

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

April 8, 2011

Lynnette Smith, Administrator  
The Manor, Inc  
577 Washington Street  
Morrisville, VT 05661

Provider ID #:475057

Dear Ms. Smith:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on February 9, 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



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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  476057	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  02/09/2011
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NAME OF PROVIDER OR SUPPLIER  THE MANOR, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 677 WASHINGTON STREET MORRISVILLE, VT 05661
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F 000	INITIAL COMMENTS	F 000		
F 156 SS=B	<p>An unannounced on-site recertification survey was conducted from 02/07/11 - 02/09/11 by the Division of Licensing and Protection. The following are regulatory findings.</p> <p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5) (i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services.</p>	F 156	<p>On February 22, during Resident Council meeting Resident #19 was made aware of the Vermont Long Term Care Ombudsman Project, and was given a pamphlet with instructions in how to make contact and what services are available. Resident #101 and 104 were not present at this meeting and were counseled 1:1 by the Social Services Director of same.</p> <p>To further clarify the information we currently distribute upon admission regarding Resident Rights, area resources, abuse/neglect, and grievances, a separate and distinct item marked, "Information about the Ombudsman", will be added to the "acknowledgement of receipt" checklist that currently concludes the admission paperwork. In the case of a POA/surrogate/representative signing the paperwork, an additional copy of will be provided to the resident at the time of admission.</p> <p>During the March 2011 resident council meeting, and annually thereafter, a review discussion of the Resident Rights, Ombudsman, definitions of abuse and neglect, annual facility survey results and the necessary contact information, and where this information is posted will be conducted.</p> <p>The residents will be offered a new copy of the Resident Rights. The meeting facilitator will also remind the</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Amelita Smith</i>	TITLE <i>Administrator</i>	(X6) DATE 3.7.11
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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 156	<p>Continued From page 1</p> <p>including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and</p>	F 156	<p>Residents' of where our survey results are located for public viewing. The inclusion of this discussion at the meeting will be posted in advance so that the residents may be notified.</p> <p>Ongoing council meeting minutes will continue to include that residents were asked if they have any questions or concerns about their rights and if anyone wishes to speak to the Ombudsman about an unsettled grievance that they may have. This information will also be documented in the minutes.</p> <p>Copies of Resident Council meeting minutes will be provided to QA to assure compliance.</p> <p>To be completed by 3/9/11.</p> <p><i>F156 POC Accepted 3/31/11 S. Emmons / JRMcotarN</i></p>	
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F 156	<p>Continued From page 2</p> <p>provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff and resident interviews (Residents #19, 101&amp; 104), the facility failed to educate residents on their rights regarding how to access State Survey &amp; Certification survey results, the role of the State Ombudsmen and how to contact them, and the State's 800 number to report concerns regarding abuse, neglect or misappropriation of property. Findings include:  Per interview on 2/7/11 at 2:00 PM with the Resident Council President (#19), s/he stated that s/he was not aware of the following: 1) That residents were able to access the State survey results or where they were posted, 2) Who the Ombudsman is and what their role is, and 3) That there is a State 800 number for residents to</p>	F 156	THIS PAGE LEFT BLANK	

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F 156	Continued From page 3 report concerns about abuse, neglect or misappropriation of resident property. After confirming the above, she stated to the surveyor, 'Please tell me where these things are because as Resident Council President, I should know.'  In addition, per interview with Residents #101 & 104 on 2/8/11 between 10-10:15 AM, the residents confirmed that they were also not aware on how to access the State survey results, who the Ombudsman is and the State's 800 number for reporting resident concerns.  Per interview on 2/9/11 at 2:15 PM with the Social Worker (the person assigned to help facilitate Resident Council) s/he confirmed, after reviewing Resident Council meeting minutes for the past year, that there had been no discussion/education for residents on how they could access the State survey results, what the Ombudsman's role is and how to contact them, and how to access the State's 800 number.	F 156			
F 167 SS=B	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE  A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility.  The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability.  This REQUIREMENT is not met as evidenced by:	F 167	On March 7 Resident #19, 101 and 104 were shown the location of the facility copy of the State Survey & Certification survey results by the Social Services Director. Resident #104 stated that he knew that they were there.		

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F 167	Continued From page 4 Based on staff and resident interviews (Residents # 19, 101, 104), the facility failed to ensure that residents were informed that the most recent survey results are available for review by the residents or where the results are posted. Findings Include:  Per interview with the Resident Council President on 2/7/11 at 2:00 PM, s/he stated that s/he was 'unaware' that the State Survey & Certification results are posted at the facility or where they are located. In addition, per interviews with Residents #104 & 101 on 2/8/11 between 10 - 10:15 AM, both residents confirmed that they were unaware that they could view the State survey findings or where they were posted. Per interview with the Social Worker (the person assigned to help facilitate Resident Council) on 2/9/11 at 2:15 PM, she confirmed, after reviewing the Resident Council minutes for the past year, that there had been no discussion regarding how the residents could access the survey results or where they are posted.	F 167	During the March 2011 resident council meeting, and annually thereafter, a review discussion of where the State Survey & Certification survey results may be accessed will be conducted.  Copies of Resident Council meeting minutes will be provided to QA to assure compliance.  To be completed by 3/9/11.  <i>F167 POC Accepted 3/31/11 S. Emmons / P. McArthur</i>	
F 176 SS=B	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE  An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe.  This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of records, the facility failed to ensure that a resident who self-administered medications was screened appropriately by an interdisciplinary team for 1 applicable resident. (Resident #88) Findings	F 176	For resident #88, medications were removed and the assessment was done 2/8/11. A locked box was obtained and medications were returned to room on 2/9/11.  All residents are at risk. All residents will be screened for self administration of medication on admission. Consulting pharmacist will monitor for screening during monthly reviews.  Copies of the pharmacy monitoring reports will be provided to QA to assure compliance.  This will be completed by 3/9/2011.	

*F176 POC Accepted 3/31/11  
S. Emmons / P. McArthur*

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F 176	Continued From page 5 include:  1. Per observation during the afternoon of 02/07/11 and during the day on 02/08/11, the following medications/supplements were on the bedside table of Resident #88: Nature's tears, Fibermucl, Resverstrol 100 mg (milligrams), and Memory & Brain w/ Acetyl L-Carnitine [contains Vitamin A, D, ginkgo, turmeric, and bacopa]. A physician's order and nursing note dated 09/20/10 states "may have Nature's tears at bedside, - noted meds in Med room on spruce unit - no locked area in room for supplements". Per record review on 02/08/11 at 4:30 PM, there was no nursing assessment to determine safe self-administration nor was there a written care plan that addressed the storage of the medication/supplement. Per interview 2/8/11 at 4:15 PM, the DNS (Director of Nursing Services) confirmed there was no assessment or care plan for self administration of medications, nor should the meds be left on the bedside stand.	F 176	Cove base installation has been completed in rooms for Residents #25, 27, 69, 88, 42, 53.  To upgrade the quality of Residents living interior 22,000 square feet of a high grade vinyl wood plank flooring product and 8,610 linear feet of cove base that encompassed residents rooms, hallway and common areas was installed by a contractor. The project began in July 2010 and proceeded through September 20, at which time with all the flooring installed the contractor left to go fulfill other contracts but with the intent to return to the project in three (3) weeks. At the end of three weeks The Manor made several attempts to initiate the completion of work by the contractor who maintained that the return would be scheduled. By November 2010 it was obvious they would not return and the decision was made that the project would be completed by the facility Maintenance staff. This project began and was scheduled amongst other routine maintenance throughout the building. At the time of the survey 7,826 of the 8,610 linear feet had been installed. Although, a handful of resident rooms had not yet been completed, they were not being ignored.  To be completed by 3/9/11.	
F 253 SS=B	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES  The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.  This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain a comfortable interior for 5 of 33 resident rooms. (Residents #25, 27, 69, 88, 42, 53) Findings include:  1. During interview on 02/07/11 at 12 noon, Resident #25 stated that the base board, which	F 253		

F253 POC Accepted 2/3/11  
S. Emmons RN / AMcIntyre

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F 253	Continued From page 6 was missing, "has been this way since August" and would be happy if it was repaired. During further observations on 02/07/11, in the afternoon, the base cove [base board covering] was missing, exposing torn dry wall material in the rooms of residents #25, 27, 69, 88, 42, and 53. Per interview on 02/09/11 at 9:45 AM, the Director of Maintenance confirmed the above observations.	F 253		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS  A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.  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.  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).  This REQUIREMENT is not met as evidenced by Based on record review and staff interviews, the facility failed to assure that a care plan was developed for use of an indwelling catheter for 2	F 279	F279 For residents #110 and #98, care plans to reflect use of foley catheters were completed on 2/11/11.  All residents are at risk. All residents will be screened on admission for foley catheter use and care plan developed at that time. Infection control nurse will audit for care planning when doing monthly surveillance.  Completed audits will be provided to QA to assure compliance.  To be completed by 3/9/2011.  F279 POC Accepted 3/31/11 SEMMONS RN / ANCOUARN	

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F 279	Continued From page 7 applicable residents in the Stage 2 sample (Residents #110 and #98). Findings include:  1. Per record review on 2/9/11, Resident #110 was hospitalized on 2/3/11, and returned to the facility on 2/4/11 with a Foley catheter in place. The resident's prior admission in January 2011, did not include Foley catheter use. Per further record review, the Plan of Care did not address the use and care of the catheter for this resident. Per interview on 2/9/11, at 11:50 AM, the Director of Nurses confirmed that a care plan had not been developed to reflect the indwelling catheter for this resident.  2. Per record review, Resident #98 was re-admitted to the facility on 12/24/2010 after a hospitalization, with an indwelling Foley catheter. Per review of the care plan on 2/9/11, the care plan stated a Foley catheter was in place, but contained no parameters for the provision of catheter care or Foley catheter maintenance. Per interview with the Unit Manager on 2/8/11 at 11:40 AM and the Director of Nurses at 11:45 AM, each confirmed during interview that a care plan was not developed to reflect measurable objectives or specific interventions related to the use of the indwelling Foley catheter.	F 279		
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.  This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to follow professional standards of	F 281	F281 For residents #110 and #98, MD orders for catheter use were in place by 2/15/11.  All residents are at risk. All residents will be screened for foley catheter use on admission and orders will be obtained at that time. Infection control nurse will audit for orders during monthly surveillance.  Completed audits will be provided to QA to assure compliance.  To be completed by 3/9/11.	

F281 POC Accepted 3/3/11  
SEMMONS RN / INCOTARN

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F 281	<p>Continued From page 8</p> <p>practice by not obtaining a complete physician's order for an indwelling Foley catheter for 2 residents (#98, #110). Findings include:</p> <p>1. Per record review on 2/9/11, Resident #98 was re-admitted to the facility on 12/24/10 from an acute care hospital with a Foley catheter. There were no physician orders for the catheter in the discharge information. On 12/26/10, a nurses note states that the Foley catheter was leaking and was replaced with a 16 F (French) Foley catheter. On 12/27/10, a physician's order was obtained from the resident's primary care physician which stated 'Foley catheter for incontinence....change Foley catheter every 1 month and as needed'. The order contained no information regarding type of Foley catheter, diameter size of catheter or size of balloon. Per interview on 2/9/11 at 11:45 AM the Director of Nurses confirmed that there was no physician's order in place from 12/24/10 until 12/27/10, when an incomplete telephone order was obtained. Refer also to F279.</p> <p>2. Per record review on 2/9/11, Resident #110 returned to the facility on 2/4/11, after a brief hospitalization with an indwelling Foley catheter in place. Per review of the hospital discharge records and other physician orders, there was no documentation at the time of readmission for the catheter use. On 2/7/11, the Director of Nursing obtained a telephone order to "continue Foley catheter". The resident had the Foley catheter in place for 4 days without a physician's order, and then on 2/7/11 when an order was obtained, it was incomplete for the size of catheter, size of balloon, and orders regarding frequency of replacing the catheter. Per interview on 2/9/11 at 11:55 AM, the Director of Nursing confirmed that</p>	F 281	THIS PAGE LEFT BLANK	

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F 281	Continued From page 9 the resident had no physician order for the use of the catheter for 4 days, and then had an incomplete telephone order on 2/7/11. Refer also to F279.	F 281		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION  Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.  This REQUIREMENT is not met as evidenced by: Per record review and staff interviews, the facility failed to ensure provision of range of motion, splint application, and/or document refusal of care for 2 of 4 residents in the targeted sample (Resident #1 & #67). Findings include:  1. Per record review and staff interviews, there is no documentation to ensure provision of passive range of motion and splint application for Resident #1. Staff interviews were conducted with 2 LNA's on 2/9/11 at 9:20 AM and 9:30 AM, respectively, and they stated they did not document passive range of motion and the application of splints. They also stated that Resident #1 frequently became combative when passive range of motion was attempted and they were unable to provide it. The findings were	F 318	F318 For residents #1 and #67 ROM and splint use will be put into LNA documentation in ECS system by 3/7/11.  All residents are at risk. All residents put on or removed from ROM or splint/ brace programs will be identified by nursing and therapy, and ECS LNA charting will be implemented by 3/7/11.  Audits will be performed by DNS or designee monthly x3 and reported at QA meeting in July.  To be completed by 3/9/11.  F318 POC Accepted 3/31/11 S.Emmons RN / A. Meot RN	

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  475057	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  02/09/2011
NAME OF PROVIDER OR SUPPLIER  THE MANOR, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 577 WASHINGTON STREET MORRISVILLE, VT 05661	
(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)
F 318	Continued From page 10 confirmed in an interview with the Unit Manager and the Director of Nursing on 2/9/11 at 10:30 AM.  2. Per record review on 02/08/11 at 4:30 PM, Resident #87's care plan directed staff to provide ROM (range of motion) to maintain strength for the neck. Per interview with LNA staff on 02/08/11 at 5:00 PM, ROM documentation is noted on the LNA's care sheet. Per further record review of the electronic record there was no documentation to indicate that staff were providing ROM. Per interview on 02/09/11 at 1:03 PM, the Director of Nursing confirmed that the LNA's are not documenting the ROM, which is a system issue and acknowledged that there is no evidence to show how and when the LNA's are providing ROM.	F 318	
F 329 SS=D	483.25(I) 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	F 329	F329 For resident #73, upon interview survey team member was informed by Unit Manager that physician office had been called about pharmacy recommendation twice and faxed once with no response from physician noted.  Unit Manager faxed recommendations to physician again on 2/9/11 with answer obtained on 2/11/11.  All residents are at risk. Medical Director was notified 2/9/11 of issue, and will provide education to physicians about it. Nurse Management will continue to review pharmacy reports monthly and follow up with physicians about any recommendations.

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NAME OF PROVIDER OR SUPPLIER  THE MANOR, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 677 WASHINGTON STREET MORRISVILLE, VT 05664		
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F 329	Continued From page 11 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 record review and staff interviews, the facility failed to assure that 1 applicable resident (Resident #73) was free from unnecessary medications. Findings include:  1: Per record review, the facility failed to assure that pharmacy recommendations for Resident #73 regarding a dose reduction of a psychoactive medication were followed up on by the physician. Per review of physician notes and orders, Resident #73 had an increase in the daily dose of lorazepam (an anti-anxiety medication) in July 2010. In August 2010, the pharmacist review recommended "a reduction of the Lorazepam dose raised in July". On 10/15/10, the pharmacist review recommended "revisit Lorazepam". The pharmacist review note of 1/21/11 stated "repeat the three comments not responded to." Following the pharmacist review on 2/7/11 there is a notation stating "no response 2-7". There is no evidence found in the record that the facility has requested that the physician follow-up to the above pharmacy recommendations.  In an interview on 2/9/11 at 10:20 AM, the Unit Manager confirmed that the physician has not responded to the pharmacy recommendations and there is no documentation of the physician	F 329	Pharmacy report reviews will be provided to QA to assure compliance.  To be completed by 3/9/11.  F329 POC Accepted 3/31/11 S. Emmons RN / J. McArthur		

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NAME OF PROVIDER OR SUPPLIER  THE MANOR, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 577 WASHINGTON STREET MORRISVILLE, VT 05661		
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F 329  F 431 SS=E	<p>Continued From page 12</p> <p>revisiting the lorazepam dose since the increase in July 2010. S/he also confirmed that there is no evidence of the facility requesting physician follow up to the pharmacy recommendations.</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS &amp; BIOLOGICALS</p> <p>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.</p> <p>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.</p> <p>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.</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>	F 329  F 431	<p>F431 The Spruce Unit PPD bottle was found to be dated on the vial instead of the box upon inspection by the Unit Manager. (Medication Nurse working on day of survey was an LPN) All vials of expired medication were discarded on day of survey.</p> <p>All residents are at risk. DNS or designee will perform monthly audits.</p> <p>Monthly audits will be provided to QA to assure compliance.</p> <p>To be completed by 3/9/11.</p> <p><i>F431 PDC Accepted 3/31/11</i> <i>S. Emmons RN / J. McFarlan</i></p>	

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F 431	<p>Continued From page 13</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to assure that expired and/or undated medications were not available for resident use. Findings include:</p> <p>1. Per observation on 2/9/11, the Spruce Unit medication refrigerator contained a vial of opened and undated PPD tuberculin innoculant. This medication should be discarded 30 days after opening according to manufacturer's recommendation. The refrigerator also contained a vial of tetanus toxoid, labeled with an expiration date of May 12, 2010, and a vial of Pneumovax vaccine labeled with an expiration date of January 22, 2011. The above findings were confirmed by the Medication RN (Registered Nurse) at 1:15 PM on 2/9/11.</p> <p>2. Per observation on 2/9/11, the Elmore Unit medication refrigerator contained 1 vial of PPD tuberculin innoculant which was opened and undated. This refrigerator also contained three vials of Pneumovax vaccine, all of which expired on 11/26/10. Additionally, several cuturettes expired in 2009 and 2010 were found on the medication storage room shelf with laboratory supplies. The above findings were confirmed with the Unit Manager on 2/9/11 at 1:30 PM.</p>	F 431	<p style="text-align: center;">THIS PAGE LEFT BLANK</p>	
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