice.</li> <li>How will the facility identify other residents having the potential to be affected by the same deficient practice? <b>All residents requiring a comprehensive assessment could be affected.</b></li> <li>What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? <b>MDS Coordinator will be re-educated on timeliness of completion of comprehensive assessments by 2/5/11.</b></li> <li>How will the facility monitor its corrective actions to ensure that the deficient practice will not recur? <b>DNS/Designee will audit 3 residents per week for 3 months on timeliness of comprehensive assessments. Results to Quarterly QA meeting.</b></li> <li>Include dates when a corrective action will be completed. <b>DNS/Designee will be responsible for monitoring to assure compliance with POC and regulatory requirements by 2/5/11.</b></li> </ol> <p><i>F272 POC Accepted 2/3/11. BHOWERN / PIMCOTURN</i></p>	

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F 272	Continued From page 2 Interview at 2:00 PM on 1/5/11.	F 272		
F 279 SS&D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to develop comprehensive care plans to address the dental issues and psychotropic drug use for 3 of 13 applicable residents. (Residents #11, #48 and #48). Findings include:</p> <p>1. Per record review, although the most current care plan, dated 10/27/10, identified Resident #11 as at risk for both weight loss and pain intolerance related to "poor dentition", it did not</p>	F 279	<p>1. How will corrective action be accomplished for those residents found to have been affected by the deficient practice? Care plan for dentician for Resident #11 was addressed on 1/5/11. Physician addressed Diagnosis for Gordon on 1/5/11. Resident #48 was discharged on 1/4/11. Care plan for Resident #48 was addressed on psychoactive medications on 1/8/11. Residents #11, #46, and #48 were not affected by this alleged deficient practice.</p> <p>2. How will the facility identify other residents having the potential to be affected by the same deficient practice? Any Resident with dental concerns or receiving psychoactive medications has the potential to be affected by this alleged deficient.</p> <p>3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? Care plan coordinator will be re-educated on addressing dental concerns and psychoactive medications on care plan by 2/3/11.</p> <p>4. How will the facility monitor its corrective actions to ensure that the deficient practice will not recur? DNS/Designee will audit 3 care plans per week for 3 months for Residents with dental concerns or receiving psychoactive medications. Results to Quarterly QA meeting.</p> <p>5. Include dates when a corrective action will be completed. DNS/Designee will be responsible for monitoring to assure compliance with POC and regulatory requirements by 2/8/11.</p> <p>F279 POC Accepted 2/3/11 BHWERN/CMCOTURN</p>	

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F 279	<p>Continued From page 3</p> <p>address the resident's oral or dental needs. During a family interview, on the morning of 1/4/11, the family member confirmed that the resident's teeth were in poor condition. During interview on the afternoon of 1/5/11, the DNS confirmed that although the family had declined a dental consult, and that the resident did suffer from mouth odor as a result of her poor dentition and overall oral condition, the care plan did not address the resident's oral/dental needs.</p> <p>2. Per record review, the most current care plan for Resident #48, dated 12/17/10, did not address the use of psychotropic medications that the resident had received on a daily basis from admission on 12/17/10 to date. The resident had physician orders for; Geodon 80 mg PO BID; Citalopram 10 mg PO daily for depression and Ativan 0.5 mg PO every 12 hours PRN for anxiety. There was no indication for the use of Geodon and although there was a diagnosis identified for use of Citalopram and Ativan the care plan did not include measurable goals for their use or identify interventions to assist staff in identification of the need for, potential side effects of, or measures to evaluate the effectiveness of any of the medications.</p> <p>3. Per record review, Resident #46's most current care plan, dated 12/10/10, did not address the use of psychotropic medications that the resident had received on a daily basis from his/her admission on 12/10/10 to date. Although there was a physician order for the use of Lorazepam 1 mg PO TID PRN for anxiety, the care plan did not include measurable goals or interventions to assist the staff in identification of the need for, potential side effects of, or methods to evaluate the effectiveness of the use of</p>	F 279		
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F 279	Continued From page 4 Lorazepam.	F 279		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS  Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.  Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.  This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to assure the drug regimen was free	F 329		

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F 329	<p>Continued From page 5</p> <p>from the use of unnecessary psychoactive drugs for 2 of 9 applicable residents. (Residents #46 and #48). Findings include:</p> <p>1. Per record review Resident #48, had received an antipsychotic drug on a daily basis from admission on 12/17/10 through the dates of survey, with no indication for its use and no evidence that staff had monitored for potential side effects or evaluated the effectiveness of the drug. In addition, there was no evidence that non pharmacological interventions had been considered to address the resident's psychosocial needs. There was a physician order, dated 12/17/10, that directed staff to administer Geodon 80 mg PO BID. During interview on the afternoon of 1/5/11, Nurse #1, who was responsible for oversight of the resident's care, stated s/he did not know why the resident was receiving Geodon, stating that the resident was on the drug when admitted to the facility. Per interview, at 2:00 PM on 1/5/11, the DNS confirmed the lack of indication for use, lack of monitoring for effectiveness and lack of consideration of non pharmacological interventions. The DNS stated that s/he had sent a fax to the physician, in response to the consultant pharmacist request for indication for use of the Geodon, and the physician had not responded to the fax, which was dated 12/22/10, as of 1/5/11. The fax was resent on 1/5/11 after the issue was brought to the facility's attention by the surveyor.</p> <p>2. Per record review Resident #46 had a physician order, dated 12/10/10, for the use of Lorazepam 1 mg PO TID PRN for anxiety. Although the resident had received this drug on an almost daily basis, from admission to the facility on 12/10/10 through the dates of survey,</p>	F 329	<p>1. How will corrective action be accomplished for those residents found to have been affected by the deficient practice? Resident # 48 was discharged. In addition to the diagnosis of depression listed on the diagnosis list in the chart, the physician was called. A diagnosis of depression was obtained for the Geodon and already noted to be on the Resident's existing diagnosis list. Licensed Nurses were re-educated on administering ativan per physician order for Resident # 46.</p> <p>2. How will the facility identify other residents having the potential to be affected by the same deficient practice?  Any resident receiving atypical antipsychotic or psychoactive medications has the potential to be affected by this alleged deficient practice.</p> <p>3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? All licensed nurses will be re-educated on protocol for administering psychoactive medications by 2/5/11.</p> <p>4. How will the facility monitor its corrective actions to ensure that the deficient practice will not recur? DNS/Designee will audit 3 records per week for 3 months of those residents on psychoactive medications. Results to Quarterly QA meeting.</p> <p>5. Include dates when a corrective action will be completed.  DNS/Designee will be responsible for monitoring to assure compliance with POC and regulatory requirements by 2/5/11.</p> <p><i>F329 POC Accepted 2/3/11. BHW RN / AmcotuRN</i></p>	

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F 329	Continued From page 6 there was no evidence that staff had identified resident specific symptoms or causes of anxiety, had considered non pharmacological interventions prior to administration of the drug, or that they had monitored the resident for potential side effects of he drug. In addition, although the physician order stated to administer the Ativan for anxiety, staff administered the drug, on at least 9 occasions between 12/15/10 and 12/22/10, for resident complaints of nausea. During interview, at 2:00 PM on 1/5/11, the DNS confirmed the lack of monitoring for potential side effects, lack of consideration of non pharmacological interventions prior to administration of the drug, and that staff had administered the Ativan for resident complaints of nausea without a physician order for that specific indication for use.	F 329		
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 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	F 431		

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NAME OF PROVIDER OR SUPPLIER  <b>REDSTONE VILLA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>7 FOREST HILL DRIVE ST ALBANS, VT 05478</b>	
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F 431	<p>Continued From page 7</p> <p>controls, and permit only authorized personnel to have access to the keys.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to assure that outdated medications were not available for resident use and failed to assure that all biologicals were secured in a manner that would prevent accessibility by residents. Findings include:</p> <p>During inspection of drug and biological storage units on the morning of 1/4/11 the following outdated drugs were identified:</p> <p>In the stock drug cabinet located in the nurse's station (all unopened containers); 3 bottles (12 oz each) of Geri Lanta antacid with an expiration dates of 10/10 or 11/10; 1 bottle (1000 tablets) Gerard Multivitamins (MV) with an expiration date of 9/10; 3 bottles (100 tablets) GeriCare MVI with/Iron, expiration of 9/10; 2 bottles (16 oz) Docusate Sodium 50 mg/ml with an expiration of 5/10; 1 bottle of same with expiration of 9/10; 3 bottles Guaiasorb DM (expectorant cough suppressant) (4 oz) with expiration of 10/10; 1</p>	F 431	<p>1. How will corrective action be accomplished for those residents found to have been affected by the deficient practice? All expired medications were removed and discarded on 1/4/11. Nystatin Topical Powder was removed from Resident #48 room and placed in a secure cabinet in the Nurses Station. Resident # 48 and all residents receiving OTC medications were not affected.</p> <p>2. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents receiving Over the counter medications and wandering cognitively impaired Residents have the potential to be affected by this alleged deficient practice.</p> <p>3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? All Licensed Nurses will be re-educated on monitoring medications for expiration dates and storage of Treatment medications by 2/5/11.</p> <p>4. How will the facility monitor its corrective actions to ensure that the deficient practice will not recur? DNS/Designee will audit weekly for 3 months for expired medications. Rounds 3 times per week of Resident areas for proper storage of treatment medications. Results to Quarterly QA meeting.</p> <p>5. Include dates when a corrective action will be completed. DNS/Designee will be responsible for monitoring to assure compliance of POC and regulatory requirements by 2/5/11.</p> <p><i>F431 POC Accepted 2/3/11. BHowe RN / P. Mottar RN</i></p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>475055</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>01/05/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>REDSTONE VILLA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>7 FOREST HILL DRIVE ST ALBANS, VT 05478</b>		
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F 431	<p>Continued From page 8</p> <p>bottle of Calcium 600 mg and Vitamin D 200 IU (60 Tablets) with an expiration of 8/10; 3 bottles Aspirin, 100 tablets of 81 mg enteric coated with expiration of 12/10.</p> <p>The Medication cart (2nd floor): 1 opened bottle Docusate Sodium (100 tablets) 100 mg with an expiration date of 12/10; 1 opened bottle Geri Lanta liquid antacid (12 oz) expired on 10/10; 1 opened bottle Aspirin, 81 mg tabs (100 tablets - 3 tablets remaining in bottle) expired on 8/10; 1 opened bottle of Acetaminophen tablets (1000 tablets; 325 mg each) expiration of 10/10; 1 unopened bottle (100 tablets) Aspirin, 325 mg enteric coated with an expiration of 9/10; 1 unopened bottle of Acetaminophen liquid 160 mg/5 ml (16 oz) with no identifiable expiration date.</p> <p>The Medication cart (1st floor): 1 opened box of Ferric x-150 polysaccharide iron 150 mg (100 capsules) with expiration date of 9/10; 1 opened bottle of MVI (1000 tablets) with expiration of 6/10; 1 opened bottle (100 tablets) MVI with iron expired 9/10; 1 opened bottle (100 tablets) 325 mg enteric coated Aspirin with expiration of 10/10; 1 unopened bottle of Geri Lanta Antacid (12 oz) with expiration of 10/10.</p> <p>The DNS confirmed during interview that there were currently no residents receiving the Aspirin 81 mg tablets that had an expiration date of 8/10, and all other opened medication containers had nearly full contents of pills or liquid.</p> <p>All outdated medications were confirmed by the DNS, during interview at 10:16 am on 1/4/11. The DNS stated that the pharmacy s/he had contacted provided the following information; that there was</p>	F 431			

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F 431	Continued From page 9 no concern of harm and the loss of efficacy was most likely minimal in the medications identified as expired.  In addition, throughout the three days of survey, a bottle of Nystatin Topical Powder was observed stored in full visual view on top of Resident #48's TV stand just inside the resident's room and accessible to anyone walking by. Resident #48 stated, during interview on the afternoon of 1/3/11, that there was a resident in the facility who wandered the halls and entered the resident's room uninvited on several occasions. During interview, on the afternoon of 1/5/11, Nurse #1 confirmed that the Nystatin had been stored inappropriately on the resident's TV stand and that it should have been stored in a secured area.	F 431			