STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING _____ B. WING _____	09/22/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANYON HILLS MANOR	1210 CANYON HILLS ROAD THERMOPOLIS, WY 82443

(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 253 SS=D	483.15(h)(2) HOUSEKEEPING/MAINTENANCE The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, review of posted directions, and review of the manufacturer's instructions, the facility failed to assure staff provided proper sanitation of shower surfaces during one of one shower cleaning. The findings were: Observation on 9/20/05 at 9:45 AM showed certified nurse aide (CNA) #15 sprayed the shower walls, floor, and chair on E hall with "U-1" disinfectant then immediately scrubbed and simultaneously rinsed all surfaces. According to the posted instructions for cleaning the shower, "U-1" disinfectant was to remain in contact with all surfaces for 10 minutes before being rinsed off. Interview with the CNA during the observation confirmed the instructions were current. Review of the manufacturer's instructions for "U-1" disinfectant revealed the solution needed to remain in contact with the surfaces for 10 minutes before disinfection occurred. Interview with the director of nursing on 9/22/05 at 8:15 AM revealed approximately 10 residents were bathed in that shower.	F 253	**Preparation and execution of the response and plan of correction does not constitute an admission of or 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 it is required by the provisions of federal and state law. For the purpose of any allegation that the facility is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 7305 of the State's Operation Manual** **F 253** It is the practice of the facility to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable interior. The C.N.A involved was in serviced by the Director of Nurses on 9/22/05. The training included the facility policy and procedure for cleaning the shower with emphasis on following the manufacturer's instructions for the solution contact time with all surfaces. On 9/22/05, the Director of Nurses in serviced the nursing staff on the shower & tub cleaning policy and procedure. The policy and procedure for cleaning the shower and tub is posted in the bathing areas.	
F 281 SS=D	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must meet professional standards of quality.	F 281		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Daniel L Rodriguez — TITLE: ADM — (X6) DATE: 10/17/05

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.

This POC accepted & all changes & corrections on 10/24/05 ds

0925 per phone conversation w/ Daniel Rodriguez, adm
& Betsy Nelson RN State Health Surveyor

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F 281	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, staff and resident interviews, and review of policies and procedures, the facility failed to assure professional standards of practice related to medication administration were followed. Staff failed to clarify physicians' orders for two of eight residents (#18, #28). The findings were: 1. Observation on 9/19/05 at 4:55 PM showed licensed practical nurse #28 administered Vytorin to resident #28. Reconciliation of the medication with the 8/4/05 recapitulation (Recap) of orders showed the physician's order was for the medication to be administered at bedtime. At 9:20 AM on 9/19/05 the director of nursing (DON) stated the resident wanted the medication given at supper, and on 9/20/05 at 2 PM the resident confirmed that statement. However, staff failed to notify the physician of the resident's preference and clarify the time the physician wanted the medication administered. According to the 2004 sixth edition of "Clinical Nursing Skills Basic to Advanced Skills," by Smith, Duell, and Martin, "If a written order is ... questionable for any reason, the physician must be notified for clarification." 2. Observation on 9/20/05 at 8:28 AM showed registered nurse (RN) #31 prepared and administered one teaspoonful of Genfiber (powdered, generic laxative) to resident #18. Reconciliation of the medication with the 9/4/05 Recap of orders showed the physician ordered "Tsp 1 q AM [every morning]." Interview with the DON on 9/20/05 at 9:30 AM revealed she read	F 281	F 253 cont. All new nursing employees will be oriented to the policy and procedure of cleaning the shower and tub with emphasis on following the manufacturer's instructions for the solution contact time with all surfaces. The charge nurses will monitor compliance by observing the solution contact time for disinfecting surfaces in the bathing and shower areas weekly for a month and monthly thereafter. 1:1 training or counseling will be provided as indicated. The Director of Nurses or designee will discuss results of audits with corrective action taken with the Quality Assurance and Assessment at least quarterly. **COMPLETION DATE: 10/21/2005** **F 281** It is the practice of the facility to provide or arrange services that meet professional standards of quality. The charge nurse clarified the time for administering Vytorin with resident #28's physician. The charge nurse clarified the dose of Genfiber with resident #18's physician. All orders were reviewed to assure there were no other orders that required clarification. Corrective action will be taken as indicated.	

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F 281	Continued From page 2 the order as one tablespoonful. At 9:33 AM the RN who administered the medication stated she interpreted the order as one teaspoonful. However, no one had contacted the physician for clarification of the order. According to the 2004 sixth edition of "Clinical Nursing Skills Basic to Advanced Skills," by Smith, Duell, and Martin, "If a written order is ... questionable for any reason, the physician must be notified for clarification." 3. Review of the facility's undated policy and procedure, "Nursing Procedures 507 Physicians' Orders," revealed clarification of questionable orders was not addressed. However, interview with the corporate nurse consultant on 9/21/05 at 4:23 PM revealed part of a nurse's duties was to obtain clear orders and clarify if necessary.	F 281	On 9/22/05, the Director of Nurses inserviced the nurses on the policy of contacting the physician for clarification of any questionable order. The Director of Nurses or designee will monitor compliance weekly for one month and monthly thereafter. Any trends with corrective action will be discussed at the monthly Quality Assurance and Assessment Committee meeting. **COMPLETION DATE: 10/21/2005**	
F 282 SS=E	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 and family interview, the facility failed to provide care in accordance with the written plan of care for seven of nine sample residents (#13, #15, #16, #17, #24, #34, #35). The findings were: 1. The following problems were identified regarding the facility's failure to provide	F 282		

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F 282	Continued From page 3 restorative services in accordance with the plan of care: a. According to the 9/1/05 care plan, resident #13 received restorative services three to six times per week. However, review of the September 2005 restorative daily documentation revealed the resident did not receive any services from September 6th through September 12th (7 days). b. Review of the 9/15/05 care plan showed resident #15 received restorative services three to six times per week. However, review of the September 2005 restorative daily documentation revealed the resident did not receive any services from September 6th through September 12th (7 days). c. Review of the 7/7/05 care plan revealed resident #17 received restorative services three to five times per week. However, review of the September 2005 restorative daily documentation revealed the resident did not receive any services from September 6th through September 12th (7 days). d. According to the 8/19/05 care plan, resident #24 received restorative services three to six times per week. However, review of the September 2005 restorative daily documentation revealed the resident did not receive any services from September 6th through September 12th (7 days). During an interview on 9/22/05 at noon, a family member stated the resident did not receive exercises like he/she was supposed to. e. Review of the 8/18/05 care plan showed resident #34 received a functional maintenance program (FMP) three to six times per week. However, review of the September 2005 restorative daily documentation revealed the resident did not receive any services from September 6th through September 12th (7 days).	F 282	**F 282** It is the practice of the facility to provide or arrange services that are provided by qualified persons in accordance with each resident's written plan of care. The nurses on the unit will be responsible for assuring the restorative programs are provided as ordered. The restorative nursing assistant (RNA) has reviewed the restorative program of resident #13, #15, #17, #24, #34, & #35 with the Director of Nurses, MDS coordinator, and charge nurses in order that the programs can be provided in the absence of the designated restorative nursing assistant. Resident #16 expired.	

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F 282	Continued From page 4 f. According to the 9/15/05 care plan, resident #35 received restorative services three to five times per week. However, review of the September 2005 restorative daily documentation revealed the resident did not receive any services from September 6th through September 12th (7 days). During an interview on 9/21/05 at 8:25 AM, the restorative aide confirmed residents did not receive restorative services September 6th through the 12th. The restorative aide stated she did not work those days, and no staff took over her duties. On 9/21/05 at 2:15 PM the director of nursing (DON) stated restorative services were not provided September 6th through the 12th because the restorative aide did not work those days and the facility was short staffed. The DON stated she did not have any available staff who could take over the restorative duties. 2. Observation on 9/20/05 at 8 AM showed resident #16 wore knee high TED hose (compression stockings). Review of the 11/18/04 annual Minimum Data Set (MDS) assessment showed the resident had severe cognitive impairment and was admitted with diagnoses including deep vein thrombosis. According to the 7/28/05 care plan and the 8/8/05 physician's orders, the resident was to wear thigh high TED hose during the day. Interview with registered nurse (RN) #32 on 9/21/05 at 1:45 PM confirmed the order and care plan were current and the resident was supposed to wear thigh high TED hose.	F 282	The Director of Nurses, MDS coordinator, and restorative nursing assistant have reviewed all current restorative programs. Their care plans have been reviewed and updated as indicated to reflect the resident's current restorative program. The nurses have identified all residents with orders for compression stockings. The resident's care plan and C.N.A. assignment record were reviewed to ensure the TED hose order was current. Corrective action will be taken as needed. On 10/21/2005, the restorative nursing assistant inserviced the nurses and CNAs on the restorative program. On 10/21/2005, the nursing staff was inserviced on the TED hose policy with emphasis on making sure the resident is wearing the TED hose as ordered. This in-service was completed by the Director of Nurses The Director of Nurses or designee will monitor compliance weekly for a month, and monthly thereafter. Results of audits with corrective action will be discussed at the least quarterly at the Quality Assurance and Assessment committee. **COMPLETION DATE: 10/21/2005**	
F 311 SS=E	483.25(a)(2) ACTIVITIES OF DAILY LIVING A resident is given the appropriate treatment and	F 311		

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F 311	Continued From page 5 services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview and family interview, the facility failed to assure restorative nursing services were provided for six of six sample residents (#13, #15, #17, #24, #34, #35) and ten non-sample residents (#5, #14, #20, #23, #25, #28, #30, #31, #36, #39) who required restorative services. The findings were: 1. According to the 9/1/05 care plan, resident #13 received restorative services three to six times per week. Review of the 8/11/05 restorative referral showed an exercise program was to be done with the resident three to six times per week. However, review of the September 2005 restorative daily documentation revealed the resident did not receive any services from September 6th through September 12th (7 days). 2. Observation on 9/19/05 at 4:30 PM and on 9/20/05 at 11:05 AM and 11:30 AM showed staff did not assist resident #15 to ambulate to and from the bathroom or to meals. However, the observation on 9/19/05 showed the resident was able to stand by holding onto the grab bars in the bathroom. Review of the 3/2/05 annual MDS assessment and the May 2005 nursing notes showed the resident was able to ambulate independently until s/he sustained a fall with a fracture on 5/31/05. According to the 7/29/05 therapy notes, the resident was referred to the maintenance restorative nursing program [provided by the CNAs] for ambulation three to	F 311		

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four times a day or more with a front wheeled walker and staff assistance. Review of the maintenance documentation showed the resident was to walk to and from meals and to the bathroom..

According to the September 2005 maintenance restorative nursing documentation, staff assisted the resident with ambulation on two days and the resident refused on four days. The remainder of the documentation through 9/21/05 was blank. Interview with certified nurse aide (CNA) #23 on 9/21/05 at 3:20 PM revealed she thought the program was discontinued. However, during the same interview, CNA #25 stated the resident was not assisted to ambulate even though s/he could stand. Interview with the RNA on 9/21/05 at 3:21 PM revealed the maintenance program had not been discontinued.

Review of the 9/15/05 care plan showed the resident received restorative services [provided by the restorative nurse aide] three to six times per week. Review of the updated restorative referral (dated 6/16/05, 7/29/05 and 8/2/05) showed the resident was to receive the following services three to six times per week: pendulum exercises to the left upper extremity, ambulation, and hamstring stretches. However, review of the September 2005 restorative daily documentation revealed the resident did not receive any services from September 6th through September 12th (7 days).

3. Observation on 9/19/05 at 3:20 PM revealed resident #17 seated in a wheelchair with his/her feet rotated inward at the ankles. Review of the 10/28/04 annual Minimum Data Set (MDS) assessment showed the resident had severe cognitive impairment and bilateral contractures of the ankles. According to the 7/7/05 quarterly MDS

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assessment, the resident had limitations on both sides of the body with full loss of voluntary movement in all areas.

Review of the 7/7/05 care plan revealed the resident received restorative services [provided by the restorative nurse aide] three to five times per week. The September 2005 restorative daily documentation showed the resident was to receive upper extremity range of motion and range of motion to the feet. However, review of the September 2005 restorative daily documentation revealed the resident did not receive any services from September 6th through September 12th (7 days).

Review of the September 2005 maintenance restorative nursing documentation showed range of motion (ROM) exercises to the resident's feet were discontinued on 9/1/05 "until trained by the RNA [restorative nurse aide]." Further review showed the program had previously been performed by the night nursing staff. Interview with the RNA on 9/21/05 at 3:15 PM confirmed the night staff were to perform the maintenance exercises for the resident's feet, but the exercises had not been provided since 9/1/05. The RNA stated the program was discontinued when the facility did not have regular staff working the night shift. The RNA further stated there were now regular staff on the night shift, but the training program had not been completed as she and the director of nursing "forgot" about it.

4. Review of the 7/28/05 significant change MDS assessment revealed resident #24 required limited assistance with activities of daily living (ADLs). According to the 8/19/05 care plan, the resident received restorative services three to six times per week. Review of the 8/2/05 and 8/3/05 restorative referrals showed the resident was

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F 311	Continued From page 8 supposed to have exercises and ADL training three to six times per week. However, review of the September 2005 restorative daily documentation revealed the resident did not receive any services from September 6th through September 12th (7 days). During an interview on 9/22/05 at noon, a family member stated the resident did not receive exercises like he/she was supposed to. 5. Review of the 8/18/05 care plan showed resident #34 received a functional maintenance program (FMP) three to six times per week. Review of the 6/29/05 and 7/29/05 restorative referrals showed the resident was supposed to receive upper and lower extremity exercises and ambulation three to six times per week. However, review of the September 2005 restorative daily documentation revealed the resident did not receive any services from September 6th through September 12th (7 days). 6. Review of the 9/15/05 quarterly MDS assessment revealed resident #35 required extensive assistance with transfers. In addition, the resident had range of motion limitations to both arms, hands, legs, and feet. According to the 9/15/05 care plan, the resident received restorative services three to five times per week. Review of the 1/17/05 and 7/29/05 restorative referrals showed the resident was supposed to receive exercises and transfer training three to five times per week. However, review of the September 2005 restorative daily documentation revealed the resident did not receive any services from September 6th through September 12th (7 days). 7. Review of the September 2005 restorative daily	F 311	**F 311** It is the practice of the facility that the resident is provided the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a) (1) of this paragraph. On 9/22/05, the Director of Nurses discussed with the nursing staff the necessity of providing the restorative program as ordered. On 10/21/2005, the Director of Nurses instructed the nurses on their responsibility for making sure the restorative programs are provided as care planned. The restorative nursing assistant has instructed the nurses and CNAs on the restorative program of resident #13, #15, #17, #24, #34, #35, #14, #20, #23, #25, #28, #30, #31, & #39. Resident #5 has been discharged. Resident #36 expired. The Director of Nurses, MDS coordinator, and restorative nursing assistant have reviewed the current restorative programs and updated the resident's care plan as needed.	

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F 311	Continued From page 9 documentation book revealed the following non-sample residents also did not receive restorative services September 6th through September 12th: #28, #25, #14, #31, #5, #20, #39, #30, #36, #23). 8. During an interview on 9/21/05 at 8:25 AM, the restorative aide confirmed residents did not receive restorative services September 6th through the 12th. The restorative aide stated she did not work those days, and no staff took over her duties. On 9/21/05 at 2:15 PM the director of nursing (DON) stated restorative services were not provided September 6th through the 12th because the restorative aide did not work those days and the facility was short staffed. The DON stated she did not have any staff who could take over the restorative duties.	F 311	On 10/21/2005, the restorative nursing assistant instructed the nurses and CNAs on the current restorative programs. The Director of Nurses or designee will monitor compliance in providing the restorative program weekly for a month and monthly thereafter. Any concerns with corrective action with the discussed monthly at the Quality Assurance and Assessment committee meeting. **COMPLETION DATE: 10/21/2005**	
F 312 SS=E	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; resident, family, and staff interviews; and review of medical records, policies and procedures, and resident council minutes, the facility failed to assure that six of eight sample residents (#15, #17, #24, #34, #35, #37) who were dependent on staff for bathing received baths as scheduled. In addition, staff failed to provide appropriate incontinence (perineal) care for two of four incontinent	F 312		

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F 312	Continued From page 10 residents (#14, #15) who required staff assistance. The findings were: BATHING: 1. Review of the 6/7/05 resident council meeting minutes revealed residents stated they were not getting their baths twice per week. On 9/20/05 at 8:30 AM, employee #21 stated there was not enough staff, so baths did not always get done. During an interview on 9/20/05 at 10:20 AM, employee #9 stated bathing did not get done because the facility was short of staff. On 9/21/05 at 2:15 PM, the director of nursing stated baths were documented on the monthly bathing sheets. The DON stated if the bath was not documented, there was no way to know if the resident received the bath or not. 2. Review of the 9/15/05 quarterly Minimum Data Set (MDS) assessment showed resident #35 required extensive staff assistance for bathing. According to the bathing schedule, the resident was scheduled for baths twice per week, on Wednesday and Saturday. Review of the September 2005 bathing documentation showed the resident did not get his scheduled bath/shower on 9/7/05, therefore he was not bathed twice that week. On 9/19/05 at 7:50 PM, a family member stated the resident did not get baths twice a week like he/she was supposed to. 3. Review of the 8/4/05 quarterly MDS assessment revealed resident #37 required extensive staff assistance for bathing. According to the bathing schedule, the resident was scheduled for baths twice per week, on Tuesday and Friday. Review of the September 2005 bathing documentation showed the last	F 312		

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F 312	Continued From page 11 documented bath/shower was on 9/6/05. Review of the August 2005 bathing documentation showed the resident did not get his/her scheduled bath on 8/16/05. The last documented bath in August for this resident was on 8/19/05. 4. Review of the 7/28/05 significant change MDS assessment showed resident #24 required extensive staff assistance for bathing. According to the bathing schedule, the resident was scheduled for baths twice per week, on Wednesday and Saturday. Review of the September 2005 bathing documentation showed the resident had a bath on 9/10/05, but the next bath was not until 9/17/05. Review of the August 2005 bathing documentation showed the resident did not have his/her scheduled bath on 8/10/05. In addition, the resident had a bath on 8/13/05, but the next bath was not until 8/24/05. During an interview on 9/22/05 at noon, a family member stated the resident did not get baths like he/she was supposed to. 5. According to the 7/7/05 quarterly MDS assessment, resident #17 had severe cognitive impairment and was totally dependent on staff for bathing. Review of the 7/7/05 care plan showed staff were to assist the resident with personal hygiene every day and a bath was scheduled every other night. However, according to the documentation, the resident only received a bath on the 2nd, 6th, 11th, 13th, 15th, and 19th of September 2005. 6. Review of the 8/18/05 significant change MDS assessment showed resident #34 was alert and oriented but required physical assistance from staff with bathing. Review of the 6/17/05 care plan showed the resident was to receive showers	F 312		

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F 312	Continued From page 12 twice a week. According to the documentation, the resident received showers on the 3rd, 6th, 10th, and 16th of September 2005; the resident refused a shower on 9/19/05. Interview with the resident on 9/22/05 at 8:45 AM confirmed his/her bath was missed during the week of 9/11/05 - 9/17/05. 7. According to the 9/15/05 quarterly Minimum Data Set (MDS) assessment, sample resident #15 had moderate cognitive impairment (poor decisions, required cues and supervision), and required physical assistance from staff with bathing. Review of the 6/29/05 care plan showed staff were to assist the resident with a weekly bath or shower as needed. Review of the bathing schedule showed staff were to assist the resident with showers twice a week, but the only documented showers or baths during the month of September 2005 were on 9/16/05 and 9/20/05. PERINEAL CARE: 1. According to the 9/15/05 quarterly Minimum Data Set (MDS) assessment, sample resident #15 had moderate cognitive impairment (poor decisions, required cues and supervision) and was incontinent of urine daily. Observation on 9/19/05 at 4:30 PM showed certified nurse aide (CNA) #25 assisted the resident to the toilet. The resident's incontinence brief was saturated, there was a strong smell of urine, and the resident's clothing was wet. The CNA stated the resident "was pretty soaked." However, when providing perineal care, the CNA cleansed the resident's buttocks but failed to cleanse the penis, scrotum, and anterior groin which were also in contact with urine. According to the facility's undated policy and procedure #119 -14, "Providing Perineal Care," perineal care	F 312	**F 312** It is the practice of the facility to provide the resident who is unable to carry out activities of daily living with the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Resident #15, #17, #24, #34, #35, & #37 are scheduled for at least two baths or showers per week unless otherwise indicated. On 9/22/05, the Director of Nurses instructed the nursing staff that perineal care must be provided according to the facility's established policy and procedure, including to res. #14 & 15 The bath schedule for each resident has been identified on the C.N.A. assignment record. The ADL deficit care plan for each resident has been reviewed to ensure the resident's bathing and peri-care needs are reflected on the plan of care.	

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F 312	Continued From page 13 "promotes cleanliness...prevents infections...removes irritating and odorous secretions..." The policy and procedure also instructed staff to cleanse the penis and scrotum. 2. Observation on 9/19/05 at 4 PM showed CNAs #15 and #23 assisted non-sample resident #14 to the bathroom. The resident was incontinent of urine and his/her clothing was wet. CNA #23 confirmed the resident's incontinence and stated his clothing was wet because a brief was not used to hold the incontinence pad in place. When providing incontinence care, the CNAs cleansed the resident's buttocks, but failed to cleanse the genitals and anterior groin and thighs which were also in contact with urine. According to the facility's undated policy and procedure #119-14, "Providing Perineal Care," perineal care "promotes cleanliness...prevents infections...removes irritating and odorous secretions..." In addition, the policy and procedure instructed staff to cleanse the penis and scrotum.	F 312	On 10/21/2005, the Director of Nurses instructed the nursing staff that residents must receive their baths as scheduled. If a bath or shower is not done on the shift scheduled, the charge nurse must arrange for the bath to be done on the next shift or by the next day. This need must be documented on the shift report record. The nursing staff was instructed on the documentation requirements. Beginning 10/11/05, C.N.A.'s completed a pericare skill competency. The Charge Nurses will monitor compliance weekly for a month and monthly thereafter. Results of the audits with corrective action taken as indicated will be reported to the Quality Assurance and Assessment committee monthly. **COMPLETION DATE: 10/21/2005**	
F 332 SS=E	483.25(m)(1) MEDICATION ERRORS The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, staff interviews, and review of the manufacturer's instructions, the facility failed to maintain a medication error rate below five percent (%). Observation revealed 3 non-significant medication errors out of 51 opportunities for error which resulted in an error rate of 5.88 %. The	F 332		

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F 332	Continued From page 14 findings were: 1. Observation on 9/20/05 at 5:35 PM showed licensed practical nurse (LPN) #28 prepared Prevacid Solutab and seven other oral medications to administer to resident #37. The LPN crushed all eight medications, mixed them in applesauce, and administered them to the resident. Reconciliation of the medications with the physician's 9/4/05 recapitulation (Recap) of orders showed Prevacid Solutab was to be "given in water only. Not to be given with other meds [medications]. Give Solutabs after current supply of packets is completed." Further review showed the original order with the same instructions was written on 6/30/04. Interview with the LPN at 5:37 PM on 7/20/05 revealed she thought the instructions to give the medication alone with water only applied to the packets, not to the Solutabs. Review of the manufacturer's instructions revealed Prevacid Solutabs should be placed on the tongue and allowed to disintegrate, with or without water. The instructions also specified, "Prevacid should be taken before eating. Prevacid products should not be crushed or chewed. " 2. Observation on 9/21/05 at 8:13 AM showed LPN #29 prepared and administered Augmentin (an antibiotic) for resident #8. The LPN was unable to locate the antibiotic in the medication cart so she obtained it from the emergency box. Reconciliation of the medication with the physician's orders showed Augmentin was ordered on 9/1/05 for seven days only. Interview with the LPN on 9/21/05 at 8:45 AM revealed she looked at the 9/1/05 admission orders instead of the medication administration record when preparing the medications.	F 332	**F 332** It is the practice of the facility to ensure that it is free of medication error rates of five percent or greater. The Director of Nurses requested the pharmacy to indicate on the label the amount of Vitamin D in Calcarb. The resident's physician was contacted for clarification of the Calcarb with Vitamin D order. On 10/18/2005, the Director of Nurses instructed the nurses on the proper procedure for administering Prevacid Solutab to resident #37 and to carefully read medication orders prior to administration to prevent errors. The nurses were also instructed to make sure the medication label matches the physician's order, follow the manufacturer's instructions for administering the medication, and to clarify any questionable orders with the resident's physician. The medication orders were reviewed to ensure the medication label matches the physician's order. Any questionable orders will be clarified with the resident's physician. residents will receive medications as ordered, including res. # 8. The Director of Nurses or designee will monitor compliance weekly for a month and monthly thereafter. Results of the audits with corrective action taken will be reported to the Quality Assurance and Assessment committee monthly. **COMPLETION DATE: 10/21/2005**	

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F 332	Continued From page 15 3. Observation on 9/21/05 at 8:20 AM showed registered nurse (RN) #32 prepared and administered Calcarb 600 milligrams (mg) with Vitamin D. Reconciliation of the medication with the 9/15/05 orders showed the physician ordered Calcium with Vitamin D 600 mg. Review of the itemized label on the medication bottle showed the amount of Vitamin D was not legible so the facility questioned the pharmacy. On 9/21/05 at 2:15 PM the director of nursing reported the amount of Vitamin D in the Calcarb was 200 mg, not 600 mg as orlginally ordered.	F 332		
F 353 SS=E	483.30(a) NURSING SERVICES - SUFFICIENT STAFF The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.	F 353		

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This REQUIREMENT is not met as evidenced by:
Based on observation, medical record review, review of resident council meeting minutes and the staffing schedule, resident and family interviews, and staff interviews, the facility failed to assure adequate staffing to provide bathing for seven of nine sample residents (#15, #17, #22, #24, #34, #35, #37) and restorative services for six of six sample residents (#13, #15, #17, #24, #34, #35) and ten non-sample residents (#5, #14, #20, #23, #25, #28, #30, #31, #36, #39). The findings were:

Upon entering the facility at 2 PM on 9/19/05 observation showed the director of nursing (DON) working as a certified nurse aide (CNA). At that time the DON stated the administrator was currently not in the facility as he was transporting a resident in the van. Interview with the administrator and DON on 9/19/05 at 2:40 PM revealed the facility was short staffed and that the agency staff person scheduled that day did not show up. Observation from 2:40 PM until observations ceased at 6:45 PM showed the administrator assisted the staff as allowed, and the DON continued to work as a CNA.

Confidential interview with employee #15 on 9/19/05 at 3:35 PM revealed the "pool staff" (agency staff person) did not show up this morning so the DON and the social worker (also a CNA) were working as CNAs. The staff person also stated there had been a lot of pool staff who did not show up for work recently.

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F 353	Continued From page 17 Interviews with employees #8 and #9 on 9/20/05 at 10 AM revealed they did not have enough help. Both employees stated management did not help serve breakfast trays unless the surveyors or corporate people were present. The employees stated breakfast was usually at 8:30 AM instead of at 7:30 AM, as scheduled, because there were no staff available to start serving at 7:30 AM. The employees stated they were angry there was not enough help and that it hurt not to be able to provide proper care for the residents. Furthermore, both employees stated tasks were not always completed. As an example they showed a plastic molded chair containing urine which had not been cleaned up from the previous shift. Interview with employee #35, who worked the previous shift, and review of the schedule revealed there was one registered nurse and one CNA for 40 residents. BATHING 1. Review of the 6/7/05 resident council meeting minutes revealed residents stated they were not getting their baths twice per week. An interview with employee #21 on 9/20/05 at 8:30 AM revealed there was not enough staff, so baths did not always get done. An interview with employee #9 on 9/20/05 at 10:20 AM revealed bathing did not get done because the facility was short of staff. On 9/21/05 at 2:15 PM, the director of nursing stated baths were documented on the monthly bathing sheets. The DON stated if the bath was not documented, there was no way to know if the resident received the bath or not. 2. Review of the 9/15/05 quarterly Minimum Data Set (MDS) assessment showed resident #35	F 353		

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F 353	Continued From page 18 required extensive staff assistance for bathing. According to the bathing schedule, the resident was scheduled for baths twice per week, on Wednesday and Saturday. Review of the September 2005 bathing documentation showed the resident did not get his scheduled bath/shower on 9/7/05, therefore he was not bathed twice that week. On 9/19/05 at 7:50 PM, a family member stated the resident did not get baths twice a week like he/she was supposed to. 3. Review of the 8/4/05 quarterly MDS assessment revealed resident #37 required extensive staff assistance for bathing. According to the bathing schedule, the resident was scheduled for baths twice per week, on Tuesday and Friday. Review of the September 2005 bathing documentation showed the last documented bath/shower was on 9/6/05. Review of the August 2005 bathing documentation showed the resident did not get his/her scheduled bath on 8/16/05. In addition, the last documented bath in August was on 8/19/05. 4. Review of the 7/28/05 significant change MDS assessment showed resident #24 required extensive staff assistance for bathing. According to the bathing schedule, the resident was scheduled for baths twice per week, on Wednesday and Saturday. Review of the September 2005 bathing documentation showed the resident had a bath on 9/10/05, but the next bath was not until 9/17/05. Review of the August 2005 bathing documentation showed the resident did not have his/her scheduled bath on 8/10/05. In addition, the resident had a bath on 8/13/05, but the next bath was not until 8/24/05. During an interview on 9/22/05 at noon, a family member stated the resident did not get baths like he/she	F 353		

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F 353	Continued From page 19 was supposed to. 5. According to the 7/7/05 quarterly MDS assessment, resident #17 had severe cognitive impairment and was totally dependent on staff for bathing. Review of the 7/7/05 care plan showed staff were to assist the resident with personal hygiene every day and a bath was scheduled every other night. However, according to the documentation, the resident only received a bath on the 2nd, 6th, 11th, 13th, 15th, and 19th of September 2005. 6. Review of the 8/18/05 significant change MDS assessment showed resident #34 was alert and oriented but required physical assistance from staff with bathing. Review of the 6/17/05 care plan showed the resident was to receive showers twice a week. According to the documentation, the resident received showers on the 3rd, 6th, 10th, and 16th of September 2005; the resident refused a shower on 9/19/05. Interview with the resident on 9/22/05 at 8:45 AM confirmed his/her bath was missed during the week of 9/11/05 - 9/17/05. 7. According to the 9/15/05 quarterly Minimum Data Set (MDS) assessment, sample resident #15 had moderate cognitive impairment (poor decisions, required cues and supervision), and required physical assistance from staff with bathing. Review of the 6/29/05 care plan showed staff were to assist the resident with a weekly bath or shower as needed. Review of the bathing schedule showed staff were to assist the resident with showers twice a week, but the only documented showers or baths during the month of September 2005 were on 9/16/05 and 9/20/05.	F 353		

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F 353	Continued From page 20 8. Review of the 7/14/05 quarterly MDS assessment showed resident #22 needed limited staff assistance for bathing. Review of the September 2005 bathing documentation showed it was blank. There were no documented baths, nor documented refusals. During an interview on 9/21/05 at 1:30 PM, the resident stating he/she needed staff assistance to take baths. The resident stated staff did not help with baths like they were supposed to, and his/her last bath was about a week ago. RESTORATIVE 1. According to the 9/1/05 care plan, resident #13 received restorative services three to six times per week. Review of the 8/11/05 restorative referral showed an exercise program was to be done with the resident three to six times per week. However, review of the September 2005 restorative daily documentation revealed the resident did not receive any services from September 6th through September 12th (7 days). 2. Observation on 9/19/05 at 4:30 PM and on 9/20/05 at 11:05 AM and 11:30 AM showed staff did not assist resident #15 to ambulate to and from the bathroom or to meals. However, the observation on 9/19/05 showed the resident was able to stand by holding onto the grab bars in the bathroom. Review of the 3/2/05 annual MDS assessment and the May 2005 nursing notes showed the resident was able to ambulate independently until s/he sustained a fall with a fracture on 5/31/05. According to the 7/29/05 therapy notes, the resident was referred to the maintenance [provided by the CNAs] restorative nursing program for ambulation three to four times a day or more with a front wheeled walker	F 353		

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F 353	Continued From page 21 and staff assistance. Review of the maintenance documentation showed the resident was to walk to and from meals and to the bathroom.. According to the September 2005 maintenance restorative nursing documentation, staff assisted the resident with ambulation on two days and the resident refused on four days. The remainder of the documentation through 9/21/05 was blank. Interview with certified nurse aide (CNA) #23 on 9/21/05 at 3:20 PM revealed she thought the program was discontinued. However, during the same interview, CNA #25 stated the resident was not assisted to ambulate even though s/he could stand. Interview with the RNA on 9/21/05 at 3:21 PM revealed the maintenance program had not been discontinued. Review of the 9/15/05 care plan showed the resident received restorative services [provided by the restorative nurse aide] three to six times per week. Review of the updated restorative referral (dated 6/16/05, 7/29/05 and 8/2/05) showed the resident was to receive the following services three to six times per week: pendulum exercises to the left upper extremity, ambulation, and hamstring stretches. However, review of the September 2005 restorative daily documentation revealed the resident did not receive any services from September 6th through September 12th (7 days). 3. Observation on 9/19/05 at 3:20 PM showed resident #17 seated in a wheelchair with his/her feet rotated in at the ankles. Review of the 10/28/04 annual Minimum Data Set (MDS) assessment showed the resident had severe cognitive impairment and bilateral contractures of the ankles. According to the 7/7/05 quarterly MDS assessment, the resident had limitations on both sides of the body with full loss of voluntary	F 353		

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	535051	A. BUILDING _____ B. WING _____	09/22/2005

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F 353	Continued From page 22 movement in all areas. Review of the 7/7/05 care plan revealed the resident received restorative services [provided by the restorative nurse aide] three to five times per week. The September 2005 restorative daily documentation showed the resident was to receive upper extremity range of motion and range of motion to the feet. However, review of the September 2005 restorative daily documentation revealed the resident did not receive any services from September 6th through September 12th (7 days). Review of the September 2005 maintenance [provided by the CNAs] restorative nursing documentation showed range of motion (ROM) exercises to the resident's feet were discontinued on 9/1/05 "until trained by the RNA [restorative nurse aide]." Further review showed the program had previously been performed by the night nursing staff. Interview with the RNA on 9/21/05 at 3:15 PM confirmed the night staff were to perform the maintenance exercises for the resident's feet, but the exercises had not been provided since 9/1/05. The RNA stated the program was discontinued when the facility did not have regular staff working the night shift. The RNA further stated there were now regular staff on the night shift, but the training program had not been completed as she and the director of nursing "forgot" about it. 4. Review of the 7/28/05 significant change MDS assessment revealed resident #24 required limited assistance with activities of daily living (ADLs). According to the 8/19/05 care plan, the resident received restorative services three to six times per week. Review of the 8/2/05 and 8/3/05 restorative referrals showed the resident was supposed to have exercises and ADL training	F 353	**F 353** It is the practice of the facility to have sufficient nursing staff to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care	

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F 353	Continued From page 23 three to six times per week. However, review of the September 2005 restorative daily documentation revealed the resident did not receive any services from September 6th through September 12th (7 days). During an interview on 9/22/05 at noon, a family member stated the resident did not receive exercises like he/she was supposed to. 5. Review of the 8/18/05 care plan showed resident #34 received a functional maintenance program (FMP) three to six times per week. Review of the 6/29/05 and 7/29/05 restorative referrals showed the resident was supposed to receive upper and lower extremity exercises and ambulation three to six times per week. However, review of the September 2005 restorative daily documentation revealed the resident did not receive any services from September 6th through September 12th (7 days). 6. Review of the 9/15/05 quarterly MDS assessment revealed resident #35 required extensive assistance with transfers. In addition, the resident had range of motion limitations to both arms, hands, legs, and feet. According to the 9/15/05 care plan, the resident received restorative services three to five times per week. Review of the 1/17/05 and 7/29/05 restorative referrals showed the resident was supposed to receive exercises and transfer training three to five times per week. However, review of the September 2005 restorative daily documentation revealed the resident did not receive any services from September 6th through September 12th (7 days). 7. Review of the September 2005 restorative daily documentation book revealed the following	F 353	Prior to the survey and ongoing, the Director of Nursing and the Administrator attempted to provide sufficient nursing staff on a 24-hour basis to meet the needs of our residents. Six employees including the administrator are currently enrolled in a nurse aide training course. Agency CNAs have been contracted to assist in meeting the staffing needs. The facility administration continues to work on recruiting additional nursing staff. The Director of Nurses reviews the staffing needs on a daily basis and makes adjustments as indicated to meet the needs of the residents. Regardless of staffing challenges, the Director of Nurses instructed the nursing staff on 9/22/05 that every attempt must be made on a daily basis to provide the residents with the necessary care and services with emphasis on providing the restorative program and baths according to the resident's plan of care. On 10/21/2005, the restorative nursing assistant instructed the Director of Nurses, MDS coordinator, social service director who is a C.N.A, and licensed nurses on the restorative Level II programs. The restorative nursing assistant instructed the nurses and CNAs on the restorative maintenance programs on 10/21/2005.	

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F 353	Continued From page 24 non-sample residents did not receive restorative services September 6th through September 12th: #28, #25, #14, #31, #5, #20, #39, #30, #36, #23). 8. During an interview on 9/21/05 at 8:25 AM, the restorative aide confirmed residents did not receive restorative services September 6th through the 12th. The restorative aide stated she did not work those days, and no staff took over her duties. On 9/21/05 at 2:15 PM the director of nursing (DON) stated restorative services were not provided September 6th through the 12th because the restorative aide did not work those days and the facility was short staffed. The DON stated she did not have any staff who could take over the restorative duties.	F 353	On 10/21/2005, the Director of Nurses instructed the nursing staff on the resident bathing policy and procedure. The Director of Nurses or designee will monitor compliance weekly with the residents' restorative programs and baths for a month and monthly thereafter. Any trends will be analyzed and the results reported to the Quality Assurance and Assessment committee monthly. **COMPLETION DATE: 10/21/2005**	
F 371 SS=E	483.35(h)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE The facility must store, prepare, distribute, and serve food under sanitary conditions. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of the manufacturer's instructions, the facility failed to assure staff provided appropriate sanitation of kitchen equipment or maintained a clean surface on the stove. The findings were: Observation in the kitchen on 9/19/05 at 5 PM showed the cook pureed bread then washed the blender, lid, and blade in the 3-compartment sink. The wash water was discolored and had particles of grease floating on top. The cook rinsed the items, then dipped them in the sanitizing solution, removed them immediately, and used them to	F 371		

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F 371	Continued From page 25 blend more food items. A few minutes later the cook washed, rinsed, and sanitized the large metal tray used to bake the meat in the same manner. Interview with the dietary manager (DM) on 9/20/05 at 5:10 PM revealed she thought the sanitizing solution should remain in contact with the equipment for 30 seconds. However, review of the manufacturer's instructions on the label of the sanitizing solution revealed the required contact time for the product being used was one minute. Review of the 2005 Food Code (U.S. Public Health Service, FDA), section 4-703.11, revealed after being cleaned, equipment food-contact surfaces and utensils shall be sanitized in "...(C) Chemical manual or mechanical operations, including the application of sanitizing chemicals by immersion, manual swabbing, brushing, or pressure spraying methods, using a solution as specified under 4-501.114 by providing: ...(3) An exposure time of at least 30 seconds for other [other than chlorine-based sanitizers] chemical sanitizing solutions..." Observation of the kitchen on 9/19/05 at 2:05 PM revealed the entire top of stove was covered with raised areas of baked-on debris. In addition the oven handles were sticky to the touch. Observation on 9/20/05 at 4:40 PM showed the condition of the stove and oven handles was unchanged. Interview with the DM at 4:45 PM on 9/20/05 revealed the stove was sandblasted every six months. However, the DM was unable to determine when this last occurred. At that time the DM verified the baked-on debris on the stove and confirmed that the handles felt sticky. Interview with the DM on 9/21/05 at 1:55 PM revealed she contacted the company that did the sandblasting for the facility. The DM reported the	F 371	**F 371** It is the practice of the facility to store, prepare, distribute, and serve food under sanitary conditions. The plan is to have the stove steam cleaned on 10/22/2005. On 10/22/2005, the dietary staff completed a skill competency on the proper procedure of sanitizing equipment and utensils. On 10/22/2005, the dietary manager reviewed the cleaning procedures and schedules with the dietary staff. The cleaning procedures and schedules are posted in the kitchen as a reminder to the staff. The dietary manager has completed a sanitation inspection of the kitchen. Corrective action was taken as indicated. The Dietary Manager has made arrangements for the stove to be steam cleaned on a routine schedule. On 10/11/05, the dietary staff was inserviced on the sanitizing equipment procedure and the ongoing cleaning procedures. The dietary manager will monitor compliance weekly for a month and monthly thereafter. Results with corrective action taken will be reported to the Quality Assurance and Assessment committee at least quarterly. **COMPLETION DATE: 10/22/2005**	

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F 371	Continued From page 26 company was "behind cleaning the stove." Review of the 2005 Food Code (U.S. Public Health Service, FDA), sections 4-601.11 and 4-602.13, revealed "...(C) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris....Nonfood-contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residues..."	F 371		
F 426 SS=E	483.60(a) PHARMACY SERVICES - PROCEDURES A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to assure medications were received and available for resident use when scheduled for two of nine sample (#16, #24) and one non-sample resident (#18). The findings were: 1. Review of the 11/18/04 annual Minimum Data Set assessment showed resident #16 had diagnoses including spastic quadriplegia. Observation on 9/20/05 at 8 AM showed the resident kept his/her arms extended and wrists crossed. The resident required total staff assistance with activities of daily living and transfers were done per mechanical lift. Interview with certified nurse aide (CNA) #8 during the	F 426		

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F 426	Continued From page 27 observation revealed the resident would exhibit muscular rigidity and jerky movements at times. According to the 1/28/05 physician's orders, the resident was to receive Baclofen three times a day. Further review of the order showed "Must stay on Baclofen, cannot use anything else." Review of nursing documentation dated 7/25/05 at 1 PM revealed the resident's prescription for Baclofen (a skeletal muscle relaxant) had not been filled for the past two weeks. Review of the July 2005 medication administration record (MAR) confirmed the resident did not receive Baclofen as scheduled from 7/11/05 through 7/27/05. According to the 2003 Mosby's "Nursing Drug Reference," Baclofen should not be discontinued abruptly as "hallucinations, spasticity, tachycardia [rapid heart rate] will occur." 2. Observation of the 8 AM medication pass on 9/20/05 revealed the following concerns: 1. Resident #24 did not receive Colace at 8 AM as scheduled. Licensed practical nurse (LPN) #28 stated the medication would arrive from the pharmacy at 9 AM and she would administer it then. 2. Resident #18 did not receive Colace at 8 AM as scheduled. Interview with registered nurse #31 during the observation revealed the facility was out of the medication. At 10:25 AM on 9/20/05 LPN #28 stated the medication did not arrive as the pharmacy backordered it. Review of the memo from the pharmacy confirmed the backorder. The LPN further stated she thought the facility was trying to change pharmacies for stock medications due to problems with availability. 3. Interview with the director of nursing on 9/21/05	F 426	**F 426** It is the practice of the facility provide pharmaceutical services including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals to meet the needs of each resident. Resident #16 has expired. The Director of Nurses will maintain an extra container of Colace in stock at all times to assure Colace is readily available. The Director of Nurses is in the process of making arrangements to order stock medications from a medical supplier. The Director of Nurses, or designee, will follow up with pre-authorizations within 24 hours if there has not been a response from the resident's physician. Medication was ordered given to all res. as indicated The nurses have reviewed all medication orders to ensure the medications are available as needed. res. #18 dc'd. On 10/21/2005, the Director of Nurses inserviced the nurses on the medication preauthorization process and the medication ordering and reordering policy and procedure with emphasis on the procedure to follow if the medication has not arrived as needed. The Director of Nurses or designee will monitor compliance weekly for a month and monthly thereafter. Any trends will corrective action taken will be reported to the Quality Assurance and Assessment committee at least quarterly. **COMPLETION DATE: 10/21/2005**	

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F 426	Continued From page 28 at 3:58 PM confirmed the facility was in the process of seeking a different pharmacy to supply stock medications. However, the process was not finalized yet.	F 426		
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 assure certified nurse aides (CNAs) adjusted the flow rate of oxygen in accordance with Wyoming Board of Nursing directives for one of one sample resident who used oxygen (#35). The findings were: According to the Wyoming Board of Nursing advisory opinion on oxygen administration (number 01-108, revised 1/04), "...if the patient's name and liter flow are clearly identified on the tank, it can be turned back on again by a CNA at the same liter flow as is marked." Observation on 9/19/05 at 4:25 PM revealed CNA #23 replaced the portable oxygen tank for resident #35. The CNA put the nasal cannula on the resident, then turned the oxygen flow rate to three (3) liters per minute (LPM). The oxygen flow rate was not marked on the portable tank, the	F 492	**F 492** It is the practice of the facility to 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. The oxygen flow rate is identified on resident #35's concentrator. On 9/22/05, the Director of Nurses instructed the nursing staff that the liter flow must be clearly identified whenever the portable oxygen tank is replaced to allow the CNAs to adjust the oxygen flow rate. The oxygen concentrators and portable tanks have been reviewed for all residents requiring oxygen to assure the flow rate is clearly identified. On 9/22/05, the Director of Nurses informed CNAs that they are not to adjust the resident's oxygen flow rate unless a licensed nurse has clearly identified the resident's name and liter flow on the tank. The Director of Nurses or designee will monitor compliance weekly for a month, and monthly thereafter. Results of the audits with corrective action taken will be discussed with the Quality Assurance and Assessment committee at least quarterly. **COMPLETION DATE: 10/21/2005**	

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F 492	Continued From page 29 concentrator, or above the resident's bed. Later that day, at 6:11 PM, the flow rate was set at 2 LPM. Interview with the director of nursing (DON) on 9/20/05 at 8:50 AM revealed the resident should receive oxygen at 2 LPM. Review of the August 2005 physician orders showed the resident should receive oxygen at 2 LPM. During an interview on 9/21/05 at 3:50 PM, the DON stated CNAs could adjust the flow rate of oxygen only if the flow rate was posted.	F 492		