



AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING
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

November 16, 2009

Suzanne Anair, Administrator
Springfield Health & Rehab
105 Chester Rd
Springfield, VT 05156

Provider #: 475025

Dear Ms. Anair:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **October 14, 2009**. Please post this document in a prominent place in your facility.

We will follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Suzanne Leavitt, RN, MS
Licensing Chief

Enclosure



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

PRINTED: 10/27/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475025	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/14/2009
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NAME OF PROVIDER OR SUPPLIER SPRINGFIELD HEALTH & REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 105 CHESTER RD SPRINGFIELD, VT 05156
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F 241 Continued From page 1
the next table were watching Resident #167 being fed. When asked by the surveyor why the 2 residents were not served, the staff stated "I have to feed those two". Per interview the evening nurse confirmed that residents are to be assisted timely and staff should sit while feeding a resident.

F 248 483.15(f)(1) ACTIVITIES
SS=D
The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.

This REQUIREMENT is not met as evidenced by:
Based on observation and record review, and confirmed by staff interview, the facility failed to provide activities as noted per assessment for 1 applicable resident (Resident #4). Findings include:

Per observation during the first two days of survey, Resident #4 was not engaged in activities and remained in the room. Per record review on 10/13/09, had a initial activity assessment on 9/18/09, which indicated that the resident would enjoy, among other interests, bingo, games, books, puzzles, music, and 1:1 visiting, and was care planned to receive activities at least once per week. Per the Activity sheet (dated 9/14/09 - 10/13/09) the resident was recorded as being engaged with a 1:1 visit on 9/18/09 and bingo on 9/26/09 with no documented activity for the month of October. Per interview on 10/14/09 at 12:45 P.M. the Activity Director confirmed that the initial assessment was noted as the 1:1 visit and the

F 241 Results of these audits will be reviewed at the centers Quarterly Quality Committee meeting.

Corrective Action date is 11/13/09 →
*POC Accepted 11/16/09
Pamela Moturn*

F 248 All residents have the potential to be effected by this deficient practice.

Resident #4 was end of life comfort care and has since expired.

An audit of all residents' Participation records have been reviewed. Any residents that have not been participating have received an updated assessment. This has been done to increase resident involvement and participation.

All new residents will be assessed upon admission. In addition, any Residents that haven't participated in activities for 5 days will be reviewed and updated accordingly. The staff, in activities, have been educated regarding the above.

Participation records will be reviewed weekly for 60 days, then monthly for 6 months.

The director of activities is responsible for compliance.

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F 248 Continued From page 2
resident was at bingo only once since admission.

F 279 483.20(d), 483.20(k)(1) COMPREHENSIVE
SS=D 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 staff interview and record review, the facility failed to ensure that there was a comprehensive care plan for 1 resident in the sample (Resident #103). Findings include:

Per review of the clinical record for Resident #103 on 10/14/09 at 3:00 PM, the facility failed to develop a comprehensive care plan to address the residents urinary incontinence needs. The initial Minimum Data Set (MDS) dated 8/20/09 triggered the Resident Assessment Protocol

F 248 Results of these audits will be reviewed at the centers Quarterly Quality Committee meeting.

F 279 The facility will achieve compliance by November 13, 2009

*POC Accepted 11/16/09
Diana Motaruk*

Resident # 103 has since been discharged to home. While a resident here she experienced 5 episodes of incontinence over a 5 day period. She returned to her normal state of continence when her health improved.

All residents have the potential to be effected by this deficient practice.

All LNA flow sheets and Care plans have been assessed. All residents that have triggered for incontinence on the MDS during the past 90 days will have a comprehensive review.

All new admits will be assessed upon admission.

Random audits will be done weekly for 60 days & monthly for 6 months.

Results of the audits will be reviewed at the Quarterly Quality Improvement Committee Meeting.

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F 279 Continued From page 3
(RAP) for urinary incontinence and the facility indicated it would proceed with care planning. During interview with the Unit Manager (UM) and Director of Nurses (DNS) at 3:18 PM on 10/14/09, they both confirmed that there was no comprehensive care plan for urinary incontinence that included measurable objectives and timetables.

F 280 483.20(d)(3), 483.10(k)(2) COMPREHENSIVE SS=D CARE PLANS

The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.

A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.

This REQUIREMENT is not met as evidenced by:
Based on resident and staff interview the facility failed to assure that the opportunity to participate in the care planning process, in accordance with the resident's rights, was provided to 1 of 14

F 279 Corrective Action date is 11/13/09. 11/13/09
*POC Accepted 11/16/09
Janet Mestarn*

F 280 All residents have the potential to be effected by this deficient practice.

On 11/02/09 a care plan meeting was held for resident #74.

The social worker has been educated on the requirement to invite not only responsible party, but the resident if appropriate to attend.

In the future all residents that can participate in their care plan meeting will be invited in advance. In addition, it will be documented if they should refuse.

Documentation of resident will be monitored weekly for 60 days and quarterly for 6 months.

Results of the audits will be reviewed at the Quarterly Quality Improvement Committee Meeting.

Corrective Action date is 11/13/09

*POC Accepted 11/16/09
Janet Mestarn*

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F 280	<p>Continued From page 4</p> <p>applicable residents (Resident #74). Findings include:</p> <p>Per interview, on the afternoon of 10/12/09, Resident #74 stated that s/he had not been invited to participate in his/her care planning process. Per record review the MDS (Minimum Data Set) assessments for 3/19/09, 3/31/09, 4/8/09, and 5/7/09 revealed that the resident was coded as "responsible for self" and the most current MDS assessments, dated 6/15/09 and 9/9/09 showed that the resident was "responsible for self" as well as "family member responsible". In addition the most current MDS assessments identified the resident as having no memory problems and independent in cognitive skills for daily decision making. Despite the documented evidence of the resident's cognitive ability to participate in the care planning process, there was no evidence that the resident had ever been invited to do so.</p> <p>During interview, at 9:22 AM on 10/14/09, the Director of Social Services confirmed that the resident is self responsible, has no memory problems, is independent in cognitive skills for daily decision making and, with the exception of one time only, has not been invited to participate in the the care planning process since his/her admission on 3/19/09. S/he agreed that the resident should be invited to all care plan meetings.</p>	F 280	<p>F281</p> <p>All residents have the potential to be effected by this deficient practice.</p> <p>The order for resident #91 has been clarified and is receiving med as ordered.</p> <p>All resident MAR's have been reviewed for accuracy.</p> <p>The MD order system has been reviewed and revised.</p> <p>All licensed staff have been educated for appropriate and accurate orders.</p> <p>Random audits will be done weekly for 60 days & monthly for 6 months.</p> <p>Resident #117 was evaluated by therapy and is currently being followed.</p> <p>All therapy screens will be put in a mailbox on the units and the department head or designee will check daily.</p>	
F 281 SS=D	<p>483.20(k)(3)(i) COMPREHENSIVE CARE PLANS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced</p>	F 281	<p>Random audits will be done weekly for 60 days & monthly for 6 months.</p>	

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F 281 Continued From page 5
by:
Based on staff interview and record review the facility failed to assure that care and services were provided in accordance with physician orders and professional standards of nursing practice for 2 applicable residents in the total sample. (Residents #117 and #91). Findings include:

1. Per observation and interview staff failed to follow acceptable professional standard by not obtaining a clear physician's order for an Albuterol Nebulizer for Resident #91. During the medication administration on 10/12/09 at 4:30 PM the staff nurse was observed taking a nebulizer vial from another resident's box. When asked why, the nurse stated that Resident's #91 medication had not been received from the pharmacy and when asked if that was the [correct] dose the nurse replied "oh I guess I'd better check that, I didn't realize there might be different doses". Per record review of the physician's order, no dose was written. Per interview at 5:00 PM the evening charge nurse called the physician to clarify the dose and confirmed that the order did not have a dosage identified.
2. Per interview and record review staff failed to assure that a recommendation for a physical therapy screening for Resident #117 was completed in a timely manner. During interview, on the morning of 10/13/09, Resident #117 stated that s/he wished s/he could self propel in a wheelchair (w/c), stating that it was not possible to do so in the cardiac chair that was currently utilized by her/him when out of bed. Per record review a Request for Rehabilitation Screen, dated 8/3/09, which identified the resident's problems as "positioning problems" stated, under comments;

F 281
Results of these audits will be reviewed at the Quarterly Quality Improvement Committee Meeting.
Corrective action date 11/13/09 →
*POC Accepted 11/16/09
Pamela Moore RN*

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F 281 Continued From page 6
"please read (psychological services progress note) consult, requesting w/c." The psychological services progress note, dated 8/2/09, stated; "it bothers (resident) thatcan't have a wheelchaircan roll around in".

During interview, on the morning of 10/14/09, the Nurse Unit Manager confirmed that the rehabilitation screening had not been completed as of the current date. This was also confirmed by the Director of Rehabilitation Services who stated, during interview at 3:03 PM on 10/14/09, that s/he had never received a referral to complete a rehab screen for the resident.

F 311 483.25(a)(2) ACTIVITIES OF DAILY LIVING
SS=D

A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section.

This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the facility failed to ensure appropriate services were provided to maintain or improve abilities for 1 applicable resident (Resident #168). Findings include:

Per observations made during the evening meal on 10/12/09, Resident #168 was served supper at 5:15 PM. The Resident did not initiate self feeding, nor did staff offer cueing or assistance with self feeding for a 20 minute period. At 5:35 PM a Licensed Nurse Aide (LNA) approached, and while standing over the resident, initiated feeding and did not offer cueing and/or assist for self feeding. Per record review, the Resident's care plan stated to assist as needed with eating.

F 281

F 311

All residents have the potential to be effected by this deficient practice.

Resident #168's care plan has been reviewed and LNA flow sheets updated as necessary.

The facility will re-educate all licensed staff to include LNA's. The in-service is titled Dignity & Dinning. This in-service will include dignity, assistance with eating and food quality.

All care plans have been reviewed for dining to ensure that needs are appropriately documented. This information will be communicated to the LNA through the LNA care plan.

All new admissions will be assessed at the time of admission.

Random audits of LNA flow sheets & dinning observations will be conducted. This will occur weekly for 60 days and quarterly for 6 months.

Results of the audits will be reviewed at the Quarterly Quality Improvement Committee Meeting.

Corrective action date is 11/13/09

*POC Accepted 11/14/09
Pamela McArthur*

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F 325 SS=E	<p>483.25(i) NUTRITION</p> <p>Based on a resident's comprehensive assessment, the facility must ensure that a resident -</p> <p>(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and</p> <p>(2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to ensure that residents maintain acceptable parameters of nutritional status for 2 applicable residents (Resident #4, #144). Findings include:</p> <p>1. Per record review and interview, Resident # 4 had weight loss over a one month period in which neither staff nor the dietician, assessed the weight loss, monitored changes or implement interventions such as supplements. In addition, the weight loss was not identified until brought to the attention of the facility by the surveyor. Neither the nursing admission assessment note nor the weight book listed a weight for the 9/12/09 admission, however, the dietitian listed Resident #4's weight as 120 lbs (pounds) 'per the hospital record'. Per the weight book, the weights were as follows: on 9/25/09 the recorded weight was 113.8 lbs, and on 9/28/09 the weight was 111 lbs. The resident was discharged to the hospital on 10/1/09 and re-admitted on 10/4/09, however the weight was taken 4 days later on 10/8/09 at 103.6</p>	F 325	<p>F 325</p> <p>The facility conducted a comprehensive review of resident #4 and #144's record. Resident # 144 was also reviewed by the Registered Dietitian. The MD was notified and supplements were started. The resident's current weight is 106. The MD visited resident #4 on 10/15/09. The resident was end of life comfort care and has since expired.</p> <p>All residents have the potential to be effected by this alleged deficient practice.</p> <p>The systems in place have been reviewed and revised. All residents with significant weight loss will be reviewed weekly by the At Risk Team.</p> <p>The system will be reviewed weekly for 60 days and quarterly for 6 months.</p> <p>Results of these audits will be reviewed at the centers Quarterly Quality Committee meeting.</p> <p>Corrective Action date is 11/13/09 →</p>	

*POC Accepted 11/16/09.
Samuel Mota RN*

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F 325 Continued From page 8
lbs, on 10/9/09 - 103 lbs, 10/10/09 - 101.4 lbs and on 10/13/09 - 99.8. There were no nursing notes to address the weight changes in the chart. Per interview on 10/14/09 at 9:20 AM the unit manager confirmed that the expectation is that weights are done immediately upon admission, weekly for a month for a new admit and weight loss is brought to the attention of the dietician, all of which did not occur.

2. Based on record review and interview, staff failed to identify, assess, or develop approaches or interventions for Resident #144 who had a 13 lbs weight loss in a seven week period. Per a physician order, weights were ordered weekly. Per the weight book the admission weight on 8/4/09 was 119 lbs. On 8/7/09 the weight was recorded as 111.8 lbs, on 8/17/09 -108 lbs, weight on 8/29/09 was 110 lbs , 9/8/09 was 108 lbs, 9/10/09 -107.8 lbs and on 9/28/09 - 106.2 lbs, in which the unit manager, at 3:00 PM at 10/13/09, confirmed that several of the weights were not done every week.
Per interview on 10/13/09 @ 4:44 PM, the Registered Dietician (RD) confirmed that the loss of weight was 'missed during rounds' and no evaluation as to the weight loss 'had been picked-up' by the RD or staff. In addition, the dietician stated that had s/he known of the weight loss, s/he would have assessed and recommend snack and or nutritional supplements for the weight loss.

F 329 483.25(I) UNNECESSARY DRUGS
SS=D
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

F 325

F329

F 329

A comprehensive review of Resident # 117's medications was done. The order has been Clarified and the resident has an Indication for the Ativan.

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F 329 Continued From page 9

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 that the medication regimen was free from unnecessary drugs for 2 applicable residents in the total sample (Resident #117, #46). Findings include:

1. Per record review staff failed to clarify an indication for the PRN (as needed) use of an anti-anxiety medication for Resident #117. Per observation, on the morning of 10/13/09, the resident received Ativan PO (by mouth) and stated that staff gave him/her the drug to help decrease the anxiety s/he felt when in the shower. A physician order, dated 7/21/09, stated to administer Lorazepam (anti-anxiety med) 0.5 mg PO every 6 hours PRN (as needed), but lacked

F 329

The resident had no untoward effects from this alleged deficient practice.

All residents on a drug regimen have the potential to be effected by this alleged deficient practice.

The unit manager or designee will review documentation of residents with anti-psychotic medications and verify the presence of an Indication.

Admission medications will be reviewed by 2 licensed nurses.

Pharmacy consults will be monitored by the DNS or designee to ensure consults are followed through.

This will be monitored weekly for 60 days and quarterly for 6 months.

Results of the audits will be reviewed at the Quarterly Quality Improvement Committee Meeting.

Corrective Action date is 11/13/09

POC Accepted 11/16/09.
Pamela Mota RN

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F 329	Continued From page 10 any indication for it's use. Although there was a behavior monitor record that identified the targeted behavior of "yelling out" as a reason to administer the medication, it did not include any other indications for the use of Ativan. During interview, on the morning of 10/14/09, both the medication nurse and the Nurse Unit Manager each confirmed the lack of an indication for the PRN use of Ativan. 2. Per interview and record review, the facility failed to assure that Resident #46 is free from unnecessary medications. Staff failed to assure that pharmacy recommendations were acted upon or addressed by the physician for this resident, who is on multiple psychoactive medications. Resident #46 receives a twice daily scheduled anti-anxiety medication, and during a Medication Regimen Review on 5/15/09, a recommendation was made by the pharmacist to the physician which stated: "Consider taper Ativan dose at this time to help demonstrate lowest effective dose. Clinical progress note required if both psychotherapeutics continue." Per review of the physician progress notes, there were no clinical progress notes from 5/09 to present that specifically addressed the use of Ativan, and no dose reduction has been attempted in that time frame. During an interview on 10/14/09 at 2:35 PM, the Unit Manager confirmed that there is no evidence in the medical record that the physician addressed the pharmacy recommendation.	F 329	
F 371 SS=F	483.35(i) SANITARY CONDITIONS The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and	F 371	F 371 All residents have the potential to be effected by this deficient practice.

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F 371	<p>Continued From page 11</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations and interview, the facility failed to store, prepare, distribute, and serve food under sanitary conditions. Findings include:</p> <p>During the initial kitchen tour which occurred on 10/12/09 at 10:15 am, the following observations were made:</p> <ol style="list-style-type: none"> 1. Black fuzzy mold was noted on a large plastic bottle of Worcestershire sauce in the walk-in refrigerator. 2. Plate covers that were washed that morning and ready for use, had food particles on them. 3. Per observation of a machine wash of 4 trays filled with dishes, the dishwasher temperatures did not reach 150 degrees for the wash cycle. When interviewed the Food Service Supervisor (FSS) stated that the gauge under the sink was the correct temperature and was the one being used rather than the one on the dishwasher machine. When further investigated, the gauge under the sink was in fact broken, and the temperature was not 150 degrees. Per interview that same morning, the Maintenance Director confirmed that the gauge under the sink was inaccurate and the water temperature for the wash cycle did not reach 150 degrees. 	F 371	<p>On 10/12/09 at the time of the Rounds, the container of Worcestershire sauce was discarded and all of the dishes were re-washed due to the dish machine temperature of 148 degrees versus the standard of 150 degrees.</p> <p>All dietary staff has been in-serviced on safe dishwashing temperatures and the process to report equipment failure.</p> <p>Daily sanitation rounds will be done by the dietary manager or designee. Rounds will include dishwashing machine temperatures.</p> <p>The Director of dietary or designee will monitor for compliance.</p> <p>The Director of Dietary will report to the CQI committee 2 times and then at the discretion of the committee.</p> <p><i>POC Accepted 11/16/09. Pamela Motar</i></p>	11/13/09
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW The drug regimen of each resident must be	F 428		

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F 428 Continued From page 12
reviewed at least once a month by a licensed pharmacist.

The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.

This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to assure the pharmacist identifies and reports irregularities in residents' drug regimens, and that pharmacy recommendations are acted upon for 2 applicable residents (Residents #46, #117). Findings include:

1. Per interview and record review, the facility failed to assure that pharmacy recommendations were acted upon or addressed by the physician for Resident #46, who is on multiple psychoactive medications. Resident #46 receives a twice daily scheduled anti-anxiety medication, and during a Medication Regimen Review on 5/15/09, a recommendation was made by the pharmacist to the physician which stated: "Consider taper Ativan dose at this time to help demonstrate lowest effective dose. Clinical progress note required if both psychotherapeutics continue." Per review of the physician progress notes, there were no clinical progress notes from 5/09 to present that specifically addressed the use of Ativan, and no dose reduction has been attempted in that time frame. During an interview on 10/14/09 at 2:35 PM, the Unit Manager confirmed that there is no evidence in the medical record that the physician

F 428 **F428**

All residents on a drug regimen have the potential to be effected by this alleged deficient practice.

The resident did not, nor does the resident have any untoward effects from her current medications.

The MD has reviewed resident# 46's pharmacy recommendation and has noted that this resident's medications and dosage will remain the same.

A comprehensive review of Resident # 117's medications was done. The order has been Clarified and the resident has an Indication for the Ativan.

The unit manager or designee will review documentation of the residents with anti-psychotic medications and verify the presence of an indication.

The resident had no untoward effects from this alleged deficient practice.

Admission medications will be reviewed by 2 licensed nurses.

Pharmacy consults will be monitored by DNS or designee to ensure consults are followed through.

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F 428	Continued From page 13 addressed the pharmacy recommendation. 2. Per record review the consulting pharmacist failed to identify an irregularity in the medication regimen for Resident #117 who was receiving a PRN (as needed) dose of an anti-anxiety medication without any indication for it's use. A physician order, dated 7/21/09, stated to administer Lorazepam (anti-anxiety med) 0.5 mg PO (by mouth) every 6 hours PRN, but lacked any indication for it's use. Per review of the monthly pharmacy reviews there was no evidence that the pharmacist had identified or addressed this irregularity. During interview, on the morning of 10/14/09, the Nurse Unit Manager confirmed the lack of an indication for the PRN use of Ativan and the lack of evidence that the pharmacist had addressed the irregularity.	F 428	This will be monitored weekly for 60 days and quarterly for 6 months. Results of the audits will be reviewed at the Quarterly Quality Improvement Committee Meeting. Corrective Action date is 11/13/09 → <i>POC Accepted 11/16/09. Janella Metaran</i>
F 441 SS=E	483.65(a) INFECTION CONTROL The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to assure that staff consistently	F 441	F441 No residents were harmed by this alleged deficient practice. All residents have the potential to be effected by this deficient practice. All bulk containers of Thicket have been removed, and replaced with single packets. All nursing and dietary staff have been in-serviced. This will be monitored weekly for 60 days and quarterly for 6 months. These audits will be in conjunction with dinning observations.

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F 441	Continued From page 14 utilized appropriate infection control practices during medication administration. Findings include: Per observation, on the afternoon of 10/12/09 and the morning of 10/14/09, respectively, the plastic med cups utilized to measure amounts of 'thick' powder, used to thicken liquids for residents requiring it, were stored inside the two separate containers of powder on two separate med carts. During interview, at the time of each of the individual observations, each of the respective nurses agreed that the med cups should not be stored inside the containers for recurrent use. Per interview, on the morning of 10/14/09, the Infection Control nurse confirmed that cups used to measure the thick powder should not be left in the containers and re-used because of the potential for contamination.	F 441	Results of the audits will be reviewed at the Quarterly Quality Improvement Committee Meeting. Corrective Action date is 11/13/09 <i>POC Accepted 11/16/09 Janella Motarn</i>	