

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

PRINTED: 11/27/2007  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045375</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R-C</b> <b>11/08/2007</b>
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NAME OF PROVIDER OR SUPPLIER  <b>PARKVIEW REHABILITATION &amp; HEALTHCARE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2600 BARROW ROAD</b> <b>LITTLE ROCK, AR 72204</b>
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{F 000}	INITIAL COMMENTS	{F 000}		
{F 309} SS=D	<p>483.25 QUALITY OF CARE</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure a urinary catheter collection bag was positioned below the bladder at all times to facilitate drainage and failed to ensure the catheter tubing was secured to prevent potential trauma to the urinary meatus for 1 (Resident #2) of 2 case mix residents with indwelling urinary catheters (Residents #2 and #8). The failed practices had the potential to affect 4 residents with indwelling urinary catheters, as documented on the facility's Resident Census and Conditions of Residents form dated 11/5/07. The findings are:</p> <p>Resident #2 had a diagnosis of Urine Retention. The Significant Change Minimum Data Set (MDS) dated 10/3/07 documented the resident was severely impaired in cognitive skills for daily decision-making, totally dependent on staff for toilet use and had an indwelling urinary catheter.</p> <p>a. On 11/6/07 at 11:50 a.m., the resident was sitting in a wheelchair in the dining room with a urinary catheter in place. There was no leg strap or other means of securing the catheter tubing.</p>	{F 309}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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{F 309}	Continued From page 1  b. On 11/6/07 at 1:35 p.m., the resident was in bed. The catheter tubing remained unsecured.  c. On 11/7/07 at 3:05 p.m., the resident was in bed receiving wound care. The catheter tubing remained unsecured. Licensed Practical Nurse (LPN) #4 picked up the catheter bag, raised it above the resident's head approximately 12 inches then moved it to the other side of the bed.  d. On 11/7/07 at 3:18 p.m., the resident remained in bed while the wound care procedure was being completed. The catheter tubing remained unsecured. LPN #4 picked up the catheter bag and held the bag above the resident's bed rail. The LPN held the bag in this position for 2 minutes, with tension on the catheter tubing. There was no leg band on the catheter tubing to prevent tension and or potential trauma to the urinary meatus.  e. On 11/8/07 at 2:05 p.m., the resident stated she had worn leg bands in the past to secure her catheter tubing. When asked if the leg band had caused her any problems, she stated, "No, it's all right. I've had it before."	{F 309}			
{F 314} SS=D	483.25(c) PRESSURE SORES  Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.	{F 314}			

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{F 314}	Continued From page 2  This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure pressure relieving devices were provided for 1 (Resident #1) of 9 case mix residents with pressure ulcers (Residents #1, #2, #3, #4, #5, #9, #11, #12 and #14). This failed practice had the potential to affect 5 residents with pressure ulcers on their heels, as documented on a list provided by the Administrator on 11/8/07 at 2:20 p.m. The findings are:  Resident #1 had a diagnosis of Cardiovascular Disease.  a. The Braden Scale Assessment form dated 8/16/07 documented the resident had very limited mobility, a potential for shear/friction problems, was chairfast, constantly exposed to moisture, probably had inadequate nutrition and slightly limited sensory perception. The total pressure ulcer risk score was 11, which indicated the resident was at high risk for pressure ulcer development.  b. The Minimum Data Set dated 8/27/07 documented the resident had modified independence in cognitive skills for daily decision making, required extensive assistance of staff for dressing and personal hygiene, was totally dependent for bathing, had one Stage II pressure ulcer, had a pressure relief device in the bed and chair and was on a turning/repositioning program.  c. A physician order dated 10/31/07 documented: "Paint left heel with Betadine soln [solution]... Nursing to do list: Wound clinic multi [multiple]	{F 314}			

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{F 314}	Continued From page 3 stage 2 ulcers on bottom and ulcer on left heel."  d. A physician order dated 11/6/07 documented: "Apply Thera Boots while in bed and when in wheelchair."  e. On 11/6/07 at 8:26 a.m., the resident was sitting in a wheelchair in the dining room with non-skid socks on both feet. Her feet were positioned directly on the footrests of the wheelchair. There was no pressure relief on the footrests.  f. On 11/8/07 at 10:55 p.m., Licensed Practical Nurse (LPN) #3 was asked what interventions for pressure relief were used for the resident's feet when in the wheelchair before the Thera Boots were ordered on 11/6/07. The LPN stated, "She had a blue boot on ... It was like a Thera Boot, but came up a little higher. She came back from the hospital with the blue boot last week."  g. On 11/8/07 at 11:15 a.m., the Assistant Director of Nursing (ADON) was asked what type of pressure relief was used for the resident's feet when in the wheelchair prior to 11/6/07. The ADON stated, "...She had a blue Thera Boot on the left foot, not on both feet. When I came in Monday, [11/5/07], she had that blue boot on. I got here about 7:30 or 8:00 [a.m.]. They had probably laid her down and got her back up and didn't put it back on."	{F 314}			
F 322 SS=D	483.25(g)(2) NASO-GASTRIC TUBES  Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea,	F 322			

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F 322	<p>Continued From page 4</p> <p>vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure feeding tube placement was verified prior to flushing the tube with water for 2 of 2 case mix residents with feeding tubes (Residents #8 and #15). The failed practice had the potential to affect 5 residents with feeding tubes, as documented on the Resident Census and Conditions of Residents form provided by the Administrator on 11/5/07 at 4:00 p.m. The findings are:</p> <p>1. Resident #8 had diagnoses of Malignant Neoplasm of Larynx and Dysphagia. The Significant Change Minimum Data Set (MDS) dated 10/9/07 documented the resident was moderately impaired in cognitive skills for daily decision-making and had an enteral feeding tube.</p> <p>a. A physician order dated 10/8/07 documented: "Fibersource HM 75 cc/hr [cubic centimeters per hour] per PEG [percutaneous endoscopic gastrostomy] continuous with H2O [water] 50 cc/2hr [50 cc every 2 hours] 7A-7P, 7P -7A [7:00 a.m. to 7:00 p.m. and 7:00 p.m. to 7:00 a.m.]."</p> <p>b. On 11/6/07 at 10:50 a.m., Licensed Practical Nurse (LPN) #1 disconnected the resident's feeding tube, inserted a syringe and flushed the syringe with 60 cubic centimeters (cc) of water without auscultating to verify placement of the tube in the resident's stomach.</p>	F 322		

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F 322	Continued From page 5 2. Resident #15 had diagnoses of Cerebrovascular Accident and Diabetes. The Quarterly MDS dated 9/24/07 documented the resident was moderately impaired in cognitive skills for daily decision-making and had a feeding tube.  a. A physician order dated 11/1/07 documented: "Glucerna continuous @ [at] 80 cc [cc's per hour]. Water Flush 60 cc/2 hr enteral tube 7A-7P, 7P-7A."  b. On 11/7/07 at 9:35 a.m., LPN #2 placed the resident's feeding pump on hold, disconnected the feeding tube and inserted a 60 cc syringe. The LPN then administered 30 cc of water into the gastrostomy feeding tube, using the syringe barrel to push the water into the tube. The LPN did not verify placement of the feeding tube in the resident's stomach prior to flushing.  3. On 11/8/07 at 11:50 a.m., the Director of Nursing (DON) was asked if there were facility guidelines or a policy and procedure for the care of feeding tubes. The DON stated, "No."  4. On 11/8/07 at 5:00 p.m., the DON was asked how often feeding tube placement should be checked. The DON stated, "The nursing practice you should know to check placement. If it's been connected, I would I have always checked placement."	F 322			
{F 323} SS=E	483.25(h) ACCIDENTS AND SUPERVISION  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	{F 323}			

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{F 323}	Continued From page 6  This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure hazardous substances were stored in a secure area and used needles/syringes were properly inserted into a secure SHARPS container upon disposal to prevent potential access by cognitively impaired residents. The failed practices had the potential to affect 19 residents who resided on the 100, 300 and 400 Halls and were cognitively impaired and independently mobile, as documented on a list provided by the Administrator on 11/8/07 at 2:20 p.m. The facility also failed to ensure soft belt restraints were applied in accordance with the manufacturer's instructions to prevent potential accidents/injuries to 2 (Residents #9 and #10) of 3 case mix residents with soft belt restraints in use (Residents #9, #10 and #14). This failed practice had the potential to affect 10 residents with soft belt restraints in use, as documented on a list provided by the Administrator on 11/8/07 at 2:20 p.m. The findings are:  1. The Manufacturer's Recommendations for the Adjusta-Loop Cushion Belt (Soft Belt Restraint) in use in the facility was provided by the Administrator on 11/08/07 at 2:20 p.m. and documented: "...Wheelchair application: ...Place both straps behind the patient and pass the ends through the space between the wheelchair seat and backrest ... Behind the wheelchair, cross the straps and place the right loop over the left kick-spur and the left loop over the right kick-spur	{F 323}			

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{F 323}	Continued From page 7 ..."  2. Resident #10 had a diagnosis of Cerebrovascular Accident. The Minimum Data Set dated 10/29/07 documented the resident was moderately impaired in cognitive skills for daily decision making and had no restraints in use.  a. A physician order dated 9/24/07 documented: "Soft Belt Seat Belt when in wheelchair due to unsteadiness for safety."  b. On 11/6/07 at 8:30 a.m., the resident was sitting in a wheelchair in the dining room with a soft belt restraint in place. The straps of the soft belt were threaded between the armrest and the metal side of the wheelchair chair instead of behind the resident as directed in the manufacturer's guidelines.  3. Resident #9 had a diagnosis of Alzheimer's Disease. The Minimum Data Set dated 9/6/07 documented the resident was moderately impaired in cognitive skills for daily decision making and had no restraints in use.  a. A physician order dated 8/23/07 documented: "Soft Belt Seat Belt when in a chair due to unsteadiness D/T [due to] poor judgement due to Alzheimer's Disease ..."  b. On 11/7/07 at 3:50 p.m., the resident was sitting in a wheelchair in the dining room with a soft belt restraint in place. The straps of the soft belt were wrapped around the metal part of the armrest bars on each side. The right strap was attached to the right kick-spur and the left strap attached to the left kick-spur. The straps were not crisscrossed in back as recommended in the	{F 323}			

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{F 323}	Continued From page 8 manufacturer's guidelines.  4. On 11/5/07 from 12:24 p.m. to 2:25 p.m. during the initial tour of the facility with the Assistant Director of Nursing (ADON), the following observations were made:  a. Room 414B - One 8-ounce bottle of Convatec Aloe Vesta Multipurpose foam peri-cleanser and body wash was sitting on the TV cabinet. The label on the bottle documented: "Warning - For external use only. May cause eye irritation. Rinse eyes with water if contact should occur. Consult a physician if irritation persists..."  b. Room 403 - One 8-ounce bottle of Aloe Vesta Multipurpose foam cleanser was sitting on the top of the nightstand.  c. Room 401 - A 3-plug extension cord was plugged into the 2 plug wall outlet next to the nightstand. A radio and lamp were plugged into the extension cord.  e. Room 411 - Three used razors were on the windowsill in the room and had no cap or covering over the blades.  5. On 11/7/07 at 8:22 a.m., Licensed Practical Nurse (LPN) #3 placed a used insulin syringe into the top of a SHARPS container on the medication cart, but did not lift the lid to drop the syringe into the container itself.  a. On 11/7/07 at 8:38 a.m., LPN #3 placed a used insulin syringe into the inner lid of the SHARPS container, but did not lift the lid to drop the syringes into the secured container. Two syringes were in full view and still accessible from	{F 323}			

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{F 323}	Continued From page 9 the top of the container.  b. On 11/7/07 at 9:00 a.m., LPN #3 left the medication cart with the sharps container unattended in the center of the 100 Hall. One resident propelled past the cart in a wheelchair and 1 visitor walked past the cart while it was unattended. No other staff members were in the hall.  c. On 11/7/07 at 9:11 a.m., LPN #3 returned to the medication cart and stated she had gone to the kitchen. The insulin syringes remained in view.  d. On 11/7/07 at 9:20 a.m., LPN #3 was asked how to properly dispose of used syringes. She stated, "You put them in the SHARPS container and dispose of them." She then looked at the SHARPS container and saw the syringes. She lifted the lid and dropped the syringes into the secured container. The LPN stated, "I should have closed that."	{F 323}			
{F 328} SS=E	483.25(k) SPECIAL NEEDS  The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.  This REQUIREMENT is not met as evidenced	{F 328}			

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{F 328}	Continued From page 10 by: Based on observation, record review and interview, the facility failed to ensure oxygen was administered at the physician-ordered flow rate for 1 (Resident #3) of 5 case mix residents who received respiratory services (Residents #3, #4, #7, #8 and #13). The facility also failed to ensure tracheostomy (trach) care was provided and tracheostomy supplies were maintained in a manner to prevent potential infection for 1 of 1 case mix resident who had a tracheostomy (Resident #8). The failed practices had the potential to affect 22 residents who received oxygen therapy and 1 resident who had a tracheostomy, as documented on lists provided by the Administrator on 11/8/07 at 2:20 p.m. The findings are:  1. Resident #8 had diagnoses of Malignant Neoplasm of Larynx, Aponia and Dysphagia. The Significant Change Minimum Data Set (MDS) dated 10/9/07 documented that the resident was moderately impaired in cognitive skills for daily decision making and received oxygen therapy, suctioning and tracheostomy care.  a. A physician order dated 9/24/07 documented: "Suction PRN [as needed]... to clear secretions." A physician order dated 10/18/07 documented: "Apply moisture to tracheostomy to maintain mobile secretions. Intrain oxygen 2.0 - 3.0 liter/min [2 to 3 liters per minute] to maintain pulse oximetry > [greater than] or equal to 90%..."  b. On 11/5/07 at 1:27 p.m. during the initial tour of the facility with Assistant Director of Nursing (ADON) #1 the resident's inner tracheostomy cannula was dislodged and lying outside the trach stoma. The inner cannula remained attached to	{F 328}			

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{F 328}	<p>Continued From page 11</p> <p>the trach collar. The trach strap had reddish-brown stains on both sides surrounding the cannula and was wet with secretions. ADON #1 left the room and returned with Licensed Practical Nurse (LPN) #1. The resident's call light was on the floor and out of the resident's reach. The oxygen humidifier cannister was empty.</p> <p>c. On 11/5/07 at 1:29 p.m., LPN #1 donned gloves and removed the soiled trach strap then, wearing the same non-sterile gloves, picked up the inner trach cannula and reinserted it into the resident's tracheostomy, then removed it when the resident began to cough.</p> <p>d. On 11/5/07 at 1:30 p.m., LPN #1, still wearing the same gloves, removed a sterile trach care kit from the nightstand drawer. The LPN removed the soiled gloves and, without washing his hands or donning clean gloves, opened a sterile suction catheter kit and placed it on the overbed table. The LPN donned non-sterile gloves that he removed from the pocket of his lab jacket. The ADON brought a Styrofoam cup into the room and poured water from a plastic 1-gallon container labeled, "Nursery purified water" into the cup. The ADON placed the cup of water on the overbed table next to the trach care kit. The ADON was asked what the solution was in the container. She stated, "Sterile water." The plastic water container was marked with Resident #8's name but did not document the date it was originally opened.</p> <p>e. On 11/5/07 at 1:32 p.m., LPN #1 opened the sterile trach care kit and picked up the sterile brush from the kit, touching the bristles of the brush with his non-sterile gloves. The LPN then laid the brush down, removed the supplies from</p>	{F 328}			

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{F 328}	<p>Continued From page 12</p> <p>the sterile trach care kit and placed them on the overbed table top without any preparation to clean or cover the table. LPN #1 picked up the Styrofoam cup and poured the water into the sterile trach care kit tray. The LPN opened the nightstand drawer and removed a package of sterile gloves and opened the package. The LPN removed the non-sterile gloves and donned another pair which he removed from the pocket of his lab jacket. The glove he placed on his right hand ripped in the palm area as it was applied.</p> <p>f. On 11/5/07 at 1:35 p.m., the resident's oxygen remained off while LPN #1 connected a sterile suction catheter to the suction machine while wearing the torn, non-sterile gloves. The LPN suctioned the resident then removed the gloves. The LPN did not wash or sanitize his hands.</p> <p>g. On 11/5/07 at 1:37 p.m., the resident's oxygen remained off. LPN #1 picked up the Styrofoam cup and poured water into the plastic lined box from the suction kit, then donned the sterile gloves. The LPN stated, "We need peroxide. This is improvising now, 'cause we don't have what we need - peroxide." The LPN then dropped the trach cannula into the container of water, picked up the brush and cleaned the cannula with water instead of peroxide. ADON #1 was still in the resident's room at this time.</p> <p>h. On 11/5/07 at 1:40 p.m., LPN #1 placed the inner cannula into the resident's tracheostomy and applied the new trach strap.</p> <p>i. On 11/5/07 at 1:45 p.m., LPN #1 removed the sterile gloves and, without washing his hands, opened the humidifier canister and poured the solution from the gallon container labeled,</p>	{F 328}			

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{F 328}	<p>Continued From page 13</p> <p>"Nursery purified water" into the humidifier and closed the lid. The LPN then turned the oxygen concentrator on and placed the oxygen mask over the trach.</p> <p>j. On 11/6/07 at 11:33 a.m., the gallon container of water labeled, "Nursery purified water" was lying on the floor of the resident's room.</p> <p>k. On 11/6/07 at 11:51 a.m., LPN #1 entered the resident's room and picked the gallon container up off the floor, uncapped the lid and poured water from the container into the resident's oxygen humidifier canister.</p> <p>l. As of 11/7/07 at 9:00 a.m., there was no documentation in the physician orders or Plan of Care to address the required care of the tracheostomy.</p> <p>m. On 11/8/07 at 11:50 a.m., the Director of Nursing (DON) was asked if the facility had a policy and procedure for tracheostomy care. The DON stated, "On that trach care, I haven't done one yet." The DON was asked if LPN #1 had been trained in trach care. The DON stated, "That's why I had [ADON #2] and [ADON #1] working with him when he first came. He's an agency nurse. There isn't a check list at this point ... They go with the agency nurses and make sure they can do care ..."</p> <p>n. On 11/8/07 at 12:00 p.m., ADON #2 was asked if LPN #1 was trained in trach care. She stated, "No." She was asked if she had ever observed LPN #1 perform trach care. She stated, "No."</p> <p>o. On 11/8/07 at 12:12 p.m., LPN #2 was asked</p>	{F 328}			

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{F 328}	<p>Continued From page 14</p> <p>if she received training on trach care at the facility. She stated, "No."</p> <p>p. On 11/8/07 at 12:15 p.m., ADON #1 was asked if she had trained LPN #1 on trach care. She stated, "I watched trach care; I witnessed." She was asked when she had observed trach care. ADON #1 stated, "I can't remember when. When he first started coming out." ADON #1 was asked if the LPN had any problems with skills competency. The ADON stated, "No." ADON #1 was asked if there was documentation of the LPN being observed or checked off on trach care. She stated, "No."</p> <p>q. On 11/8/07 at 5:20 p.m., the DON was asked if there were any additional trach care policies or information. The DON stated, "No, I don't have any."</p> <p>2. Resident #3 had diagnoses of Congestive Heart Failure and Pleural Effusion. The Minimum Data Set dated 8/27/07 documented the resident was moderately impaired in cognitive skills for daily decision making and did not receive oxygen therapy.</p> <p>a. A physician order dated 11/2/07 documented: "Oxygen 1-2 liter/min [liters per minute] PRN [as needed]."</p> <p>b. On 11/5/07 at 4:24 p.m. and 11/6/07 at 8:30 a.m., the resident was in bed with oxygen infusing via nasal cannula. The flow meter on the oxygen concentrator was set to deliver oxygen at 3.25 liters per minute, instead of 1 to 2 liters per minute as ordered by the physician.</p> <p>c. On 11/6/07 at 10:38 a.m., the resident was in</p>	{F 328}			

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{F 328}	Continued From page 15 bed receiving oxygen via nasal cannula. The flow meter on the oxygen concentrator was set to deliver oxygen at 3.5 liters per minute, instead of 1 to 2 liters per minute as ordered by the physician.  d. On 11/6/07 at 1:35 p.m., the resident was in bed receiving oxygen via nasal cannula. The flow meter on the oxygen concentrator was set to deliver oxygen at 3.0 liters per minute, instead of 1 to 2 liters per minute as ordered by the physician.  e. On 11/6/07 at 3:20 p.m., the resident was in bed receiving oxygen via nasal cannula. The flow meter on the concentrator was set to deliver oxygen at 3.0 liters per minute, instead of 1 to 2 liters per minute as ordered by the physician.  f. On 11/7/07 at 8:03 a.m., 10:03 a.m. and 2:40 p.m. and 11/8/07 at 8:17 a.m., the resident was in bed receiving oxygen via nasal cannula. The flow meter on the concentrator was set to deliver oxygen at 3.25 liters/minute.  g. On 11/8/07 at 11:05 a.m., the Director of Nursing (DON) was asked what flow rate of oxygen this resident was supposed to receive. The DON stated, "One to two liters per minute." The DON was asked who was responsible for setting the flow rate of the oxygen. The DON stated, "The Nurse."	{F 328}			