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

PRINTED: 08/29/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535026	A. BUILDING B. WING	C 08/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHEYENNE HEALTH CARE CENTER	2700 E 12TH STREET CHEYENNE, WY 82001

(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 ~~The following common abbreviations are used~~ throughout this document: cc -cubic centimeter	F 000		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY 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 observation, medical record review, and staff interview, the facility failed to ensure dignity was maintained during 1 of 1 observation of resident care (#2). The findings were: Review of the medical record showed resident #2 was admitted to the facility on 7/31/13 with diagnoses which included Parkinson's disease. Review of the resident's plan of care showed s/he needed staff assistance with activities of daily living, and was a safety risk due to confusion. During an observation on 8/12/13 at 7:15 PM, the resident asked CNA #1 to put him/her into bed. The resident was in a recliner with wheels in his/her room, and was reclined. At 8:15 PM, the resident asked the surveyor to place him/her in bed. Observation at that time showed the resident had a strained facial expression. The surveyor then asked CNA #1 to assist the resident to bed. The aide returned at 8:20 PM (1 hour and 5 minutes) with CNAs #2 and #3 and placed the resident in bed using a mechanical lift. During an interview immediately after the transfer, the aides	F 241	**Preparation and/or execution of the response and plan of correction do not constitute admission of agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of federal and state law require it.** F-241 **Corrective Action** Resident #2 was assisted to bed at 8:20 p.m. on 7/31/13 by nursing staff.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Dan Stachs	Nursing Home Administrator	9-6-13

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.

POC accepted. Call to Dan Stachs, NHA on 9/13/13 @ [illegible]
Janelle Cody, ONK

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	535025	A. BUILDING _____ B. WING _____	C 08/16/2013

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F 000	INITIAL COMMENTS The following common abbreviations are used throughout this document: cc -cubic centimeter	F 000	Identification of Others The Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, and/or Designee will conduct random observations of staff to determine whether residents are provided services per their request and in a timely manner. The Social Services Assistant/Designee will conduct random resident interviews to confirm residents are treated with dignity and respect related to needs being met timely.	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY 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 observation, medical record review, and staff interview, the facility failed to ensure dignity was maintained during 1 of 1 observation of resident care (#2). The findings were: Review of the medical record showed resident #2 was admitted to the facility on 7/31/13 with diagnoses which included Parkinson's disease. Review of the resident's plan of care showed s/he needed staff assistance with activities of daily living, and was a safety risk due to confusion. During an observation on 8/12/13 at 7:15 PM, the resident asked CNA #1 to put him/her into bed. The resident was in a recliner with wheels in his/her room, and was reclined. At 8:15 PM, the resident asked the surveyor to place him/her in bed. Observation at that time showed the resident had a strained facial expression. The surveyor then asked CNA #1 to assist the resident to bed. The aide returned at 8:20 PM (1 hour and 5 minutes) with CNAs #2 and #3 and placed the resident in bed using a mechanical lift. During an interview immediately after the transfer, the aides	F 241		

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F 241	Continued From page 1 said they placed residents in bed in the order they were assisted out of bed so that no resident was left up too long. They further stated they should have explained this to the resident, and let him/her know how long it would be before they could provide transfer assistance.	F 241	**Monitoring** The Director of Nursing/Designee will bring the results of the audits to the monthly QA&A Committee for 3 months for review and recommendations. Date of compliance is September 29, 2013.	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview, the facility failed to clarify an order concerning tube feeding administration for 1 of 2 sample residents (#5). In addition, the facility failed to clarify an order concerning supplemental oxygen delivery for 1 of 5 sample residents (#2) who required supplemental oxygen. The findings were: 1. Review of the medical record for resident #5 showed the resident had a 9/19/12 physician's order for Jevity 1.2 Cal per percutaneous endoscopic gastrostomy (PEG tube) at 90 ccs per hour for 18 hours via pump to provide 1620 ccs in 24 hours and 1944 calories in 24 hours. Review of a 6/20/13 faxed communication to the physician showed facility staff requested comfort measures for the resident that included cessation of tube feedings. Review of the 6/21/13 physician's written response showed the tube feeding was not addressed. Review of the nursing notes and July 2013 MARs showed the facility stopped the resident's tube feeding on	F 281	F-281 **Corrective Action** Resident #5's tube feeding order was clarified by their physician on 6/27/13 and restarted the same day. Resident #2 received a physician clarification order for the use of supplemental oxygen.	

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F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview, the facility failed to clarify an order concerning tube feeding administration for 1 of 2 sample residents (#5). In addition, the facility failed to clarify an order concerning supplemental oxygen delivery for 1 of 5 sample residents (#2) who required supplemental oxygen. The findings were: 1. Review of the medical record for resident #5 showed the resident had a 9/19/12 physician's order for Jevity 1.2 Cal per percutaneous endoscopic gastrostomy (PEG tube) at 90 ccs per hour for 18 hours via pump to provide 1620 ccs in 24 hours and 1944 calories in 24 hours. Review of a 6/20/13 faxed communication to the physician showed facility staff requested comfort measures for the resident that included cessation of tube feedings. Review of the 6/21/13 physician's written response showed the tube feeding was not addressed. Review of the nursing notes and July 2013 MARs showed the facility stopped the resident's tube feeding on	F 281	**Identification of Others** A facility-wide audit will be conducted by the Director of Nursing/Designee to confirm residents receiving enteral nutrition are being administered in accordance with the physician's order. A facility-wide audit will be conducted by the Director of Nursing/Designee to confirm residents with supplemental oxygen are administered in accordance with the physician's order.	

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F 281	Continued From page 2 6/21/13. Further review showed the resident's tube feeding was not resumed until 6/27/13 (6 days). Review of the 6/27/13 physician orders showed the physician, when made aware the resident's tube feedings had been discontinued by staff without an order, ordered a restart to the residents feeding tube nutritional regimen with a graduated increase to ensure the resident received his/her adequate nutritional care needs. Review of a 7/2/13 physician's progress note showed, "order for comfort care misinterpreted." 2. Review of the medical record for resident #2 showed the resident had a diagnosis of hypoxia, and a 7/31/13 physician order for oxygen to be delivered at 2 liters per minute via nasal cannula. The review showed the resident was sent to a local hospital on 8/1/13 when assessed as unresponsive, and returned to the facility on 8/5/13. Review of the physician's orders at that time showed the resident did not have an order for supplemental oxygen. On 8/12/13 at 6:57 PM the resident was observed with a nasal cannula in his/her nose attached to a portable oxygen tank. During an interview with RN #2 on 8/12/13 at 9 PM, she confirmed the resident required oxygen at all times, but an order for the oxygen had not been obtained. According to Smith, Duell, and Martin in "Clinical Nursing Skills: Basic to Advanced Skills", 7th Edition, 2008: "Skills and functions that professional nurses perform in daily practice include: ...Administer treatments per physician's order."	F 281	**Systemic Changes** The Staff Development Coordinator/Designee will conduct training with all licensed nurses addressing the reviewing, noting, and following of physician orders. The Director of Nursing/Designee will conduct random weekly audits times 4 weeks and monthly times 2 of physician orders to confirm orders are reviewed, noted, and appropriately followed with emphasis on residents receiving enteral nutrition and supplemental oxygen. **Monitoring** The Director of Nursing/Designee will bring the results of the audits to the monthly QA&A Committee for 3 months for review and recommendations. Date of compliance is September 29, 2013.	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN	F 282		

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F 282	Continued From page 3 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 follow the care plan for 1 of 8 sample residents (#5). During an observation on 8/12/13 at 7:05 PM, resident #5 had a tube feeding infusing via pump at 50 ccs per hour. Review of the physician's orders showed the resident was to receive 50 ccs per hour for 18 hours out of a 24 hour period. The 1000cc bottle was dated 8/11/13 and started at 11 PM (20 hours and 5 minutes from observation). However, the bottle had 850 ccs remaining. The August 2013 MAR showed the residuals were all zero for that time period. Interview with the risk manager on 8/12/13 at 9:10 PM confirmed this was a "spiked" bottle, and nothing could be added once started. Review of the nursing notes showed the resident's tube feeding was not held for any residuals since the bottle was hung. Review of the August 2013 MAR showed that, accounting for the tube feeding being held for dilantin (seizure medication) for the 8 AM and 12 Noon doses (Hold 1 hour before and 1 hour after =200 ccs), the resident should have received 800 ccs of tube feeding since the bottle was hung (650 ccs more than was administered). Review of the resident's care plan for enteral nutrition, last updated 7/16/13, showed the first approach as, "Tube feeding as ordered." During an interview with RN #1 on 8/12/13 at 8:40 PM she stated she had been working since 2 PM, and was unsure	F 282	F-282 **Corrective Action** Resident #5 received a new enteral nutrition bottle on 8/12/13 reflecting the appropriated date of administration. Resident #5's physician was contacted and notified of the medication variance on 8/12/13. **Identification of Others** A facility-wide audit will be conducted by the Director of Nursing/Designee on all residents receiving enteral nutrition to confirm the bottle is labeled appropriately and is being administered in accordance with the physician's order.	

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F 282	Continued From page 3 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 follow the care plan for 1 of 6 sample residents (#5). During an observation on 8/12/13 at 7:06 PM, resident #5 had a tube feeding infusing via pump at 50 ccs per hour. Review of the physician's orders showed the resident was to receive 60 ccs per hour for 18 hours out of a 24 hour period. The 1000cc bottle was dated 8/11/13 and started at 11 PM (20 hours and 6 minutes from observation). However, the bottle had 850 ccs remaining. The August 2013 MAR showed the residuals were all zero for that time period. Interview with the risk manager on 8/12/13 at 9:10 PM confirmed this was a "spiked" bottle, and nothing could be added once started. Review of the nursing notes showed the resident's tube feeding was not held for any residuals since the bottle was hung. Review of the August 2013 MAR showed that, accounting for the tube feeding being held for dilantin (seizure medication) for the 8 AM and 12 Noon doses (Hold 1 hour before and 1 hour after =200 ccs), the resident should have received 800 ccs of tube feeding since the bottle was hung (650 ccs more than was administered). Review of the resident's care plan for enteral nutrition, last updated 7/16/13, showed the first approach as, "Tube feeding as ordered." During an interview with RN #1 on 8/12/13 at 8:40 PM she stated she had been working since 2 PM, and was unsure	F 282	**Systemic Changes** The Staff Development Coordinator/Designee will educate licensed nurses addressing following physician orders and appropriately labeling the enteral nutrition bottle. The Director of Nursing/Designee will conduct random weekly audits times 4 weeks and monthly times 2 to confirm the enteral nutrition bottle is labeled appropriately and is being administered in accordance with the physician's order. **Monitoring** The Director of Nursing/Designee will bring the results of the audits to the monthly QA&A Committee for 3 months for review and recommendations. Date of compliance is September 29, 2013.	

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F 282	Continued From page 4 why only 150 ccs of the resident's tube feeding had been infused from 8/11/13 at 11 PM through 8/12/13 at 7:05 PM (20 hours and 5 minutes). She acknowledged the resident should have received more than 150 ccs of nutritional tube feeding at that time, but was unsure exactly how much the resident should have received.	F 282		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL 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 medical record review and staff interview, the facility failed to ensure that 1 of 4 residents (#9) who required interventions for a change in condition received adequate care. The findings were: Review of the medical record for resident #9 showed s/he had diagnoses which included vascular dementia, type II diabetes, and left Charcot joint ankle. Review of the resident's blood glucose monitoring documentation showed the residents highest recorded glucometer reading was 394 mg/dl (milligrams per deciliter), and the physician's orders were to contact him for over 400 mg/dl. Otherwise, treat using the	F 314	F-314 **Corrective Action** Resident #9 has been discharged from the facility on 07/25/13. **Identification of Others** A facility-wide audit will be conducted of all residents with orders for ace wraps or compression-type garments to determine if the physician's order contains frequency of removal. Skin will be inspected to determine if there is an alternation in skin integrity.	

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F 314	Continued From page 5 ordered sliding scale. The documentation showed this was followed by staff. Review of the 7/21/13 change of condition form at 10:15 PM faxed to the physician showed the resident's left foot was swollen, and had been discovered that day. Review of this form also showed the resident was confused, and had been started on an antibiotic on 7/20/13 for a urinary tract infection. Review of the physician's orders showed an order on 7/22/13 at 11 AM to obtain an x-ray with two views of the left ankle. Further physician order review showed a 7/23/13 order at 11:40 AM for an orthopedist consult that week, and an order to "wrap ankle in ace wrap." The following concerns were identified: a. The order did not specify frequency of removing the wrap to relieve pressure, and the facility failed to clarify the order to determine frequency of ace wrap removal. b. Review of the nursing notes showed the resident's left foot was first noticed as swollen on 7/21/13. Review of the nursing note on 7/23/13 at 1:34 PM showed the resident's left ankle was wrapped with an ace wrap. The notes on 7/23/13 at 1:46 PM, 7/23/13 at 10:50 PM, 7/24/13 at 2:45 AM, 7/24/13 at 10:45 AM, and 7/25/13 at 1:20 AM documented nursing assessments of the left foot. However, the documentation failed to show the wrap was removed to relieve pressure. c. The nursing note on 7/25/13 at 10:15 AM stated, "CNA notified me that the resident had a new blister to the top of her left foot." The documentation showed the ace wrap was removed at that time, and the resident had no feeling to the left foot. The physician was notified and the resident was sent to the local emergency room via ambulance. d. During an interview with the physician on 8/15/13 at 11:45 AM, he stated the probable	F 314	Systemic Changes The Staff Development Coordinator/Designee will provide education to nursing staff addressing the identification of high-risk residents for pressure ulcers, the types of appropriate interventions necessary to reduce the occurrence of pressure ulcers, and appropriate documentation which supports all interventions. Education will include the use of ace wraps and other compression garments and also include: the frequency of removal of the ace wraps or compression garments as stated in the physician's order, documentation of removal, and inspection of skin integrity after removal. The Director of Nursing/Designee will conduct weekly audits times 4 weeks and monthly times 2 to confirm physician's orders include frequency of removal of ace wraps or other compression garments, and physician orders are appropriately followed.	

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	535025	A. BUILDING _____ B. WING _____	C 08/15/2013

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F 314	Continued From page 6 cause of the blister to the top of the resident's left foot was the result of too much pressure from the ace wrap. According to Smith, Duell, and Martin in "Clinical Nursing Skills: Basic to Advanced Skills, "7th Edition, 2008: "Applying a Figure Eight Bandage" staff is required to "9. Assess extremity after 20 minutes and then every 2 to 4 hours, and rewrap every 8 hours."	F 314	**Monitoring** The Director of Nursing/Designee will bring the results of the audits to the monthly QA&A Committee for 3 months for review and recommendations. Date of compliance is September 29, 2013.	
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (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 (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based observation, medical record review, staff interview, and incident report review, the facility failed to provide adequate nutrition to 1 of 2 residents (#5) who required nutrition via a feeding tube. The findings were: Review of the medical record for resident #5 showed s/he had diagnoses which included schizophrenia, depressive disorder, dysphagia, and convulsions. Further review showed the	F 325		

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F 325	Continued From page 7 resident had a 9/19/12 physician's order for Jevity 1.2 Cal per percutaneous endoscopic gastrostomy (PEG tube) at 90 ccs per hour for 18 hours via pump to provide 1620 ccs in 24 hours and 1944 calories in 24 hours. Review of a 6/20/13 faxed communication to the physician showed facility staff requested comfort measures for the resident to include cessation of tube feedings. The following concerns were noted: a. Review of the 6/21/13 physician's written response showed the physician responded by ordering comfort care, and "may" have candy and pop. However, the tube feeding was not addressed. b. Review of the nursing notes and July 2013 MARs showed the facility stopped the resident's tube feeding on 6/21/13 after the physician's response to the comfort care request, and did not resume the tube feeding until 6/27/13, when the facility received an order from the physician to restart the resident's tube feeding. c. Review of a 7/2/13 physician's progress note showed, "order for comfort care misinterpreted." Review of the 6/27/13 physician orders showed the physician, when made aware the resident's tube feedings had been discontinued by staff without an order, ordered a restart to the residents feeding tube nutritional regimen with a graduated increase to ensure the resident received his/her adequate nutritional care needs. d. Review of a 6/29/13 physician's order showed a speech therapy evaluation was ordered for the resident, and oral intake was stopped at that time. Review of a 7/12/13 faxed communication to the physician from the speech therapist showed the resident was not safe for oral intake, and the physician continued the order for nothing by mouth.	F 325	**Identification of Others** A facility-wide audit will be conducted by the Director of Nursing/Designee on all residents receiving enteral nutrition to confirm the bottle is labeled appropriately and is being administered in accordance with the physician's order.	

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F 325	Continued From page 8 e. Review of an incident report concerning the resident's 6/21/13 tube feeding discontinuance, along with an interview with the DON and administrator on 8/15/13 at 2:05 PM, showed the nurse who requested comfort measures for the resident and subsequently stopped the resident's tube feeding, was fired and reported to the board of nursing. f. During an observation on 8/12/13 at 7:05 PM, the resident had tube feeding infusing via pump at 50 ccs per hour. The physician's order review showed the resident was to receive 50 ccs per hour for 18 hours out of 24 hours, as Dilantin (seizure medication) was to be given three times a day, and the tube feeding was to be held one hour before administration and one hour after administration. The 1000cc bottle was dated 8/11/13 and started at 11 PM (20 hours and 5 minutes from the observation). However, the bottle still contained 850 ccs. During an interview at that time, RN #1 stated the feedings were held for some medications, and for any residuals. She stated these were documented on the current MAR and nursing notes. The August 2013 MAR showed the residuals were all zero for that time period. Interview with the risk manager on 8/12/13 at 9:10 PM confirmed this was a "spiked" bottle, and nothing could be added once started. Review of the nursing notes showed the resident's tube feeding was not held for any residuals since the bottle was hung. Review of the August 2013 MAR showed that, accounting for the tube feeding being held for dilantin (seizure medication) for the 8 AM and 12 Noon doses (Hold 1 hour before and 1 hour after =200 ccs), the resident should have received 800 ccs of tube feeding since the bottle was hung (650 ccs less than required). During an interview with RN #1 on 8/12/13 at 8:40 she stated she had	F 325	**Systemic Changes** The Staff Development Coordinator/Designee will conduct training with licensed nurses addressing the reviewing, noting, and following of physician orders. The Staff Development Coordinator/Designee will educate licensed nurses addressing following physician orders and appropriately labeling the enteral nutrition bottle. The Director of Nursing/Designee will conduct random weekly audits times 4 weeks and monthly times 2 of physician orders to confirm orders are reviewed, noted, and appropriately followed with emphasis on residents receiving enteral nutrition. The Director of Nursing/Designee will conduct random weekly audits times 4 weeks and monthly times 2 to confirm the enteral nutrition bottle is labeled appropriately and is being administered in accordance with the physician's order.	

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Monitoring

The Director of Nursing/Designee will bring the results of the audits to the monthly QA&A Committee for 3 months for review and recommendations.

Date of compliance is September 29, 2013.

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F 325	Continued From page 9 been working since 2 PM, and was unsure why only 150 ccs had been infused. She confirmed the pump alarm had gone off several times during the shift. She had restarted the tube feeding, and was unsure why the pump alarm had gone off.	F 325		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure oxygen was delivered as ordered for 1 of 5 sample residents (#2) who required oxygen. The findings were: Review of the medical record for resident #2 showed s/he had diagnoses which included hypoxemia. Further review showed the resident had a 7/31/13 physician's order for oxygen to be delivered at 2 liters per minute via nasal cannula. Review of the daily nursing assessments from 7/31/13 admission through 8/12/13 showed the facility staff obtained daily oxygen saturation levels, the lowest being 88% on 8/6/13. On	F 328	F-328 **Corrective Action** Resident #2's oxygen tank was refilled and administered supplemental oxygen on 8/12/13.	

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F 328	Continued From page 10 8/12/13 at 6:57 PM, the resident was observed in his/her wheelchair with oxygen via nasal cannula. However, the resident's oxygen tank was empty. At that time, CNA #1 obtained the resident's oxygen saturation rate and it was 74% (normal oxygen saturation is 90% or above). During an interview at that time, CNA #1 confirmed the oxygen tank was empty when the resident had a 74% oxygen saturation reading.	F 328	**Systemic Changes** The Staff Development Coordinator/Designee will conduct training with all licensed nurses addressing the reviewing, noting, and following of physician orders. The Director of Nursing/Designee will educate nursing staff regarding the monitoring of oxygen delivery. The Director of Nursing/Designee will conduct random weekly audits times 4 weeks and monthly times 2 of physician orders to confirm orders are reviewed, noted, and appropriately followed with emphasis on residents receiving supplemental oxygen. **Monitoring** The Director of Nursing/Designee will bring the results of the audits to the monthly QA&A Committee for 3 months for review and recommendations. Date of compliance is September 29, 2013.	