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

PRINTED: 08/17/2005
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
	535031	A. BUILDING B. WING	06/03/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WIND RIVER HEALTHCARE & REHABI	1002 FOREST DRIVE RIVERTON, WY 82501

(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
F253 SS=D	483.15(h)(2) ENVIRONMENT 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 staff interview, facility observations, and review of facility policies and procedures, the facility failed to assure adequate housekeeping and sanitation measures regarding cleanliness of walls, heater and room air circulation fans, and window screen coverings. In addition, the facility failed to assure a whirlpool tub was cleaned and sanitized according to the manufacturers specifications. The findings were: Observation of the laundry rooms on 6/1/05 at 3 PM and again on 6/3/05 at 8:45AM revealed a dirty ceiling heater in the clothes dryer room. Dirt and lint had accumulated on both the inside and outside of the unit. The heater was situated over clean and folded blankets and resident gowns. In addition, observation of the air intake window screen in the washing machine room revealed an accumulation of leaves and other organic matter on the outside of the screen. Finally, the grate covering the exhaust fan in this same room was covered with dirt and lint. Observation of the oxygen tank storage room on 6/2/05 at 11:50 AM revealed there was wall tile extending four feet up from the floor. Observation revealed approximately one eighth inch of accumulated dirt and grime on the floor as well as on the top edge of the tile. On 6/1/05 at 10:05 AM in the front tub room, observation showed a dust build-up on the lift	F253	483.15(h)(2) ENVIRONMENT is met as evidenced by: The ceiling heater in the dryer room will be cleaned as well as the exhaust fan grate. The air intake window has been cleaned of organic debris. The ESD will make weekly rounds to assure these items continue to be cleaned on a routine basis. Any concerns will be addressed on discovery and forwarded to the PI Committee for any needed action. The oxygen tank storage room has been thoroughly cleaned. The oxygen storage room has been added to the monthly housekeeping cleaning schedule to assure ongoing cleanliness. The information will be shared with housekeeping staff at the departmental meeting. Regular rounds will be completed by the housekeeping supervisor. Results of these rounds will be included in the housekeeping PI review. The front tub room area has been thoroughly cleaned by the housekeeping and nursing staff. The pink plastic container cited has been discarded. The housekeeping staff and CNAs responsible for resident bathing will be inserviced on departmental cleaning responsibilities and expectations for the bathing area(s). The housekeeping supervisor will complete weekly rounds of these areas. Any areas of non- compliance will be addressed with the appropriate staff members and concerns reviewed a the PI meeting as needed. *This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Wind River Healthcare and Rehabilitation does not admit that the deficiencies listed on the HCFA 2567 exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings all deficiencies, statements, findings, facts and conclusions that form the basis for the*	7/18/05

Environmental Service director

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE ED (X6) DATE 06/27/05

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.

Reviewed w/ Bonnie Days on 7/11/05
Accepted w Changes.

JR 7/11/05

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F 253	Continued From page 1 platform, base board, Rubber Maid cabinet, heat lamps and glove dispenser. In addition, there was a build-up of hair and soap scum residue between the lift platform and the tub. Furthermore, there was a rust colored build-up in a pink plastic container located in the Rubber Maid cabinet. On 6/1/05 at 10:30 AM certified nurse aide (CNA) #1 was observed cleaning and sanitizing the Century whirlpool tub. CNA #1 used a chemical called TB Phene. She poured an unmeasured amount of the liquid into the tub, filled the tub with water, and then ran the tub for 10 minutes before rinsing. During an interview at this same time, CNA #1 stated that she used the TB Phene for cleaning the tub after two residents (one who was thought to have shingles, and one who had Methicillin Resistant Staph Aureus) used the tub. CNA #1 also stated she felt this was a better chemical to use to ensure sanitization after potentially infectious residents used the tub. Review of the facilities policy for use of the TB Phene revealed that one ounce of the solution was to be used. Interview with the infection control coordinator on 6/3/05 at 8:45 AM revealed the amount of TB Phene should have been measured to ensure sanitation.	F253	F 253 Continued From page 1 All bath aides will be Inserviced related to the proper disinfecting procedure for the whirlpool tubs. Measuring devices will be provided for use with the cleaning chemicals. The tub sanitizing protocol will be posted in the tub rooms. The DNS or designee will perform random review of use of correct sanitizing procedures.	
F279 SS=D	483.20(k) RESIDENT ASSESSMENT The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the following: The services that are to be furnished to attain or	F279	F279 483.20(k) RESIDENT ASSESSMENT will be met as evidenced by: Resident 53 is deceased. *This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Wind River Healthcare and Rehabilitation does not admit that the deficiencies listed on the HCFA 2567 exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.*	7/18/05

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F 279	F 279 Continued From page 2 maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under s483.25; and Any services that would otherwise be required under S483.25 but are not provided due to the resident's exercise of rights under s483.10, including the right to refuse treatment under s483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to ensure care plans were updated to reflect current care needs pertaining to oxygen, falls, and anti-anxiety medication for 2 (#53, #42) of 13 sample residents. The findings were: Medical record review for resident #53 showed that on 6/1/05, the physician ordered oxygen, 1 to 2 liters by nasal cannula, when necessary to keep the resident's oxygen saturation level above 90%. In addition, on 6/1/05 at 7:05 AM a fall protection mat was observed on the floor next to the resident's bed. However, medical record review showed the current care plan did not reflect the use of the oxygen or the mat next to the resident's bed. Review of the June 2005 physician's orders for resident #42 showed the resident's Xanax (anti-anxiety medication) was discontinued on 5/16/05. However, medical record review showed the May 2005 care plan was not updated to reflect this change. During an interview on 6/1/05 at 4:30 PM with the restorative nurse, it was confirmed that the care	F279	F 279 Continued From page 2 Care Plan for Resident #42 will be corrected to reflect changes in medications. Licensed nurses will be inserviced related to proper documentation and the importance of the Care Plan reflecting the current care needs of the residents The DNS or designee will perform monthly audits of random charts to ascertain that Care Plans correctly reflect the needs of the residents Any noted discrepancies will be reviewed at the monthly Performance Improvement meeting with corrective action completed as needed. *This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Wind River Healthcare and Rehabilitation does not admit that the deficiencies listed on the HCBA 2567 exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.*	

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F279	Continued From page 3 plans of resident #53 and #42 were not updated to reflect their current care needs.	F279		
F281 SS=D	483.20(k)(3)(i) RESIDENT ASSESSMENT 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, staff interview, review of facility policies, and medical record review, the facility failed to obtain or follow physician's orders for 3 of 16 (#80, #21, #36) sample residents. The findings were: Review of the closed medical record for resident #80 revealed he/she was in the final stages of end stage renal disease. Further review showed the facility sent a fax to the physician stating the family had asked to discontinue dialysis and had signed a comfort care sheet. The facility requested an order from the physician to discontinue the dialysis and to provide comfort care only. Although the physician signed the fax, he neither agreed to nor rejected the facility's requests. Review of June 2005 physician's orders for resident #36 revealed he/she had a chewing problem, malaise (vague discomfort), and fatigue. Further review revealed an order was written on 5/17/05 for speech therapy three times a week for two weeks for dysphagia (difficulty swallowing) and for diet management. Review of the entire medical record revealed no evidence speech therapy was provided. Interview on 6/3/05 at 10:45 AM with the director of nursing (DON), who	F281	F281 483.20(k)(3)(i) RESIDENT ASSESSMENT will be met as evidenced by: Resident #80 is deceased and the record is closed. The physician has clarified the order for speech therapy for resident #36. Resident #36 does not have a need for speech therapy. This was a transcription error. The physician orders will be verified by charge nurses for correctness each month. The licensed nursing staff will be inserviced related to accuracy of physician orders. The DNS or designee will review ~~random numbers of monthly~~ physician orders each month. Any discrepancies will be reviewed at the monthly Performance Improvement meeting and follow completed prior to next Performance Improvement meeting. The physician has written an order for TED hose for resident #21. Licensed nursing staff will be inserviced related to obtaining physician orders for all ____ ONS treatments. The ~~DNA~~ or designee will review physician orders for accuracy monthly. The results of the review will be included in monthly Performance Improvement meetings and follow up will be completed as needed. *This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Wind River Healthcare and Rehabilitation does not admit that the deficiencies listed on the HCFA 2567 exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings all deficiencies, statements, findings, facts and conclusions that form*	7/18/05

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F281	Continued From page 4 had consulted with the speech therapist, revealed the resident had not been treated by the speech therapist.The DoN further stated the speech therapist had not been informed of the order. Observation on 6/1/05 from 9 AM through 11 AM, on 6/2/05 at 8 AM and 3 PM, and on 6/3/05 at 9 AM revealed resident #21 was wearing TED hose (anti-embolitic stockings). Review of the May and June 2005 physician's orders revealed there was no order for the TED hose. Interview with the DON on 6/3/05 at 10:45 AM confirmed there was no physician's order for the TED hose. Review of the facility's policy titled: "Blood Glucose Equipment Check," showed blood glucose equipment checks were to be performed in order to clean, calibrate and validate proper functioning prior to obtaining blood glucose levels from residents. However, review of the front nurses' station Glucometer (a machine to check a resident's blood sugar level) Quality Control (QC) log, revealed staff failed to perform the required QC from May 13, 2005 to May 23, 2005, May 24, 2005 to May 29, 2005 and May 31, 2005. Interview with the DON on 6/3/05 at 9 AM revealed two residents on the front nurses' wing required daily blood glucose testing.	F281	F281 Continued From page 4 The blood glucose check equipment will be cleaned, calibrated and validated on a daily basis. The blood glucose check equipment log will be updated daily. The licensed nurses will receive training pertaining to equipment checks. The completion of testing and accuracy of logs will be monitored on a monthly basis by the DNS or designee. The results of the monthly review will be included in the monthly Performance Improvement meeting minutes and follow up will be completed as needed.	
F312 SS=D	483.25(a)(3) QUALITY OF CARE 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:	F312	F312 483.25(a)(3) QUALITY OF CARE will be met as evidenced by: *This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Wind River Healthcare and Rehabilitation does not admit that the deficiencies listed on the HCFA 2567 exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.*	7/18/05

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F 312	F 312 Continued From page 5 Based on observation, staff interview, medical record review, and review of facility policies and procedures, the facility failed to ensure 1 (#53) sample and 1 non-sample (#65) of 19 residents seated in the Purple Sage dining room received the necessary services to maintain good nutrition. The findings were: Review of the 4/19/05 annual Minimum Data Set (MDS) assessment for resident #53 revealed he/she had severe cognitive impairment and required extensive staff assistance with eating. Observation of the evening meal on 5/31/05 revealed the resident received his/her dinner tray at 5:45 PM. Continued observation from 5:45 PM until 6:25 PM revealed the resident was asleep and slumped over in his/her wheelchair. Observation revealed no staff assisted the resident with his/her meal during that time (40 minutes). Observation of the breakfast meal on 6/1/05 revealed the resident received his/her tray at 8:25 AM. Continued observation revealed the resident received no staff assistance from 8:25 AM until 9 AM (35 minutes). Interview with CNA #4 on 6/1/05 at 9:15 AM confirmed this resident required feeding assistance. Review of the 5/27/05 annual MDS assessment for resident #65 revealed he/she had severe cognitive impairment and required extensive staff assistance with eating. Observation of the evening meal on 5/31/05 revealed the resident received his/her dinner tray at 5:35 PM. Continued observation from 5:35 PM until 6:35 PM revealed the resident was asleep and slumped over in his/her wheelchair. Observation revealed no staff assisted the resident with his/her meal during that time (60 minutes).	F312	F 312 Continued From page 5 The SLP will re-evaluate resident #53 and resident #65 for any interventions to be utilized during mealtime. Appropriate number of staff will be available to assist serve residents in a timely manner. All nursing staff will be inserviced related to appropriate assistance of impaired residents. DNS or designee will observe meal service each week. Any further education needs identified will be provided on an as-needed basis. The results of the meal observations will be presented at monthly Performance Improvement meetings. All follow up will be completed as needed. *This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Wind River Healthcare and Rehabilitation does not admit that the deficiencies listed on the HCFA 2567 exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.*	

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F 312	Continued From page 6 Review of the facility's policy on dining standards #608-05 dated 4/9/04 revealed trays were to be served to residents who required assistance or feeding only when a staff member was available to provide assistance.	F312		
F324 SS=E	483.25(h)(2) QUALITY OF CARE The facility must ensure that each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to provide a safe environment in two of three dining rooms. The findings were: Observation of the Special Care Unit (SCU) dining room on 6/1/05 at 8:20AM revealed 13 residents eating breakfast at three dining tables. Two staff members were assisting residents at two of the three tables. The following concerns were identified: a. Review of the 3/17/05 Minimum Data Set (MDS) assessment for resident #45 revealed he/she was cognitively impaired and had a diagnosis of Alzheimer's Disease. The resident was seated at the third table with no staff present. b. The resident was observed chewing on and attempting to eat a small individual plastic serving tray of jelly. Neither of the two staff at the other two dining tables observed the resident chewing on the container. c. After approximately three minutes of chewing on the plastic, the resident spit the plastic out. Observation of the plastic jelly tray at	F324	F324 483.25(h)(2) QUALITY OF CARE will be met as evidenced by: Resident #45 will be assessed for appropriate seating during meals related to level of supervision required for safety. Staff will provide assistance as needed. The cupboard in the main dining room will have the lock replaced. The chemicals will be removed. The Environmental Services Director will make weekly rounds of the building to insure that safety measures are in place. Any discrepancies will be presented at the monthly Performance Improvement meeting and corrective action completed as needed. Restorative Staff will assess all Residents for appropriate seating during meals and needed assistance. *This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Wind River Healthcare and Rehabilitation does not admit that the deficiencies listed on the HCFA 2567 exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.*	7/18/05

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F 324	; Continued From page 7 that time revealed the hard plastic to be mangled and almost chewed in half. Observation in the main dining room on 6/2/05 at 12:30 PM and again on 6/3/05 at 10 AM revealed a cupboard in a corner. The cupboard lock had been removed. Inside the cupboard were four containers containing caustic chemicals including one bottle of Windex, one bottle of industrial strength window cleaner which was labeled "Do Not Drink," one bottle of generic glass cleaner containing ammonia, and one bottle of a cleaning product labeled "Krud Kleaner" which was labeled as an "eye and skin irritant." Interview with the maintenance director on 6/3/05 at 10:35 PM revealed the facility was in the process of painting the cupboards. As a result, the lock had been removed for approximately one week.	F324		
F371 SS=E	483.35(h)(2) DIETARY SERVICES The facility must store, prepare, distribute, and serve food under sanitary conditions. This REQUIREMENT is not met as evidenced by: Based on staff interview, and random observations, the facility failed to ensure sanitary conditions for the storage of cooking utensils. In addition, the facility failed to close open food containers and to prevent cross contamination of food items. The findings were: Observations in the freezer on 5/31/05 at 3:30 PM, on 6/1/05 at 4:50 PM, and again on 6/2/05 at 5:15 PM revealed an opened 30 pound sack of frozen peas. Interview with the kitchen manager on 6/3/05 at 9:15 AM confirmed the container	F371	F371 483.35(h)(2) DIETARY SERVICES will be met as evidenced by: The cited bag of frozen peas has been removed from the freezer. Food scoops have been cleaned. The dietary staff will be re-inserviced in the areas of proper food storage and ~~food~~ cleanliness. The DSM will make weekly rounds to assure ongoing compliance with requirements. Any deficiencies noted will be corrected at time of rounding. Continuing issues of non-compliance will be forwarded to the PI Committee for further action recommendations. *This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Wind River Healthcare and Rehabilitation does not admit that the deficiencies listed on the HCFA 2567 exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.*	7/18/05 compliance

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F371	Continued From page 8 should be closed while in storage. Observation on 5/31/05 at 3:35 PM revealed two preparation/cooking utensils (food scoops) with several small spots of crusty food debris on them. Interview with the cook at that time revealed the utensils had not been cleaned properly. Observations on 5/31/05 at 3:34 PM and again on 6/2/05 at 5:20 PM revealed a mechanical mouse trap in the food storage area. The manufacturer's label identified the device as a <|,Tin Cat,-,. The trap was located on the third shelf of a four shelf storage unit. Directly next to this unit was another four shelf unit. On the bottom shelf of this unit with an open box of potatoes.	F371	F371 Continued From page 8 The "Tin Cat" has been placed on the floor. These traps are supplied by the pest control company and location will be checked on their weekly rounds. Any misplacement will be reported to the DSM for further needed review with dietary staff. Any environmental concerns will be forwarded by the DSM to the PI Committee for any needed action.	
F431 SS=D	483.60(d) PHARMACY SERVICES Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure expired medications were not available for resident use. One of two medication refrigerators contained expired medications. The findings were: Observation of the back nurses' station medication refrigerator on 6/2/05 at 3 PM revealed the following expired medications: a. Humulin N insulin for resident #8,	F431	F431 483.60(d) PHARMACY SERVICES will be met as evidenced by: Any expired drugs will be removed from the refrigerator. The Staff Development Coordinator will inservice the nurses responsible for medication review. The charge nurses will review the drugs in the refrigerator and the medication carts for expiration dates on a monthly basis. All expired drugs will be removed from the medication carts and refrigerators. The DNS or designee will review and present any discrepancies to the Performance Improvement committee with a corrective plan as needed. *This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Wind River Healthcare and Rehabilitation does not admit that the deficiencies listed on the HCFA 2567 exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.*	7/18/05

The Expired Humulin N, Travatan, & phenazopyridine sited have been destroyed.

SR 7/11/05

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535031	A. BUILDING B. WING	06/03/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WIND RIVER HEALTHCARE & REHABI	1002 FOREST DRIVE RIVERTON, WY 82501

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F431	Continued From page 9 expiration May 1, 2005. b. Travatan (antiglaucoma) ophthalmic solution for resident #16, expiration February 2006. c. Phenergan (anti-nausea) 25 mg suppositories, expiration March 2005. d. Two boxes of Phenergan 25mg suppositories for resident #17, expiration May 2005. e. Emergency stock of Phenergan 25mg suppositories, expiration March 2005. Interview with the consultant pharmacist on 6/2/05 at 3 PM revealed nursing staff were responsible for checking on expired medications.	F431		
F492 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 and staff interview, the facility failed to ensure certified nurse aides (CNAs) did not perform duties that were outside their scope of practice. Throughout days of the survey, CNAs were observed adjusting the rate of oxygen liter flow for 3 (#53, #48, #70) of 13 sample residents. The findings were: Review of the 6/1/05 physician's orders for resident #53 revealed he/she was to receive oxygen when necessary to keep his/her oxygen saturation (a method to determine a resident's	F492	F492 483.75(b) ADMINISTRATION will be evidenced by: Resident #53 is deceased. Resident #48 and resident #70 will have the oxygen liter flow posted on his/her concentrator and on the regulator of the e-tank. The Staff Development Coordinator will inservice CNA's on the related scope of practice of a certified nursing assistant and adjustment of oxygen liter flow. Each resident that has orders for oxygen will have the current liter flow posted on the concentrator and the regulator for their e-tank. The charge nurse will monitor the posted liter flow for accuracy. *This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Wind River Healthcare and Rehabilitation does not admit that the deficiencies listed on the HCFA 2567 exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.*	7/18/05

JR 7/11/05

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F492	Continued From page 10 gas exchange and oxygenation transport ability, and is normally over 90%) level at 90%. On 6/1/05 at 7:05 AM, CNA #2 was observed placing an oxygen cannula on the resident. Without knowing the resident's oxygen saturation level, CNA #2 adjusted the meter flow to two liters. On 6/1/05 at 10 AM, CNA #3 was observed placing an oxygen cannula on resident #48. CNA #3 adjusted the meter flow to four. Interview with CNA#1 revealed there was nothing in the resident's room or on the oxygen equipment that informed staff of what liter flow the resident required. On 6/2/05 at 12 noon, CNA #4 was observed changing an empty oxygen cylinder for a full cylinder for resident #70. CNA #4 adjusted the oxygen rate to two liters.	F492		
F514 SS=D	483.75(l)(1) ADMINISTRATION The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure physician orders were transcribed accurately on the monthly computer printouts, and the medication administration records (MARs) for 1 (#70) of 16 sample residents. The findings were: Review of the 10/27/04 original physician's order	F514	F514 483.75(l)(1) ADMINISTRATION will be met as evidenced by: The record for resident #70 has been thoroughly reviewed and the physician has clarified the order for Ativan. Monthly physician orders and MAR's will be cross-checked to assure accuracy. for all Residents Licensed nursing staff will be inserviced related to documentation and the necessity of verifying correct orders. Random charts will be audited for accuracy and the results presented at the monthly Performance Improvement meeting. Any corrective actions will be completed. *This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Wind River Healthcare and Rehabilitation does not admit that the deficiencies listed on the HCFA 2567 exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiencies.*	7/18/05

YR 9/11/05

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F 514	F 514 : Continued From page 11 for resident #70 revealed the resident was prescribed Ativan (antianxiety) 0.25mg when necessary for an anxiety attack. In addition, the resident was not to be given a second dose of Ativan within six hours of the previous dose. However, review of the April 2005 and May 2005 computer physician's orders printouts and the April 2005 and May 2005 MARs, showed the Ativan order was transcribed as 0.25 mg by mouth everyday related to anxiety secondary to physiological decline exhibited by shortness of breath, fear and anxiety. Interview with the director of nursing on 6/3/05 at 09 AM confirmed the physician's orders and MARs were transcribed incorrectly.	F514	*This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Wind River Healthcare and Rehabilitation does not admit that the deficiencies listed on the HCFA 2567 exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.*	