



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

February 5, 2010

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

Provider #: 475057

Dear Ms. Smith:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **December 17, 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,

A handwritten signature in cursive script that reads "Suzanne E. Leavitt RN, MS".

Suzanne Leavitt, RN, MS
Licensing Chief

Enclosure



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

PRINTED: 12/30/2009
FORM APPROVED
OMB NO. 0938-0391

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 12/17/2009
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)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		JAN 1 1 2010
F 279 SS=D	<p>A recertification survey was completed on 12/17/09, as authorized by the Federal Centers for Medicare and Medicaid Services. The following regulatory violations were found.</p> <p>483.20(d), 483.20(k)(1) 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 care plans to meet the assessed needs for 2 of 24 residents in the applicable sample. (Residents #56 & 91) Findings include:</p> <p>1. Per record review on 12/17/09 for Resident #</p>	F 279	<p>All residents have the potential to be affected by this deficient practice.</p> <p>Care plan has been amended to reflect accurate staging of pressure area on coccyx for resident # 56 and pain management addressed in resident # 91 care plan to reflect current pain management regimen.</p> <p>Wound Nurse to update care plan weekly to reflect status of wound, i.e., improving/worsening and new treatments/interventions ordered and implemented. Wound nurse will communicate with MD if need for new treatment is needed.</p> <p>All licensed staff to assess residents for pain level every shift, or more often as needed. Licensed staff will notify resident's physician if current pain management plan is ineffective. Licensed staff to follow through with physician ensuring an appropriate pain management regimen is achieved.</p> <p>All licensed staff will re-assess effectiveness of pain management and pressure area interventions every shift, or more often as needed. It is the responsibility of all licensed staff to initiate and update care plans, to notify physician and the resident's family of order/status changes.</p> <p>Staff meetings conducted instructed nursing staff to communicate with each other regarding when areas of skin break down first observed and or if a resident is complaining of pain.</p> <p>Weekly Pressure Area Form Log Book has been developed and is being used by Wound Nurse. All Licensed staff, ADONS and DON receives copy of weekly wound care rounds.</p>	

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

John Smith

TITLE

Administrator

(X6) DATE

1.8.10

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 279	Continued From page 1 56, a care plan for a pressure ulcer (a Stage 2 ulcer was documented in the nursing notes on 10/27/09) was not developed until 11/24/09 when the pressure ulcer was then classified as a Stage 4. 2. Per record review on 12/16/09, a care plan to address pain management was not developed for Resident #91 who was identified in the resident admission assessment as having pain issues and who was receiving narcotic analgesics. Per interview on 12/17/09 at 12 noon, the DNS (Director of Nurses) confirmed that neither care plan addressed the residents' identified needs.	F 279	<i>F279 POE accepted 2/3/10</i> Continuous quality improvement measures in improving the accuracy of the care planning process is as follows: <ul style="list-style-type: none">o Bi-weekly staff meetingso Electronic Charting training weeklyo Weekly Care plan audits by ADONS and Staff Educator (all care plans to be reviewed for accuracy, i.e., reflects the resident's current status.)o Monthly QA meetings to assess efficacy of care plan documentation. Completed audits will be submitted to Quality Assessment and Assurance for quarterly review.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) COMPREHENSIVE 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.	F 280	To be completed by 1/16/10. All residents have the potential to be affected by this deficient practice. Care plan for resident #19 amended to reflect correct staging of pressure area right heel, i.e., Stage IV. Wound Nurse to update care plan weekly to reflect status of wound, i.e., improving/ worsening and new treatments/interventions implemented. Weekly Pressure Area Log Book has been developed and is being used by Wound Nurse. All Licensed staff, ADONS and DON receives copy of weekly wound care rounds.	

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F 280	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to revise the care plan to reflect each resident's current needs/status for 1 of 3 applicable residents in the sample with pressure sores. (Resident #19) Findings include: Per record review on 12/17/2009, Resident # 19's care plan dated 10/15/09 stated that the resident's right heel pressure sore was a stage 2. A nursing skin assessment note dated 12/12/2009 stated that the right heel pressure sore was a stage 4. During an interview on 12/17/09 at 12:15 PM the Assistant Director of Nursing/Unit manager (ADNS) confirmed that the current care plan had not be revised to reflect the current status of the resident's right heel pressure sore.	F 280	Continuous quality improvement measures in improving the accuracy of care planning is as follows: <ul style="list-style-type: none">• Bi-weekly staff meetings• Electronic Charting training weekly• Weekly Care plan audits by ADONS and Staff Educator (all care plans to be reviewed for accuracy, i.e., reflects the resident's current status.) ADONs and DON will make rounds with wound nurse once a month. Completed audits will be submitted to Quality Assessment and Assurance for quarterly review. <i>F280 POC accepted 2/3/10</i> <i>May Koller, RN</i> To be completed by 1/16/10.		
F 281 SS=D	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Per staff interview and record review, the facility failed to assure that nurses transcribed and/or administered all medications in accordance with professional standards of nursing practice for 1 applicable resident in the sample. (Resident #20) Findings include: Per Medication Administration Record (MAR) review on the afternoon of 12/16/09, Resident #20's physician order for an antibiotic medication failed to include the number of days the	F 281	All residents have the potential to be affected by this deficient practice. Order obtained to discontinue Cipro for resident #20. Licensed staff has been in-serviced on transcribing orders on 12/22/09. Ongoing weekly in-services continue with educating licensed staff on transcribing medications, i.e., start and stop dates. Daily audits are being done by ADONS, DON & Staff Educator when residents are started on antibiotics, i.e., checking care		

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F 281	Continued From page 3 medication was to be given (there was no end date). Per interviews on the afternoon of 12/16/09 and during the day on 12/17/09, the Director of Nurses (DNS) confirmed that the physician order was incorrect as transcribed on the MAR and that the resident received an extra dose of the antibiotic on 12/14/09, 3 days after the antibiotic should have been finished. The physician's telephone order dated 12/4/09 stated to administer the medication for a total of 7 seven days. This order was also confirmed during interview with the nurse author on the morning of 12/17/09.	F 281	plan for update(s) and MAR for correct transcription of antibiotic order. There will be audits of MARS and TARS conducted twice weekly by the ADONS, i.e., every resident's MAR and TAR to be checked for accuracy each month. Completed audits will be submitted to Quality Assessment and Assurance for quarterly review. To be completed by 1/16/10. <i>F 281 POC accepted 2/3/10 May Bolton</i>		
F 282 SS=D	483.20(k)(3)(ii) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, staff failed to consistently implement the care plan for 2 of 24 applicable residents in the sample (Resident #89 and #20). Findings include: 1. Per record review on 12/17/09, Resident #89, who has a history of verbal abuse and wandering, has a current plan of care that directs staff to perform safety checks on the resident every 15 minutes on all shifts. Per review of the 15 minute check documentation from 12/1/09 to 12/17/09, the 15 minute safety checks were not consistently signed off by staff and no documentation could be located for 4 out of 17 days. During an interview	F 282	All residents have the potential to be affected by this deficient practice. Facility wide memo sent to staff regarding every 15-minute checks for elopement. All nursing staff instructed to carry out checks as ordered and to sign-off on monitoring forms after completing check. The Primary Nurses for all shifts have been re-instructed to enforce every 15-minute monitoring by the LNAS and to instruct the LNAS to complete the forms that the checks have been completed. The Primary Nurse will check the monitoring form for completion at the end of every shift. The ADON will perform weekly audits ensuring compliance. On-going educational in-services by Nurse Management team with nursing staff regarding the importance of carrying out checks and documenting as completed, i.e., will be discussed in bi-weekly staff/unit meetings.		

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F 282	Continued From page 4 on 12/17/09 at 2:50 PM, the DNS confirmed that the 15 minute checks were not consistently documented by staff and that staff on all shifts are required to document the 15 minute checks when they are completed. 2. Per LNA (licensed nursing assistant) interview on 12/16/09 at 2:57 PM, Resident #20 was not repositioned for almost 3 hours that day, from 12 noon until 2:55 PM, the resident was up in the wheelchair in the dining room. The resident was observed in the dining room at 12:25 PM. When the LNA was asked how frequently the resident required repositioning, she stated "every 2 hours...I should have put her back to bed before my meeting". The resident's care plan for mobility stated that the resident was dependent on 2 staff for repositioning every 2 hours. Refer also to F314	F 282	Staff meetings have been held and nursing staff instructed on the importance of every 2-hour Turning and Repositioning, i.e., prevent kin break down. Continuous quality improvement is as follows: <ul style="list-style-type: none">Daily rounds by management staff to monitor and reinforce every 2 hour turning and repositioning.On-going staff education on the importance of turning and repositioning residents every 2-hours. Completed audits will be submitted to Quality Assessment and Assurance for quarterly review.	
F 314 SS=D	483.25(c) PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to assure that 1 of 3 applicable residents in the sample with pressure sores received care in a manner to promote healing during observations on one of two days of	F 314	To be completed by 1/16/10. All residents have the potential to be affected by this deficient practice. Facility-wide memo sent to nursing staff regarding the importance of turning and repositioning residents every 2-hour. Staff meetings held and nursing staff instructed on the importance of every 2-hour turning and repositioning, i.e., prevent skin break down. Continuous quality improvement is as follows: <ul style="list-style-type: none">Daily rounds by management staff to monitor and reinforce every 2-hour turning and repositioning.	F282 POC accepted 2/3/10 Mey Koth, ed

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F 314	Continued From page 5 the survey. (Resident #20) Findings include: Per observation of the Resident #20 in bed on 12/16/09 at 2 :57 PM, the resident, who has a stage 3 pressure sore, had just been put back to bed after getting up at 12 noon, per interview with the LNA providing care. The resident previously had been observed in the wheelchair in the dining room at approximately 12:25 PM. When the LNA was asked how often the resident is repositioned she stated "every 2 hours" The LNA then stated "I should have put her back to bed after lunch, before "my" meeting." The lack of repositioning, per the care plan, was verified with the DNS and the wound care nurse on 12/16/09 at 6 PM. Refer also to F282	F 314	<ul style="list-style-type: none"> o On-going staff education on the importance of turning and repositioning residents every 2-hours. o Daily educational meetings for all shifts regarding pressure area prevention to be implemented, i.e., Primary Nurses will instruct and reinforce during the shift-shift report the importance of every two hour turning and repositioning, keeping residents clean and dry, applying barrier cream to boney prominences. <p>Completed audits will be submitted to Quality Assessment and Assurance for quarterly review. <i>F314 POC accepted 2/3/10 May Butler RN</i></p> <p>To be completed by 1/16/10.</p>	
F 371 SS=E	483.35(i) SANITARY CONDITIONS The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Per observation on the first day of survey, the facility failed to store clean dishes in a sanity manner. Findings include: During the initial tour of the kitchen during the morning of 12/15/09, accompanied by the Dietary Manager, observation revealed that a fan pointing at racks of clean dishes was covered	F 371	<p>All residents have the potential to be affected by this deficient practice.</p> <p>On 12/15/09, immediately following the tour fans used in dietary were cleaned.</p> <p>To prevent this deficient practice from reoccurring the inspection of all fans in the dietary department will be weekly and cleaned as often as is necessary.</p> <p>Dietary procedures for maintaining standards for sanitary conditions have been updated to include this task and this item has been added to the dietary aide cleaning list.</p> <p>The Dietary Director or his designee will audit weekly to assure compliance is maintained.</p>	

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F 371 F 441 SS=D	Continued From page 6 with large amounts of dust and dirt. 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, staff interview and record review, the facility failed to assure that nursing staff adhered to the facility's infection control policies/procedures regarding care for 1 applicable resident in the sample. (Resident #20) Findings include: Per observations on 12/16/09 (2:57 PM) and 12/17/09 (10 AM), nurses failed to dispose of outdated sterile water used as a humidifier for Resident #20's oxygen administration. The 2 open bottles on the resident's table were dated 11/5/09 and 12/11/09. Per review of the facility's policy/procedure regarding irrigation solutions and confirmed during interviews with the DNS and the infection control nurse on the afternoon of 12/17/09, the sterile water should have been disposed of 24 hours after opening.	F 371 F 441	Completed audits will be submitted to Quality Assessment and Assurance for quarterly review. <i>F371 POC accepted 2/3/10</i> <i>May Bolter, RN</i> To be completed by 1/16/10. All residents have the potential to be affected by this deficient practice. Immediate steps were taken to correct this deficient practice for all residents, and all expired product was discarded. All nursing staff received a copy of the facility's policy regarding opened containers of solution and duration for being changed, e.g., no more than 24-hours with date and time indicated when new containers are initiated. Infection Preventionist will do random audits of residents receiving oxygen to assure that date and discard guidelines are followed. Completed audits will be submitted to Quality Assessment and Assurance for quarterly review. To be completed by 1/16/10. <i>F441 POC accepted 2/3/10</i> <i>May Bolter, RN</i>		