6/1/05 JR

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

PRINTED: 05/17/2005
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 |
|---|---|---|---|
| | 535019 | A. BUILDING _____ B. WING _____ | 05/05/2005 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| BONNIE BLUEJACKET MEMORIAL NURSING HOME | 388 SOUTH US HWY 20 BASIN, WY 82410 |

| (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 |
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| F 278 SS=B | 483.20(g) - (h) RESIDENT ASSESSMENT<br><br>The assessment must accurately reflect the resident's status.<br><br>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.<br><br>A registered nurse must sign and certify that the assessment is completed.<br><br>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.<br><br>Under Medicare and Medicaid, an individual who willfully and knowingly--<br>Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or<br>Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment.<br><br>Clinical disagreement does not constitute a material and false statement.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, medical record review, and staff interview, the facility failed to assure accurate completion of the Minimum Data Set (MDS) assessments in various areas for 3 of 10 sample residents (#15, #20, #30) for whom the assessments were required. The findings were:<br><br>1. On 5/4/05 at 1:45 PM observation showed resident #15 ambulated approximately 50 feet | F 278 | This facility will ensure assessments accurately reflect the residents' status, is conducted or coordinated and signed by an RN and each professional completing a portion of the assessment<br><br>1) a) Resident # 15 will have a ROM assessment completed by DON<br>2) a) Resident #20 will have section R2b signed and dated.<br>3) a) Resident #30 will have section R2b signed and dated.<br><br>b) All MDS's ROM and voluntary movement areas will be reviewed for appropriateness.<br>All MDS date and signature areas will be reviewed and signed and dated as appropriate.<br><br>c) All MDS staff will be inserviced regarding appropriate coding and signature times frames using State deficiency results as inservice tool.<br><br>d) This will be monitored by Medical Records through quarterly QA Meeting. | 6/16/05<br><br>6/16/05<br>6/16/05<br>6/16/05<br><br>6/16/05<br><br>6/16/05<br><br>6/16/05 |

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

Jackie Claudson — Administrator — 5-27-05

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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WYOMING DEPT OF HEALTH
HEALTH FACILITIES

Accepted with Changes: Reviewed with Jackie Claudson on 6/1/05

JP 6/1/05

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| F 278 | Continued From page 1<br>with a gait belt, walker, and contact guard assistance from one staff member. The resident's knees remained bent and s/he leaned forward into the walker. Review of the 12/7/04 quarterly MDS assessment showed the resident had no limitations in range of motion (ROM) or voluntary movement. However, the resident showed a decline on the 3/1/05 annual MDS assessment with limitations in mobility and partial loss of voluntary movement in both legs. On 5/5/05 at 10:45 AM, interview with the director of nursing (DON), who was also the MDS coordinator, revealed she coded the 12/7/04 assessment inaccurately. The resident should have been coded as limited mobility with partial loss of voluntary movement in both legs.<br>2. Review of Section AA9 showed that the admission MDS assessment for resident #20 was completed on 5/4/05. However, Section R2b was not dated. Interview with the DON on 5/4/05 at 1:20 PM confirmed the R2b date was lacking. According to the December 2002, Centers for Medicare & Medicaid Services (CMS) Revised Long-Term Care Resident Assessment Instrument (RAI) User's Manual, Version 2.0, Section R2b is for the date the coordinator signed that the assessments were completed; completion of the date is required.<br><br>3. Review of the 4/5/05 MDS assessment for resident #30 revealed Section R2a was not signed. Interview with the DON 5/4/05 at 1:20 PM confirmed the section was not signed. According to the December 2002, Centers for Medicare & Medicaid Services (CMS) Revised Long-Term Care Resident Assessment Instrument (RAI) User's Manual, Version 2.0, Section R2a is for the signature of the person coordinating the MDS assessments, and | F 278 | | |

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| F 278 | Continued From page 2<br>completion of the signature is required.<br><br>2. Review of Section AA9 showed that the Minimum Data Set (MDS) admission assessments for resident #20 was completed on 5/4/05. However, Section R2b was not dated. Interview with the DON on 5/4/05 at 1:20 PM confirmed the R2b date was lacking.<br><br>3. Review of the 4/5/05 MDS assessments for resident #30 revealed the Section R2a was not signed. Interview with the DON 5/4/05 at 1:20 PM confirmed the R2B had not been signed. | F 278 | | |
| F 318 SS=E | 483.25(e)(2) QUALITY OF CARE<br><br>Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, medical record review, staff interviews, and review of facility policies, the facility failed to provide appropriate treatment and services to increase, or prevent further decreases in, range of motion (ROM) for three of three sample residents (#9, #15, #22) with limited ROM. The findings were:<br><br>1. Review of the 3/1/05 annual Minimum Data Set (MDS) assessment showed resident #15 had limited ROM in both legs with partial loss of voluntary movement. Review of the current Restorative Care Flow Record showed the | F 318 | This facility will ensure a resident with limited range of motion receives appropriate treatment and services to increase or prevent further decrease in range of motion.<br><br>1) Resident #15 will have formal documented restorative exercise plan implemented.<br><br>a) Plan for resident #15 will include ROM exercises to ankles and toes and complete ROM exercise through all Possible planes.<br><br>b) Plan for resident #15 will include appropriate positioning to best facilitate proper ROM of all joints and planes | 6/16/05<br><br>6/16/05<br><br>6/16/05 |

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| F 318 | Continued From page 3<br>resident was to ambulate with a walker and receive active assistive range of motion (AAROM) exercises to the lower extremities with 10 repetitions to each joint. However, review of the medical record showed it lacked a formal, documented restorative exercise plan. On 5/5/05 at 1:45 PM, observation showed the resident sat in a recliner after ambulating and performed 10 repetitions of non-resistive flexion and extension exercises to the bilateral hips and knees. In addition, the resident moved each foot sideways from the knee approximately 18 inches and then back to the center 10 times. The restorative aide (RA, employee #19) supervised but did not assist. The following concerns were identified:<br>a. The resident did not perform ROM exercises to the ankles and toes, or complete ROM exercises through all possible planes for each joint. The RA did not instruct the resident to complete the exercises in the additional planes and joints.<br>b. The RA did not encourage the resident to attempt the exercises in any other position than in the recliner. Nor did the RA apply any resistance to the resident's legs or instruct the resident to completely lift his/her legs off the recliner seat.<br>c. Interview with the RA during the observation revealed she considered moving the resident's foot sideways and back to the center was abduction and adduction of the hip. However, the resident only moved his/her legs from the knees down, not from the hips.<br>d. No documented restorative exercise plan was found with the medical record. By reviewing hospital records, the director of nursing (DON) found an undated Restorative Care Flow Record in the physical therapy (PT) records which instructed staff to ambulate the resident with a front wheeled walker and provide upper and lower | F 318 | c) Plan for resident #15 will include hip ROM in all planes.<br><br>d) Plan for resident #15 will be re-evaluated by restorative nurse and PT. New plan for ROM and ambulation will be implemented and followed through RA program.<br><br>2) Resident #22 will have complete restorative nursing assessment done to include PT review and involvement. New plan for ROM exercises, including Appropriate joints and planes will be implemented.<br><br>3) Resident # 9 will have complete restorative nursing assessment done to include PT review and involvement. New plan for ROM exercises, including Appropriate joints and planes will be implemented.<br><br>4) Facilities policy will be reviewed and rewritten to include all appropriate disciplines recommendations and ROM definition. Word of mouth planning will be formulated and carried through with appropriate documentation.<br><br>New facility restorative policy will Be developed. Policy will include ROM definitions, appropriate identification of restorative need, | 6/16/05<br><br>6/16/05<br><br>6/16/05<br><br>6/16/05<br><br>6/16/05<br><br>6/16/05 |

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| F 318 | Continued From page 4<br>extremity resistive exercise three to five times per week. The exercises which were performed did not follow the instructions.<br><br>2. Review of the 3/22/05 MDS assessment revealed resident #22 had limited movement on both sides of the neck and in both arms, hands, legs, and feet with partial loss of voluntary movement in each joint. According to the 3/31/05 care plan, staff were to provide "ROM per CNA [certified nurse aide] every time prior to getting out of bed." However, review of the original Restorative Care Flow Record devised by PT and dated June 2003 showed staff were to provide "passive ROM to entire" upper and lower extremities. Review of the therapist's and physician's current orders showed ROM was not addressed. On 5/3/05 at 7:25 AM, observation showed two CNAs assisted the resident out of bed after completing passive flexion and extension exercises to the knees and elbows. The CNAs performed the exercises in a rapid and jerky manner, but neither CNA stretched the resident's joints nor exercised all joints.<br>Interview with the administrator and director of nursing on 5/5/05 at 9 AM revealed the instructions on the care plan were incorrect and should be for flexion and extension of the elbows and knees. No therapy orders for the exercises which were completed were found in the medical record nor in the restorative documentation. However, the DON found the July 2003 Restorative Care Flow Record in the PT records. That revised program was for "passive stretching to elbows & knees to allow for dressing."<br>The June 2003 and July 2003 Restorative Care Flow Records did not agree and lacked documentation explaining the differences, there was no plan which specified the current program | F 318 | 4) continued<br>interdisciplinary review, PT and restorative nurse evaluation and recommendations. All CNA staff will be inserviced regarding proper ROM techniques. Restorative Aide will demonstrate appropriate ROM techniques to include all planes. All residents identified by MDS to exhibit limited ROM will have complete restorative nursing assessment done to include PT recommendations. New plan for restorative interventions will be implemented.<br><br>This will be monitored by DON through Quality Assurance reporting monthly times three. Then quarterly reporting. | 6/16/05<br><br>6/16/06 |

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| F 318 | Continued From page 5<br>of exercises, and the actual exercises which were completed by staff did not match any previous instructions.<br><br>3. Review of the 8/31/04 annual Minimum Data Set (MDS) assessment showed resident #9 had limited ROM in both arms, hands and legs with partial loss of voluntary movement. Review of the April 2005 Restorative Care Flow Records showed the resident was to receive active or active assistive range of motion (AROM/AAROM) exercises to the shoulders, hands and fingers with 10 repetitions to each joint. That plan was discontinued on 4/13/05 and passive range of motion (PROM) to the shoulders, hands and fingers with 10 repetitions to each joint was initiated. However, no orders to change the type of restorative exercise program were found with the medical record. By reviewing purged records, the director of nursing (DON) found a July 2004 restorative program in the PT records which instructed staff to provide AROM to all extremities. In addition, staff were to provide resistive exercises to the upper and lower extremities.<br>Observation on 5/3/05 at 1:12 PM showed RA #19 assisted resident #9 with ROM exercises consisting of 10 repetitions each of flexion and extension to the bilateral shoulders, elbows, wrists, and fingers. The resident did not move the upper extremity joints through any other planes, and the RA did not provide any instructions related to further exercises for ROM. Neither documented exercise program was followed.<br><br>4. Review of the facility's 3/6/04 policy, "Restorative Nursing Program," revealed restorative care would be provided for each resident "according to their needs." Further | F 318 | | |

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| F 318 | Continued From page 6<br>review of the policy revealed the restorative program "will be initiated per therapist's recommendations" if the resident was working with a therapist. Additionally, the policy lacked the definition of ROM. However, interview with the administrator and director of nursing on 5/5/05 at 9 AM revealed ROM exercises consisted of working all joints through all planes each joint could do, unless it had been determined it was unsafe to move the joint through a specific plane. During the interview, the DON stated a lot of decisions were made by "word of mouth" and were not documented in a formalized manner. Furthermore, the administrator stated she previously identified problems following the flow of restorative care from PT, to restorative, to the CNAs, but solutions to the problems had not yet been developed.<br><br>3. Review of the 8/31/04 annual Minimum Data Set (MDS) assessment showed resident #9 had limited ROM in both arms, hands and legs with partial loss of voluntary movement. Review of the April and May 2005 restorative care plan showed the resident was to receive active or active assistive range of motion (AROM/AAROM) exercises to the shoulders, hands and fingers with 10 repetitions to each joint.<br><br>That care plan was discontinued on 4/13/05 and passive range of motion (PROM) to the shoulders, hands and fingers with10 repetitions to each joint was initiated. However, no orders to change the type of restorative exercise program were found with the medical record. By reviewing purged records, the director of nursing (DON) found a July 2004 restorative program dated July 2004 in the physical therapy (PT) records which instructed staff to provide AROM to all | F 318 | | |

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| F 318 | Continued From page 7<br>extremities. In addition, staff were to provide resistive exercises to the upper and lower extremities.<br><br>Observation on 5/3/05 at 1:12 PM showed RA #19 assisted resident #9 with ROM exercises consisting of 10 repetitions each of flexion and extension to the bilateral shoulders, elbows, wrists, and fingers. The resident did not move the upper extremity joints through any other planes, and the RA did not provide any instructions related to further exercises for ROM. Neither exercise program was followed. | F 318 | | |
| F 432 SS=D | 483.60(e) PHARMACY SERVICES<br><br>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls and permit only authorized personnel to have access to the keys.<br><br>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interviews, and review of a pharmacist's information, the facility failed to assure medications which required refrigeration were stored at proper temperatures. | F 432 | This Facility will store all drugs and biologicals in locked compartments under proper temperature controls. 3 vials of Pneumovax, 4 vials of Lantus → insulin, 1 vial of Influenza vaccine & 2 vials of PPD. All medications currently in refrigerator will be destroyed. 6/16/05<br><br>Thermometer will be purchased and placed in refrigerator. Temperature log will be placed in medication room temperatures will be logged each shift by LN's. 6/16/05<br><br>This will be monitored by DON through quarterly Quality Assurance reporting. 6/16/05 | |

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| F 432 | Continued From page 8<br>The findings were:<br><br>Observation on 5/4/05 at 9:20 AM revealed the refrigerator in the medication room lacked a thermometer and felt warm. On 5/4/05 at 11:20 AM, registered nurse (RN) #7 and the director of nursing (DON) confirmed the refrigerator lacked a thermometer. In addition, neither nurse could state how long the thermometer had been missing or find the daily temperature log. The RN stated, and demonstrated, that the door of the refrigerator must be shut firmly or it did not stay closed. The refrigerator contained medications including 3 vials of Pneumovax, 4 vials of Lantus insulin (3 unopened, 1 opened), 1 opened vial of Influenza vaccine, and 2 vials of Purified Protein Derivative (PPD) for tuberculin skin testing. Review of the instructions on each box showed all but the influenza vaccine should be stored at temperatures ranging from 36 degrees Fahrenheit (F) to 46 degrees F; influenza vaccine should be stored at temperatures ranging from 35 degrees F to 46 degrees F.<br>On 5/4/05 at 12:55 PM the DON stated the temperature log for May 2005 was not put out for staff to use. The last documented temperature reading for the refrigerator was April 30, 2005. The DON also stated the refrigerator door must be closed firmly to assure it was actually shut.<br>Review of research provided by the pharmacist showed there was no available information on PPD related to the length of time it could be stored outside the correct temperature range before it deteriorated. The note also documented that influenza vaccine kept outside the temperature range was "OK up to 72 hours as long as [it was] unopened." | F 432 | | |
| F 454 | 483.70 PHYSICAL ENVIRONMENT | F 454 | | |

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| F 454 SS=F | Continued From page 9<br><br>The facility must be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel and the public.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to ensure the building's electrical system was maintained in a safe manner. The findings were:<br><br>Observation on 5/4/05 at 8:14 AM revealed 11 electrical outlets were not ground fault interrupt (GFI) outlets. According to the NFPA 70 National Electrical Code 1999 Edition, Article 210-Branch Circuits, Section 210-8 (a) and Article 517-Health Care Facilities, Section 517-20, wet locations, all outlets within 6 feet of the outside edge of a wet bar sink are to have ground-fault circuit-interrupter protection. Outlet locations were as follows:<br>a. One single outlet over the sink in the beauty shop.<br>b. One single outlet in the bathroom next to the resident "Bathing Room". An electric shaver was plugged into this outlet and sitting on a shelf next to the sink.<br>c. Two single outlets over the counter within six feet of the sink in the "Clean utility" room. Plugged into one of these outlets was an AC adaptor.<br>d. Two outlets - a single and a double - over the counter within six feet of the sink in the "Dirty (soiled)" utility room.<br>e. One single outlet over the sink next to the nurses' station.<br>f. One single outlet over the sink in the medication room next to the nurses' station. This | F 454 | 1) This facility will be designed, constructed, equipped and maintained to protect the health and safety of residents, personnel and public.<br><br>2) a) Single outlet over sink in beauty shop will be replaced with GFI outlet.<br><br>b) Single outlet in bathroom next to resident "bathing room" will be replaced with GFI outlet. Electric shaver will be removed.<br><br>c) Two single outlets over the counter in "clean utility" room will be replaced with GFI outlets. AC adapter will be removed.<br><br>d) Single outlet and double outlet over the counter in "dirty utility" room will be replaced with GFI outlets.<br><br>e) Single outlet over the sink next to the nurses station will be replaced with GFI outlet.<br><br>f) Single outlet over the sink in the medication room will be replaced with a GFI outlet.<br><br>g) Single outlet over each sink in the Men's and Woman's public bathrooms next to the entrance will be replaced with a GFI outlet. | 6/16/05<br><br>6/16/05<br><br>6/16/05<br><br>6/16/05<br><br>6/16/05<br><br>6/16/05<br><br>6/16/05<br><br>6/16/05 |

SR 6/1/05

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

PRINTED: 05/17/2005
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 |
|---|---|---|---|
| | 535019 | A. BUILDING _____ B. WING _____ | 05/05/2005 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BONNIE BLUEJACKET MEMORIAL NURSING HOME | 388 SOUTH US HWY 20 BASIN, WY 82410 |

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| F 454 | Continued From page 10<br>outlet was also an emergency generator outlet (red covering).<br>g. One single outlet over each sink in the men's and women's public restrooms next to the facility entrance.<br>h. One "six receptacle" outlet over the counter within six feet of the sink in the serving kitchen. Plugged into this outlet was the ice making machine.<br>i. One outlet in the facility laundry room behind the washing machine contained both a standard 120 volt (V) and a 220V dryer outlet. The clothes dryer was plugged into the 220V outlet.<br>Interview with the facility maintenance supervisor on 5/4/05 at 10:00 AM and the facility administrator on 5/5/05 at 11:30 AM revealed they were not aware the outlets were not GFI. | F 454 | h) The "six receptacle" outlet located in the serving kitchen will be replaced with a GFI outlet.<br><br>i) The outlet in the facility laundry room will be replaced with a GFI outlet.<br><br>3) Facility will be checked for outlets within six feet of a water source without GFI protection. All outlets identified will be replaced with GFI outlets.<br><br>4) This will be monitored by Safety officer through annual Quality assurance reporting. | 6/16/05<br><br>6/16/05<br><br>6/16/05 |
| F 466 SS=E | 483.70(h)(1) PHYSICAL ENVIRONMENT<br><br>The facility must establish procedures to ensure that water is available to essential areas when there is a loss of normal water supply.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview, review of facility records, and review of policies and procedures, the facility failed to maintain the emergency water storage system in proper working order. The findings were:<br><br>Review of the facility's 12/1/99 policy, "Emergency Water Supply" revealed the cistern would be flushed "semi-annually". However, review of the maintenance records on 5/4/05 at 9:45 AM revealed the concrete emergency water storage | F 466 | This facility will ensure that water is available to essential areas when there is a loss of normal water supply.<br><br>1) Maintenance staff will flush the cistern now and semi-annual<br><br>2) Maintenance will review "Emergency Water Supply" policy and set-up a schedule accordingly.<br><br>3) This will be monitored by Safety officer through annual quality assurance reporting. | ~~5/20/05~~ |

PRINTED: 06/17/2005
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|---|---|---|---|
| | 535019 | A. BUILDING _____ B. WING _____ | 05/05/2005 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BONNIE BLUEJACKET MEMORIAL NURSING HOME | 388 SOUTH US HWY 20 BASIN, WY 82410 |

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| F 466 | Continued From page 11<br>cistern was last flushed in February 2002. On 5/4/05 at 9:46 AM, the maintenance supervisor stated he was unaware of the policy. Interview with the administrator on 5/4/05 at 5:50 PM confirmed the cistern should be flushed semi-annually. | F 466 | | |