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	535043	A. BUILDING _____ B. WING _____	10/26/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LARAMIE CARE CENTER	503 S 18TH ST LARAMIE, WY 82070

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) STAFF TREATMENT OF RESIDENTS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced	F 225	**F225** The facility will assure that all allegations of abuse are reported and investigated in a timely manner. Further the facility will assure that allegations of misappropriation of resident property will be reported to the proper authorities. Also the facility will assure that abuse policies utilized by staff are complete. Allegations revealed from resident #8 and #21 at Resident Council on 10/13/06 were reported to the local police, the Ombudsman, and the Office of Health Quality. The police interviewed both residents and the staff person in question. A report was sent to the Office of Health Quality within 5 days of the initial report. The allegations were unsubstantiated. Allegations revealed from resident #21 on 10/20/06 were investigated. A report was sent to the Office of Health Quality within 5 days of the initial report. The allegation was unsubstantiated. Resident #81 made an allegation of misappropriation of resident property. This resident no longer resides in the facility. To identify other residents who may have been potentially effected, an audit will be conducted by Social Services. This audit will be done by personally	

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

Ron Nelson | Administrator | 11-16-06

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.

NOV 21 2006 Reviewed w/ Ron Nelson, Admin + Joan Foust, SOC on 12/1/06.
POC accepted w/ changes (pgs. 1, 2, 5, 7, 9, 21, 22, 26, 29)
DOC = 12/8/06 Lorralee Reese 12/1/06.

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F 225	Continued From page 1 by: Based on review of resident council minutes, policy and procedure review, staff interview, and review of grievance reports, the facility failed to assure two of four allegations of abuse were reported and investigated in a timely manner. The facility also failed to report one of one allegation of misappropriation of resident property to the proper authorities. In addition, the facility failed to assure the abuse polices utilized by staff were complete. The findings were: Review of the facility policy "Abuse Prevention/Prohibition Program" dated 1/20/03, revealed a section titled, "3.5 Investigation, Protection, and Reporting Process." According to the policy, "The facility will conduct and complete an internal investigation within 48 hours and report credible suspicion and or allegations to the appropriate state enforcement agencies within ____ [blank] hours/days. A written report will be submitted within ____ [blank] hours/days, according to applicable state law." The following concerns were noted: Interview with the administrator on 10/25/06 at 12:26 PM revealed the social services director (SSD) was the staff member responsible for coordinating the follow-up for allegations of abuse, mistreatment, neglect, injuries of unknown origin and misappropriation of resident property. Interview with the (SSD) on 10/25/06 at 12:30 PM revealed her copy of the policy "also has blanks" and she was "not sure" of the time frames. Further interview with the social services director on 10/25/06 at 4 PM revealed she thought the facility had "five days to call the state, family and physician."	F 225	asking the residents about any incidents that may have occurred. If an allegation is determined, it will be reported immediately to the proper local and state agencies. The audit will be completed by November 17. Policies and procedures used by staff have been completed. ~~to~~ indicate Report of Allegations immediately & F/u Reports of Investig. w/in 5 working days are reported The Social Service Director will review 24-hour reports, Resident Council Minutes, and incident reports routinely to monitor for allegations. Information regarding abuse allegations and their investigations with outcomes will be reported monthly to the QA Committee. Social Service Director is responsible for overall compliance.	11/22/06

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F 225	Continued From page 2 Review of the resident council minutes dated 10/13/06 showed "rts [residents] state [name of nurse] was rough." The following problems were noted with the timeliness of reporting this incident to the state survey agency and the Department of Family Services or law enforcement, the timeliness of investigation, and the timeliness of reporting the results of the investigation: a. Interview with the SSD on 10/25/06 at 4 PM revealed she received a copy of the 10/13/06 resident council minutes, and was aware of the situation; however, she did not know if it was reported to the proper state authorities, or if the allegation was investigated. During an interview with the SSD on 10/26/06 at 8:15 AM, she commented, "Honestly I forgot about it." The SSD further stated she had initiated an investigation on 10/25/06 (12 days after the allegation). b. Interview with the activity director on 10/26/06 at 8:02 AM confirmed she was present during the 10/13/06 resident council meeting and documented the allegation. She further stated she did not report the situation to the administrator or any other department head. c. Interview with the SSD on 10/25/06 at 4 PM revealed the expectation was for all staff to verbally report any allegation of abuse to their supervisor, a manager, or to the SSD immediately after the incident occurred. d. Interview with the director of nursing (DON) on 10/25/06 at 4 PM revealed she was aware of an allegation that a nurse was "rough." The DON said she spoke with resident #21, as well as the nurse who was named as being involved, and the allegation was unsubstantiated. The DON said she did not think she had documented her investigation. Review of a document titled "Resident/Family/Grievance Report" faxed to the	F 225		

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F 225	Continued From page 3	F 225		

state survey agency on 10/27/06 showed the investigation for this resident was completed on 10/26/06 and the results were reported to the state survey agency on 10/27/06 (10 working days following the allegation).

e. Interview with the activity assistant on 10/26/06 at 7:52 AM revealed resident #8 was the resident who made the allegation during the 10/13/06 resident council meeting. Interview with the assistant director of nursing on 10/31/06 at 9:06 AM confirmed resident #8 made the allegation during the meeting, and resident #21 indicated she was in agreement with resident #8. Review of a document titled "Resident/Family/Grievance Report" faxed to the state survey agency on 10/31/06 showed the investigation for resident #8 was completed on 10/30/06 and the results were reported to the state survey agency on 10/31/06 (12 working days following the allegation).

f. Interview with the assistant director of nursing on 10/31/06 at 2:45 PM confirmed the allegation made during the 10/13/06 group meeting had not been reported by the facility to the state survey agency and either the Department of Family Services or law enforcement. On 10/31/06 at 4:15 PM, the assistant director of nursing communicated to the state survey agency via voice mail that all appropriate authorities would be notified of this allegation by the end of the day.

Review of a document titled "Resident/Family/Grievance Report" faxed to the state survey agency on 10/27/06, showed the facility investigated an allegation made on 10/20/06 of "an aide being rude et [and] rough" to resident #21. The report documented the

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F 225	Continued From page 4 allegation was unsubstantiated. The facility failed to notify the state survey agency immediately (within 24 hours) of this allegation. On 10/31/06 at 4:15 PM, the assistant director of nursing communicated to the state survey agency via voice mail that all appropriate authorities would be notified by the end of the day. Interview with the SSD on 10/25/06 at 4 PM revealed that on 3/1/06 resident #81 made an allegation of missing $100.00 from his/her wallet. When questioned as to whether or not the allegation was reported to the state survey agency and either the Department of Family Services or law enforcement, the social services director replied the allegation was not reported to any agency.	F 225	F241 The facility will promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. All Resident #45 and #61 will have call lights monitored and answered promptly. Random documented Manager rounds will be completed 3 times weekly for 1 month and then at least weekly for 2 months to determine call light response times. Deficient practices will be corrected immediately.	
F 241 SS=E	483.15(a) DIGNITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on review of resident council minutes, and resident and family interviews, the facility failed to respond timely to resident requests (call lights) in order to maintain the dignity of each resident. The findings were: The following problems were identified with the timely response to call lights: a. Review of resident council minutes dated 9/8/06 under the section "new business" revealed,	F 241	During the Resident Council Meetings the Activities Director will discuss response times with residents and report results to Administrator and DON monthly. All staff will be in serviced regarding their responsibility to answer call lights by December 8th. The Director of Nursing will review all audits and Resident Council minutes to monitor for any patterns and/or repeat deficient practitioners. A report will be presented at the QA Committee regarding any changes that were made necessary related to the	

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F 241	Continued From page 5 "Call lights not being answered timely." Review of the resident council minutes dated 10/13/06 under "old business" showed the certified nurse aides (CNAs) were inserviced in regard to the "long call light waits" and the resident' response was "sometimes better and sometimes worse." Under new business it was documented," CNAs were walking past lights - this was seen by other staff." b. During a confidential interview on 10/24/06 at 2 PM, six residents stated they had to wait for extended periods of time for call lights to be answered. The residents also said the staff was available, but the lights were ignored. c. During an interview on 10/26/06 at 8:40 AM, a family member of resident #45 commented call lights were not answered timely. The family member stated, "the call lights go for a long time." d. During an interview on 10/25/06 at 2:20 PM, a family member of resident #61 stated call lights were not answered timely by staff. The family member stated staff were frequently outside smoking, and not attending to resident needs.	F 241	audits. This will occur monthly for 3 months and then quarterly. The Director of Nursing has overall responsibility for compliance.	12/[illegible]06
F 248 SS=E	483.15(f)(1) ACTIVITIES 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 review of the activity calendar, and resident and staff interviews, the facility failed to	F 248		

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F 248	Continued From page 6 assure the activity program met the needs of each resident. The findings were: 1. During a confidential interview on 10/24/06 at 2 PM, seven residents stated they would like more activities. Four residents specifically commented they would like more activities on the weekends. 2. On 10/25/06 at 12:45 PM, the activity director stated residents told her they wanted more activities, especially on weekends. She stated individual residents talked to her about it, and it was brought up in resident council meetings. She stated the activity assistant worked a half day on Saturday, but other than that activity staff were not providing activities on weekends. She further stated nursing staff did not provide activities on weekends. The activity director stated they were unable to provide additional activities because they were limited with staffing hours. 3. Review of the October 2006 activity calendar showed the following activities were the only ones offered after 4:30 PM Monday through Friday: Bingo on each Monday at 6:30 PM, church at 6:30 PM on 10/12/06, and trick or treating on 10/31/06 at 7 PM. Every Saturday, the schedule was the same: coffee time at 9:30 AM, current events at 10 AM, and Lawrence Welk at 7 PM. On one day, 10/21/06, there was an additional activity at 11:30 AM (cooking for lunch). Every Sunday there was a movie at 9 AM, pet visits (no time mentioned), and various church services.	F 248	**F248** The facility will assure that the activity program meets the needs of the residents. The facility will extend evening and weekend activities. An activity preference survey will be conducted. Based on these surveys the ~~December~~ Nov + months Activity Calendar will be changed. The activity preference surveys will be conducted/reviewed at least quarterly or upon change of condition. Resident Council Meetings will discuss the current month calendar and make recommendations for changes. The Activity Director will review recommendations from the Resident Council and from the activity preference surveys and will integrate this information into the following month's Activity Calendar. The Activity Director will report monthly for the next 3 months and then quarterly to the QA Committee regarding the changes that have been integrated into the calendars. The Activity Director has overall responsibility for compliance.	12/1/06

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F 272 SS=D	483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. 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. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to complete a comprehensive assessment of all needed areas for one (#41) of 16 sample residents. The findings	F 272	F272 The facility will have a comprehensive assessment of resident needs. Resident # 41 will have a comprehensive sleep assessment completed to determine her usual sleep pattern/disturbance and possible reasons for insomnia. An audit will be completed on all residents who are on hypnotic medications to assure that a comprehensive sleep assessment was completed prior to medication being ordered. Education will be provided to all nurses regarding the necessity of a comprehensive sleep assessment required prior to any hypnotic being utilized. The Director of Nursing will review all physician orders for hypnotic medications. Follow up will be done to assure that a sleep pattern assessment was completed. Any deficient practices will be corrected immediately. A report will be provided to the QA committee monthly for 3 months and then quarterly regarding the use of hypnotic medications and the necessary sleep pattern assessments.	

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F 272	Continued From page 8 were: Review of a physician's order dated 10/19/06 showed resident #41 was prescribed Restoril (sedative-hypnotic) 30 milligrams (mg) at bedtime. Review of the medical record showed no evidence that a comprehensive sleep assessment was completed in order to determine the resident's usual sleep pattern/disturbance and possible reasons for insomnia. During an interview on 10/25/06 at 3:25 PM, the director of nursing (DON) confirmed the facility had not done a comprehensive sleep assessment for this resident.	F 272	The Director of Nursing has overall responsibility for compliance.	12/8/06
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, medical record review, and staff interview, the facility failed to ensure one (#8) of 13 sample residents with a care plan received the services according to that plan. The findings were: Observation of resident #8 on 10/24/06 from 7:46 AM until 1:04 PM (an elapsed time of 5 hours and 18 minutes) revealed the resident was seated in a wheelchair. During the observation the resident was not checked for incontinence,	F 282	**F282** The facility will assure the services will be provided or arranged by the facility by qualified persons in accordance with each resident's plan of care. Resident #8 will receive care according to her written care plan. All residents will be included on an ADL sheet. This sheet will state each resident's ADL status and assistance needed. These sheets will be updated at least quarterly or on change of condition. Nursing staff will receive education regarding positioning needs, bowel/bladder needs and proper perineal care by December 8th. All resident with new care plans followed	

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F 282	Continued From page 9 repositioned, or assisted to the bathroom. At 1:04 PM, when the resident was assisted to the bathroom by a certified nurse aide (CNA) #60 and nurse aide (NA) #55, the resident smelled of urine and the resident's attends were saturated. As the observation continued, the NA cleansed the resident's buttocks and the skin between the legs. However, the NA failed to cleanse the anterior skin areas which were also in direct contact with the urine soaked attends. Review of the medical record revealed the resident's current care plan revised on 9/2/06, instructed staff to assist the resident to change position every two hours and to keep the skin clean and dry. The toileting plan revised on 9/2/06, instructed staff to assist the resident to the toilet upon rising, before and after meals, and on night rounds. The toileting plan further instructed staff to keep the resident clean and dry and provide incontinence care after each episode of incontinence. Interview at 1:04 PM on 10/24/06 with CNA #60 and NA #55, who provided care for the resident during the observation, revealed neither knew when the resident was last repositioned or toileted. Both stated CNA #58 or CNA #48 might know. Interview with CNAs #48 (interviewed on 10/24/06 at 1:15 PM) and #58 (interviewed on 10/24/06 at 1:23 PM), as well as the restorative CNA #25 (interviewed at 1:15 on 10/24/06) and both activity personnel (interviewed on 10/24/06 at 11:18 AM and 12:53 PM) revealed none of them knew when the resident was last toileted. Interview with the staff development coordinator at 5:31 PM on 10/24/06 revealed the facility's expectation was that staff would reposition and toilet residents according to their plan of care.	F 282	Random documented Nurse Manager rounds will be completed 3 times weekly for 1 month and then at least weekly for 2 months to determine call light response times. Deficient practices will be corrected immediately The Director of Nursing will review all audits and Resident Council minutes to monitor for any patterns and/or repeat deficient practitioners. A report will be presented at the QA Committee regarding any changes that were made necessary related to the audits. This will occur monthly for 3 months and then quarterly. The Director of Nursing has overall responsibility for compliance.	12/8/06

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F 309 SS=D	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to assure staff provided timely assessment and care for one (#62) of two sample residents who experienced a change in skin condition. The findings were: According to the 8/14/06 quarterly Minimum Data Set (MDS) assessment, resident #62 required extensive assistance for transferring and was non-ambulatory. Observation during care on 10/24/06 at 9:30 AM, revealed certified nurse aide (CNA) #59 and nurse aide (NA) #54 identified two reddened areas on the resident's left upper mid-gluteal area. Interview with CNA #59 at that time revealed he had not received a report of these reddened areas, and he believed they were new. The CNA further stated he would report the change in skin condition to the nurse. Further observation of the resident on 10/24/06 at 4:57 PM revealed the resident had an irregular shaped reddened area to the left upper mid-gluteal area. The area was approximately 5 centimeters (cm) by 4 cm with a second smaller area immediately below it which was approximately 2 cm by 1 cm. Interview at that	F 309	**F309** The facility will assure that staff provide timely assessment and care for all residents who experience a change in skin condition. Resident #62 will have timely reporting of any change in skin condition. Nursing staff will receive in-service education on prompt notification to licensed nursing staff as well as co-workers that may care for the resident if a resident is found to have a change in skin condition. The CNAs will utilize a skin change report. Education will be completed by December 8th. Nurse mangers will be monitoring (3 X weekly) use of skin change reports to determine timely and accurate reporting of new skin conditions. The DON will review the nurse managers' findings and prepare a report of efficiencies/deficiencies for the monthly QA meeting for 3 months and then quarterly. The Director of Nursing has overall responsibility for compliance.	12/8/06

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F 309	Continued From page 11 time with CNA #48 and CNA #17 revealed both CNAs denied knowing of skin issues for this resident. CNA #48 stated she had come on duty at 2 PM and CNA #17 stated she had been at work since 6 AM, but was not told of any skin issues with the resident. Interview with licensed practical nurse (LPN) #2 on 10/24/06 at 5:05 PM (seven hours and thirty five minutes after the skin issue was identified by CNA #59) revealed she was unaware of any skin issues for this resident. At that time, LPN #2 reviewed the the bath record from the resident's bath on that day (10/24/06) and stated the only documentation was for a coccyx scar. When asked if staff had notified her of the reddened areas on the left gluteal from the morning observation, LPN #2 stated "No." When asked if the staff would have notified someone else, she stated that she would have been the only person notified. Medical record review showed a skin assessment note on 10/24/06, timed at 6:10 PM, (eight hours and 40 minutes after first being identified by CNA #59) that documented there were two reddened areas to the resident's left upper buttock. Interview with registered nurse #5 on 10/25/06 at 1:50 PM revealed the facility had assessed and was treating the reddened areas as "burns" from the plastic on the resident's incontinence brief. Interview with the staff development coordinator on 10/24/06 at 5:31 PM revealed the expectation for CNA staff was that skin issues would be reported immediately.	F 309		

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	535043	A. BUILDING _____ B. WING _____	10/26/2006

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F 312 SS=D	483.25(a)(3) ACTIVITIES OF DAILY LIVING A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure appropriate hygiene for one (#8) of six observations of residents who required assistance with perineal care and were incontinent. The findings were: Review of the medical record for resident #8 revealed the resident's most recent assessment was a quarterly Minimum Data Set (MDS) assessment dated 9/4/06. The facility assessed the resident as dependent for toileting and hygiene and assessed the resident as usually continent of bowel and frequently incontinent of bladder. Observation on 10/24/06 at 1:04 PM revealed the resident required assistance to the bathroom. Certified nurse aide (CNA) #60 and a nurse aide (NA) #55 removed the resident's urine saturated brief and assisted the resident to the toilet. NA #55 then provided perineal care. The observation revealed the NA cleansed the buttocks and the skin between the resident's legs, but did not cleanse the anterior skin areas which also came in contact with urine. Interview with the NA at that time verified that she had not cleansed the anterior area. Interview with the staff development coordinator at 5:31 PM on 10/24/06 revealed the facility's expectation was that during incontinence care staff would cleanse all skin	F 312	**F312** The facility will assure that staff provide appropriate hygiene for all residents that require assistance with perineal care and are incontinent. Resident #8 will receive proper perineal care. Nursing staff will receive education regarding positioning needs, bowel/bladder needs and proper perineal care by December 8th. Random documented Nurse Manager rounds will be completed 3 times weekly for 1 month and then at least weekly for 2 months to determine that staff are responding to residents' positioning and bowel/bladder needs. Monitoring will occur to assure proper peri-care is also delivered. Deficient practices will be corrected immediately The Director of Nursing will review all audits and Resident Council minutes to monitor for any patterns and/or repeat deficient practitioners. A report will be presented at the QA Committee regarding any changes that were made necessary related to the audits. This will occur monthly for 3 months and then quarterly. The Director of Nursing has overall responsibility for compliance.	12/8/06

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F 312	Continued From page 13 areas which were in contact with urine and/or feces.	F 312	**F314** The facility will assure that residents at risk for pressure ulcers, receive care, and services to prevent pressure sores.	
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, medical record review, and staff interview, the facility failed to ensure one (#8) of 12 sample residents who were identified to be at risk for pressure sores, received care and services to prevent pressure sores. The findings were: Review of the medical record for resident #8 revealed an admission resident assessment instrument (RAI) dated 3/4/06. Section "V" documented the resident triggered for further assessment information in the area of pressure sores. Review of the resident assessment protocol (RAP) for pressure sores (dated 3/4/06) documented that the resident triggered due to bowel incontinence and a stage one pressure sore on the coccyx. The assessment further documented the resident was "obese and does not move self adequately." It stated, "... staff will	F 314	Resident # 8 will receive care and services to prevent pressure sores from developing. Nursing staff will receive education regarding positioning needs, bowel/bladder needs and proper perineal care by December 8th. Random documented Nurse Manager rounds will be completed 3 times weekly for 1 month and then at least weekly for 2 months to determine that staff are responding to residents' positioning and bowel/bladder needs. Deficient practices will be corrected immediately The Director of Nursing will review all audits and Resident Council minutes to monitor for any patterns and/or repeat deficient practitioners. A report will be presented at the QA Committee regarding any changes that were made necessary related to the audits. This will occur monthly for 3 months and then quarterly. The Director of Nursing has overall responsibility for compliance.	12/8/06

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F 314	Continued From page 14 keep [the resident] clean and dry, assist to change position aprox [approximately] every 2 hours." The resident's current care plan, revised on 9/2/06, instructed staff to assist the resident to change position every two hours and to keep the skin clean and dry. The resident's most recent Braden scale (a recognized assessment tool for assessing pressure sore risk) documentation dated 8/28/06 scored the resident as "14"; a score of 18 or below indicates a resident is at risk. In addition, review of interdisciplinary (IDT) progress notes revealed a history of pressure sores. IDT notes dated 4/27/06 documented the resident had a stage 2 pressure sore on the left buttock. Review of a second pressure sore tool, titled "PUSH Tool 3.0," dated 10/21/06, documented the resident currently had a sore on the left gluteal fold. The following concerns were noted related to the resident's history for pressure sores and observation of care: a. Observation of resident #8 on 10/24/06 from 7:46 AM until 1:04 PM (an elapsed time of five hours and 18 minutes) revealed the resident was seated in a wheelchair and was not repositioned or assisted with toileting. At 8:57 AM that morning, certified nurse aide (CNA) #60 offered to assist the resident to bed, but when the resident refused, the resident was not repositioned or assisted with toileting. At 1:04 PM when the resident was assisted to the bathroom by CNA #60 and nurse aide (NA) #55, the resident was odorous of urine, and the resident's attends were saturated. b. Interview with CNA #60 and NA #55, who provided care for the resident at 1:04 PM on 10/24/06, revealed neither knew when the resident was last repositioned or toileted. Both individuals stated either CNA #14 or #58 might	F 314		

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F 314	Continued From page 15 know. Interview with both of these CNAs (#14 interviewed on 10/24/06 at 1:15 PM and #58 at 1:23 PM), as well as restorative CNA #25(interviewed at 1:15 on 10/24/06) and both activity personal (interviewed on 10/24/06 at 11:18 AM and 12:53 PM) revealed no one knew the last time the resident was toileted. c. Interview with the staff development coordinator at 5:31 PM on 10/24/06 revealed the facility's expectation was that staff would reposition and toilet residents according to their care plan.	F 314		
F 315 SS=D	483.25(d) URINARY INCONTINENCE Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure one (#8) of eight sample residents who were incontinent received care and services to prevent incontinence. The findings were: Review of the medical record for resident #8 revealed an admission resident assessment	F 315		

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F 315	Continued From page 16 instrument (RAI) dated 3/4/06. Section "V" documented the resident triggered for further assessment information in the area of incontinence. Review of the resident assessment protocol (RAP) for incontinence documented the resident triggered due to being incontinent of urine and using incontinence pads. The RAP also documented the resident did not always verbalize his/her needs timely to staff and required assistance toileting. The RAP documented a plan for staff to to ask and assist the resident to the toilet every two hours and upon request. The most recent quarterly Minimum Data Set assessment dated 9/4/06, documented the resident was frequently incontinent of urine. Review of the current care plan for incontinence, revised on 9/2/06, instructed staff to toilet the resident in the AM upon rising, before and after meals, and during night rounds. The plan also instructed the staff to keep the resident clean and dry and to provide incontinence care after each episode of incontinence. Observation of resident #8 on 10/24/06 from 7:46 AM until 1:04 PM (an elapsed time of 5 hours and 18 minutes) revealed the resident was seated in a wheelchair. During the observation the resident was not checked and changed, repositioned, or assisted to the bathroom. At 1:04 PM, when the resident was assisted to the bathroom by certified nurse aide (CNA) #60 and nurse aide (NA) #55, the resident was odorous of urine, and the resident had a saturated disposable brief. As the observation continued, the NA cleansed the resident's buttocks and the skin between the legs. However, the NA failed to clean the anterior skin areas which were also in contact with urine. Interview at the time of the observation with	F 315	**F315** The facility will assure that residents who are incontinent will receive care and services to prevent incontinence. Resident #8 will receive appropriate treatment and services to prevent incontinence. Nursing staff will receive education regarding positioning needs, bowel/bladder needs and proper perineal care by December 8th. Random documented Nurse Manager rounds will be completed 3 times weekly for 1 month and then at least weekly for 2 months to determine that staff are responding to residents' bowel/bladder needs. Deficient practices will be corrected immediately The Director of Nursing will review all audits and Resident Council minutes to monitor for any patterns and/or repeat deficient practitioners. A report will be presented at the QA Committee regarding any changes that were made necessary related to the audits. This will occur monthly for 3 months and then quarterly. The Director of Nursing has overall responsibility for compliance.	12/8/06

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F 315	Continued From page 17 CNA #60 and NA #55 revealed neither knew when the resident was last toileted. Both stated either CNA #14 or #58 might know. However, interview with of these CNAs (#14 interviewed on 10/24/06 at 1:15 PM and #58 at 1:23 PM), as well as restorative CNA #25 (interviewed at 1:15 PM on 10/24/06) and both activity personnel (interviewed on 10/24/06 at 11:18 AM and 12:53 PM) revealed no one knew the last time the resident had been toileted. Interview with the staff development coordinator at 5:31 PM on 10/24/06 revealed the facility's expectation was that staff would toilet residents according to their care plan and cleanse all skin area which came in contact with urine and/or feces.	F 315		
F 329 SS=D	483.25(l)(1) 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. This REQUIREMENT is not met as evidenced by: Based on medical record review, policy review, and staff interview, the facility failed to assure the drug regimen was free of unnecessary drugs for one (#41) of 16 sample residents. The findings were:	F 329		

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F 329	Continued From page 18 Record review for resident #41 revealed a physician's order for Restoril (sedative-hypnotic) 30 milligrams (mg) at bedtime. The order did not indicate the diagnosis or other rationale for the use of the drug. Review of the 4/06/06 admission and the 10/9/06 quarterly Minimum Data Set (MDS) assessments revealed the resident did not have insomnia. Review of the medical record also showed no evidence the resident had insomnia or a comprehensive sleep assessment done to determine the resident's usual sleep pattern/disturbance and possible reasons for insomnia. In addition, there lacked evidence non-pharmacological interventions were attempted. There also lacked evidence the facility was monitoring the effectiveness of potential side effects of the medication. Review of the care plan dated 10/11/06 showed a problem with insomnia was not addressed. During an interview on 10/25/06 at 3:25 PM, the director of nursing (DON) stated she was unaware the resident was prescribed Restoril. She stated she was not aware the resident had any problems with sleep and verified that was not a comprehensive assessment for sleep was not done for this resident. Review of the facility's pharmacy policy "Psychoactive Drug Monitoring" (policy #5515, undated) revealed "...residents receive a psychoactive medication only if designated medically necessary by the prescriber. The medical necessity is documented in the resident's medical record and in the care planning process...non-pharmacological interventions such as behavior modification or social services and their effects are documented... ." In addition, "...all of the following conditions are satisfied prior to	F 329	**F329** The facility will assure that each resident's drug regime is free from unnecessary drugs. Resident #41 will be free of unnecessary drugs. Necessary assessments will be completed to determine whether the hypnotic medication ordered is required for the resident to sleep. Outcome of the assessment will be communicated to her physician for review and recommendations. The Director of Nursing will review all new MD orders to assure that appropriate documentation and assessments are completed prior to new medications being administered. Any deficient practice will be corrected when found. Monthly reports will be presented at the QA Committee Meeting for 3 months, then quarterly regarding physician orders without assessments and the corrective actions that were taken. The Director of Nursing has overall responsibility for compliance.	12/8/06

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F 329	Continued From page 19 initiation and/or continuation of therapy: 1. Possible reversible causes for the resident's distress have been ruled out....4. The need for and response to therapy are monitored and documented in the resident's medical record."	F 329		
F 331 SS=D	483.25(l)(2)(ii) ANTIPSYCHOTIC DRUGS Based on a comprehensive assessment of a resident, the facility must ensure that 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 medical record review, policy review, and staff interview, the facility failed to assure one (#79) of five sample residents who received antipsychotic medications received gradual dose reductions. The findings were: Review of physician's orders showed resident #79 had received Zyprexa (antipsychotic) 2.5 milligrams (mg) each day since 8/4/05 for Alzheimer's dementia with agitation. Review of behavior monitoring records for April, May, June, and July 2006 showed the resident did not exhibit any of the behaviors which were being tracked (refusal of care and physical abuse to staff). Review of the 4/12/06 psychotropic review showed the facility was going to ask the physician to consider tapering and possibly discontinuing the drub because the resident was not exhibiting any behaviors. Review of a pharmacy-physician	F 331		

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F 331	Continued From page 20 communication form dated 4/14/06 showed the pharmacist documented "Pt [patient] is taking Zyprexa 2.5 mg qd [every day]. Pt has not exhibited any behaviors warranting use of this medication. Would you please consider tapering over 14 days and eventually discontinuing?". A hospice registered nurse (RN), and not a physician, responded "...continue Zyprexa 2.5 mg..." On 5/15/06, the pharmacist completed another pharmacy-physician communication form which read "...Pt is taking Zyprexa 2.5 mg qd. Pt has not exhibited any behaviors warranting use of this medication. Pt has had fall with injuries. Would you please consider tapering over 14 days and eventually discontinuing?..." There was no documented response and no documentation to follow up communication with the physician by the facility. Review of the medical record showed no evidence a dose reduction was attempted, or evidence as to why a dose reduction would be contraindicated. During an interview on 10/25/06 at 3:25 PM, the director of nursing (DON) stated the facility had a difficult time getting a dose reduction because the resident received hospice services. The DON confirmed a dose reduction was not attempted. Review of the facility's policy "Psychotropic Medications, Indications for Use and Reduction" (policy number CL-INTER-0106, 10/30/01) showed "...gradual dose reductions should be attempted to identify the lowest possible maintenance dose or to discontinue the drug completely..."	F 331	**F331** The facility will ensure that residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Resident # 79 was a closed record, was deceased at time of survey. all including those Residents receiving Hospice care will continue to be monitored by the Psychotropic Drug Review Committee. Any necessary communication sheets from the pharmacist to the physician will be sent to the primary MD. The Director of Nursing will track communication forms until they are completed/signed and will monitor responses that are returned. A report will be presented monthly at the QA Meeting antipsychotic medication and actions of the Psychotropic Drug Review Committee. The Director of Nursing has overall responsibility for compliance.	12/8/06

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F 334 SS=E	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATION The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has	F 334	**F334** The facility will have policies and procedures that meet the intent of this new F-tag. Resident #41 is alert and oriented. She is responsible for her own care. She stated that she was allergic to the flu vaccine and refused. An attempt will be made to verify this allergy through her physician. Residents #38, #41, #45, #62, #56, #25, #8, and #1 will be offered the pneumococcal vaccination. 5 Star Policy and Procedure CL-IP-3016 Resident Health Program 03/15/06 will be updated to reflect the components of this regulation. An audit will be completed on all resident charts to determine which residents are able to have the pneumococcal vaccination. Any resident that is eligible to receive the vaccination will have the components required in place on their medical record. (education, family permission, physician orders) A report will be presented to the QA Committee regarding the progress of consents, education, and vaccinations given until all eligible residents are vaccinated. The Director of Nursing has overall responsibility for compliance.	12/8/06

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F 334	Continued From page 22 already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on medical record review, policy review, and staff interview, the facility failed to develop and implement policies to assure residents received the influenza and pneumococcal vaccines. There lacked evidence of an allergy in the medical record for one (#41) of one sample resident who did not receive the influenza vaccine due to an allergy. In addition, eight (#1, #8, #25, #38, #41, #45, #56, #62) of 13 sample residents did not have evidence of being offered the	F 334		

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pneumococcal vaccine, nor was there evidence the vaccine was contraindicated. The findings were:

1. The following concerns were identified regarding the facility's failure to offer each resident the pneumococcal vaccine:

a. Review of the medical record showed resident #38 was admitted on 4/14/05. Review of the 7/24/06 quarterly Minimum Data Set (MDS) assessment showed the resident was not up to date with the pneumococcal vaccine and the reason was "not offered." Review of the medical record, including the physician orders, showed no evidence the pneumococcal vaccine was offered to the resident.

b. Review of the medical record, including physician orders, showed resident #41 was admitted on 3/29/06. Review of the medical record showed no evidence the pneumococcal vaccine was offered to the resident.

c. Review of the medical record, including physician orders, showed resident #45 was admitted on 6/23/03. Review of the medical record showed no evidence the pneumococcal vaccine was offered to the resident.

d. Review of the medical record, including physician orders, showed resident #62 was admitted on 2/13/02. Review of the medical record showed no evidence the pneumococcal vaccine was offered to the resident.

e. Observation of resident #56 revealed the resident was in isolation, had a tracheostomy, and did not respond to care being provided nor to staff voices. Review of the medical record revealed a face sheet (no date) which documented the resident resided at the facility since 9/16/03. Further record review failed to

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	535043	A. BUILDING _____ B. WING _____	10/26/2006

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reveal information regarding pneumovax status or why the resident was not vaccinated.

f. Review of the medical record for resident #25 failed to reveal vaccination status for the pneumovax vaccine or a reason why the vaccine was not administered. Review of the resident's face sheet (no date) revealed the resident resided at the facility since 3/25/06.

g. Review of the medical record for resident #8 failed to reveal vaccination status for the pneumovax vaccine or a reason why the vaccine was not administered. Review of the resident face sheet (no date) revealed the resident had resided at the facility since 2/23/06.

h. Review of the medical record for resident #1 failed to reveal vaccination status for the pneumovax vaccine or a reason why the vaccine was not administered. Review of the resident's face sheet (no date) revealed the resident had resided at the facility since 6/20/02.

During an interview on 10/24/06 at 11:30 AM, the SDC stated if the resident had received the pneumococcal vaccine, it would be listed under routine orders in the medical record. The SDC stated the facility focused on the influenza vaccine this year, so the pneumococcal vaccine was on the "back burner." Review of the Resident Census and Conditions form (CMS-672) filled out by the facility revealed 27 out of 77 residents had received the pneumococcal vaccine.

2. Review of a document provided by the staff development coordinator (SDC) showed resident #41 did not receive the influenza vaccine because the resident was "allergic." However, review of the medical record did not show the resident was offered the vaccine, nor was there evidence the

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F 334	Continued From page 25 resident was allergic to the vaccine. On 10/25/06 at 4:37 PM, the SDC confirmed the medical record did not contain documentation that the resident was allergic to the vaccine. 3. Review of the immunization policies provided by the facility revealed the facility did not have policies that stipulated the resident's medical record would include the following documentation: a. Education of the resident or the resident's legal representative regarding the benefits and potential side effects of the influenza and pneumococcal immunizations; b. The resident's immunization status and any reasons why immunizations were refused.	F 334	**F364** The facility will assure that hot foods are served at an adequate temperature. all residents, including Residents #45, #1, and #4 will receive hot food at an adequate temperature. When a resident expresses a concern regarding the temperature of their food, it will be replenished with food items of adequate temperature. The Dietary Services Director will provide education to the dietary staff on appropriate meal temperature preparation, procurement, and meal service with emphasis on maintaining proper hot serving temperatures throughout the entire meal service. Education will be completed by November 20th. A quality-monitoring tool will be implemented to assure that food is served at the proper temperature. A random audit of food temperatures will be conducted 3 times per week at separate meal times utilizing a test ray form. If temperatures prove to be out of compliance immediate one-on-one in-service with a corrective plan of action will be held at that time. A random audit of room tray plates will be conducted 2 times per week. The Dietary Services Director will request an unmarked tray to be sent out with the room tray cart. The temperature of this food will be	
F 364 SS=B	483.35(d)(1)-(2) FOOD Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation and resident interview, the facility failed to assure hot food items were served at an adequate temperature. The findings were: The following concerns were noted with the serving temperature of hot food items: a. During a confidential interview on 10/24/06 at 2 PM eight residents said their eggs were served "cold." b. Observation on 10/24/06 at 7:42 AM	F 364		

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F 364	Continued From page 26 revealed a cart with 7 room trays was pushed into the main dining room from the kitchen. At 8:07 AM (25 minutes later) resident #45 was served his/her room tray. When questioned at that time, the resident said the toast was "room temperature" and the scrambled eggs were "barely warm." c. Interview with resident #1 on 10/23/06 at 5:31 PM revealed the resident ate in the main dining room. During the interview, the resident stated some foods were not at an appropriate temperature when served. When asked for an example, the resident said the meat strips served at lunch that day were "cold." d. Interview with resident #4 on 10/23/06 at 6:40 PM revealed the soup served during the evening meal was not "hot." The resident further stated the soup did not taste good when it was not hot.	F 364	obtained after the last tray has been served to the residents. If temperatures prove to be out of compliance immediate one-on-one in-service with a corrective plan of action will be held at that time. A quality-monitoring tool will be implemented to assure overall resident satisfaction with the meal including meal temperatures and acceptability. A random audit of meal satisfaction will be conducted 2 times bi-weekly utilizing the meal satisfaction survey-dietetic services form. When noting individual or group dissatisfaction with any aspect of the meal preparation, the Dietary Services Director will initiate action to resolve the issue that has been identified. The Dietary Services Director will compile a report from the audits and present areas noted for improvement and corrective plans to the QA Committee monthly for 3 months and then quarterly. The Dietary Services Director has overall responsibility for compliance.	12/1/06

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F 368 SS=E	483.35(f) FREQUENCY OF MEALS Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community. There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below. The facility must offer snacks at bedtime daily. When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview, and policy and procedure review, the facility failed to assure each resident was offered a bedtime snack. The facility census was 77. The findings were: During a confidential interview on 10/24/06 at 2 PM, 9 residents said they were not offered a bedtime snack. Interview on 10/24/06 at 6:05 PM with registered nurse #13 revealed only certain residents were offered a snack at bedtime. Review of facility policy titled "Nourishments" dated 1/1/01, showed "Bulk HS [bedtime] snacks will be offered to all residents unless contradicted by their diet order... HS [bedtime] snacks are offered to the resident by the nursing staff. Dietary supplies the station 2 fridge area." Interview with the dietary manager on	F 368	**F368** The facility will assure that each resident is offered an HS snack. The facility will utilize a "Snack Cart" to distribute HS snacks to all residents. All residents will be offered an HS snack. Documentation will include acceptance or refusal. Nursing staff will be in-serviced regarding the procedure for passing of HS snacks and the importance of assuring that the task is completed. The Director of Nursing and Dietary Services Director will review the documentation at least weekly to assure that snacks offered are being accepted. A report will be presented to the QA Committee monthly for 3 months and then quarterly regarding the acceptance of snacks being offered. The Director of Nursing has overall responsibility for compliance.	12/8/06

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F 368	Continued From page 28 10/26/06 at 10:45 AM confirmed all residents should be served a bedtime snack according to the facility policy.	F 368	**F492** The facility will assure that licensed staff perform tasks for which they are qualified and that are within their scope of practice.	
F 492 SS=D	483.75(b) ADMINISTRATION The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure that licensed staff performed tasks for which they were qualified and that were within their scope of practice. Four random observations of residents (#1, #24, #38, #53) revealed certified nurse aide (CNA) staff adjusted oxygen flow rates. The facility census was 77. The findings were: 1. Observation of resident #1 on 10/23/06 at 5:32 PM revealed the resident was assisted into a wheelchair. Nurse aide (NA) #46 removed the resident's oxygen cannula from the concentrator, attached it to a portable oxygen container, and adjusted the oxygen flow rate to 2 liters per minute. The observation revealed no posted rate on the portable container, and a posted rate of 2 1/2 liters on the concentrator. At the time of the observation, the NA was asked how she knew what rate to set for the portable oxygen, and she replied the setting was on an activity of daily living	F 492	Resident #1, #24, #53, and #38 will be assessed for oxygen liter flow. If appropriate based on assessment, they will have the liter flow marked on the concentrator and/or portable oxygen tank. The date and initials of the nurse making the assessment will accompany the liter flow. Assessments for all residents utilizing oxygen will be conducted. Liter flow will be determined and a baseline rate will be noted. The liter flow will be posted on the concentrator and/or portable oxygen tank. If a resident is experiencing a change of condition, the RN/LPN will use their clinical judgment to titrate the oxygen needs of the resident All nursing staff will receive education regarding their scope of practice in regulating oxygen use by residents. In-servicing will be completed by 12/8/06 Random documented Manager rounds will be completed 3 times weekly for 1 month and then at least weekly for 2 months to assure that all resident oxygen equipment is marked appropriately. Deficient practices will be corrected immediately	

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F 492	Continued From page 29 (ADL) sheet. Review if the resident's medical record revealed a October 2006 medication recapitulation sheet which documented the oxygen order as continuos nasal oxygen to keep the oxygen saturation greater than 90%. 2. Observation on 10/24/06 at 7:15 AM revealed CNA #58 adjusted the portable oxygen setting for resident #24 to 2 liters. The observation revealed the oxygen concentrator was labeled 2 1/2 liters. Interview at that time with the CNA revealed she set the oxygen at two liters because the resident was "sitting." The CNA stated when the resident was lying down, it required more effort to breath. The observation revealed no posting on the portable oxygen to indicate the oxygen setting. Review of the resident's medical record revealed a October 2006 medication recapitulation which documented the oxygen was titrated to keep the saturation level equal to or greater than 90%. 3. Observation of resident #53 on 10/24/06 at 4:41 PM revealed CNA #48 adjusted the resident's portable oxygen to 2 liters. Observation of the portable tank revealed no posted oxygen setting. Interview at that time with the CNA revealed she set the flow rate to the same rate as the resident's concentrator in his/her room. Observation on 10/24/06 at 4:46 PM of the resident's concentrator revealed the oxygen flow rate was not posted on the concentrator and the concentrator was off, so the flow rate could not be observed. Interview on 10/24/06 at 4:46 PM with licensed practical nurse (LPN) #2, responsible for the resident's care, revealed she thought the resident's flow rate was 3 liters. When asked what the current setting of the concentrator was, the LPN turned the concentrator on and stated it	F 492	The Director of Nursing will review all audits to monitor for any patterns and/or repeat deficient practitioners. A report will be presented at the QA Committee regarding any changes that were made necessary related to the audits. This will occur monthly for 3 months and then quarterly. The Director of Nursing has overall responsibility for compliance.	12/8/06

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F 492	Continued From page 30 was 2 liters. After checking the resident's titration sheet, the LPN stated the resident was last titrated to 2 liters with a saturation of 91%. Review of the resident's medical record revealed the only order in the record was the original transfer order dated 11/29/2000, which documented the resident's oxygen level at 3 liters per minute and that staff were to titrate to maintain the oxygen saturation at equal to or greater than 92%. 4. Review of physician's orders showed resident #38 received oxygen to keep the oxygen saturation level above 90%. Review of the 10/19/06 activities of daily living (ADL) sheet for certified nurse aides (CNAs) showed the resident received 3 liters per minute (LPM) of oxygen. Observation on 10/24/06 at 9:20 AM showed CNA #22 put the oxygen nasal cannula on the resident, and then adjusted the oxygen flow rate on the concentrator from off to 3 LPM. The oxygen flow rate was not posted on the concentrator, nor in the resident's room. 5. According to the May 2001 decision by the Wyoming Board of Nursing (BON), a CNA may be delegated the task of adjusting the oxygen liter flow if the liter flow is clearly marked by the nurse on the concentrator and/or oxygen tank. Interview with the staff development coordinator on 10/24/06 at 5:31 PM revealed some portable oxygen tanks could not be set at half liter increments. The coordinator stated CNA staff were to check with the nurse for residents who were having titration levels adjusted.	F 492		