

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

PRINTED: 06/28/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185252	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/15/2011
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NAME OF PROVIDER OR SUPPLIER SHADY LAWN NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 2582 CERULEAN RD. CADIZ, KY 42211
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	INITIAL COMMENTS An abbreviated survey (ARO #KY 16574) was conducted on 06/15/11 and concluded on 06/15/11. The facility failed to meet minimum requirements and deficiencies were cited with the highest S/S being "D".	F 000	Submission of this plan of correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited, and is also not to be construed as an admission of interest against the facility, the Administrator or any employees, agents, or other individuals who draft or may be discussed in this response and plan of correction. In addition, preparation of this plan of correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or see the correctness of any allegation by the survey agency. Accordingly, the facility has prepared and submitted this plan of correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a plan of correction within (10) days of the survey as a condition to participate in Title 18, and Title 19 programs. The submission of the plan of correction within this timeframe should in no way be construed or considered as an agreement with the allegations of noncompliance or admissions by the facility. This plan of correction constitutes a written allegation of submission of substantial compliance with Federal Medicare Requirements.	
F 153 SS=B	483.10(b)(2) RIGHT TO ACCESS/PURCHASE COPIES OF RECORDS The resident or his or her legal representative has the right upon an oral or written request, to access all records pertaining to himself or herself including current clinical records within 24 hours (excluding weekends and holidays); and after receipt of his or her records for inspection, to purchase at a cost not to exceed the community standard photocopies of the records or any portions of them upon request and 2 working days advance notice to the facility. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, it was determined the facility failed to provide a copy of a medical record in a timely manner for one resident (#3), in the selected sample of five. Findings include: A closed record review revealed Resident #3 was admitted to the facility on 03/01/11 with diagnoses to include Chronic Airway Obstruction, Hypertension, Anxiety, Depression, Congestive Heart Failure and Pneumonia. The resident was on comfort measures and expired at the facility on 05/19/11. The resident's Power of Attorney (POA) requested a copy of the resident's record	F 153		



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Jammy Workman</i>	TITLE <i>Administrator</i>	(X8) DATE <i>7-8-11</i>
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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 their 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 153	<p>Continued From page 1</p> <p>and did not receive the copy until over a week later.</p> <p>An interview with Resident #3's POA, on 06/14/11 at 1:30 PM, revealed she requested a copy of the resident's record from the facility a few days after the resident expired. The POA was not sure of the exact date but did not receive the copy of the record for over a week. The POA stated she knew the facility was to provide a copy of the resident's record within two days after the request; however, it was not provided in that timeframe.</p> <p>An interview with the Administrator, on 06/15/11 at 7:15 PM, revealed the POA requested a copy of Resident #3's record, but the copy was not provided for at least a week. The Administrator stated the corporate office required a different release form to be signed which caused a delay in providing the copy.</p>	F 153	<p>F153 RIGHT TO ACCESS/PURCHASE COPIES OF RECORDS</p> <ol style="list-style-type: none"> 1. Resident #3's Power of Attorney has been provided a copy of the resident's record. 2. No other record requests have been received in the past 30 days. 3. The facility administrator has been re-educated by the Regional Director of Clinical Services on 7/5/11 on the requirement of resident or legal representative's right to access all records including current clinical records within 24 hours (excluding weekends and holidays) and to be provided a photocopy of the records or any portions of them upon request within 2 working days. Staff have been educated by NHA on 7/5/11 to immediately notify Administrator of any requests for records. 4. Administrator will maintain a log of all requests for records that indicates date and time request for record was received and date and time record provided to ensure all record requests are provided within 24 hours. Log will be forwarded to monthly QA committee for review and further recommendations. 	
F 157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</p> <p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of</p>	F 157		7/15/11

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F 157	<p>Continued From page 2</p> <p>treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interviews, it was determined the facility failed to ensure the family of one resident (#3), in the selected sample of five, was notified of a medication change. Additionally, the facility failed to notify the family timely after Resident #3 sustained a fall with an injury.</p> <p>Findings include:</p> <p>A closed record review revealed Resident #3 was admitted to the facility on 03/01/11 with diagnoses to include Chronic Airway Obstruction, Anemia, Anxiety, Depression, Congestive Heart Failure and Pneumonia. The resident was on comfort measures and expired at the facility on 05/19/11.</p> <p>A review of a physician's order, dated 03/02/11,</p>	F 157	<p>157 NOTIFY OF CHANGES</p> <ol style="list-style-type: none"> 1. Resident #3 no longer resides at center. 2. All physician orders received in the past 60 days and all accident and incidents that occurred in the past 60 days were reviewed by Director of Nursing (DON) and Assistant Director of Nursing (ADON) to ensure responsible party notification occurred with any order changes or falls. 3. On 6/02/11, DON, reeducated licensed nurses on requirement to immediately notify the resident's legal representative of any accident involving the resident and order changes. 4. DON and/or ADON will review all accident reports and physician orders five days a week for four weeks, three days a week for two weeks and then weekly for four weeks to ensure that responsible party is notified timely of order changes or accidents. Results of audits will be forwarded to monthly QA committee for review and further recommendations. 	7/15/11

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F 157	<p>Continued From page 3</p> <p>revealed to discontinue Nexium 40 milligrams (mg) after the current supply was gone and to start Omeprazole 40 mg daily. There was no documentation in the resident's chart which addressed notification of the responsible party regarding the medication change on 03/02/11.</p> <p>A review of an Accident/Incident Report, dated 03/22/11, revealed Resident #3 sustained a fall when he/she got up to the bathroom at 12:35 AM. The Accident/Incident Report revealed the resident sustained a hematoma on the left knee and ice was applied. The physician was notified at 1:14 AM; however, the responsible party was not notified until 6:00 AM.</p> <p>An interview with the resident's POA, on 06/14/11 at 1:30 PM, revealed Resident #3 fell on 03/22/11 around midnight and she was not notified until six (6) hours later. The POA stated she knew she should be notified immediately.</p> <p>An interview with a Licensed Practical Nurse (LPN) #2, on 06/15/11 at 12:55 PM, revealed an Accident/Incident Report was completed when a resident had a fall. The physician was to be notified immediately, but if it was in the middle of the night, the staff waited until the day shift arrived to notify the responsible party.</p> <p>An interview with LPN #1, on 06/15/11 at 5:30 PM, revealed if a resident had a fall during the night and it did not cause a significant injury, she expected the staff to wait until the morning to notify the responsible party.</p> <p>An interview with the Director of Nursing (DON), on 06/15/11 at 7:00 PM, revealed the responsible</p>	F 157			

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F 157	Continued From page 4 party should be notified of any fall, no matter what time of day or night, unless they specifically requested not to be notified during the night. She stated Resident #3's responsible party had not made a request to not be notified during the night.	F 157		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, it was determined the facility failed to thoroughly investigate bruising for one resident (#3), in the selected sample of five. Resident #3 expired at the facility on 05/19/11. After the resident's death, the responsible party reported to the facility that there was bruising on the resident's right arm. Findings include: A review of the facility's policy for "Abuse/Neglect," dated October 1999 and revised February 2011, revealed staff were to immediately, upon identification of injuries of unknown source, initiate an Accident/Incident report. The "Investigation" procedure revealed to initiate the Accident/Incident report, investigation, follow up and disposition procedure located in the manual. Collect data on the Accident/Incident report. Initiate the investigation which included following the algorithm "Investigation: Incident of Unknown Origin" and using the "Incident of	F 226	F 226 DEVELOP/IMPLEMENT ABUSE/NEGLECT, ETC POLICIES 1. Resident #3 no longer resides at center. 2. Skin assessment completed on all in-house residents to ensure all identified areas of bruising have been investigated thoroughly. All accident reports completed in past 60 days have been reviewed by ADM and DON to ensure thorough investigation conducted on all areas of bruising. 3. Licensed nurses re-educated by DON on 6/20/11 regarding requirement to initiate Accident/Incident report upon identification of injuries of unknown source and to initiate investigation process. DON re-educated on requirement that all bruising must be thoroughly investigated 4. All Accident/Incident reports will be reviewed by ADM weekly to ensure thorough investigation completed on any injury of unknown source. Results of reviews will be forwarded to monthly QA committee for review and further recommendations.	7/15/11

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F 226	<p>Continued From page 5</p> <p>Unknown Origin: Internal Investigation Data Sheet".</p> <p>A closed record review revealed Resident #3 was admitted to the facility on 03/01/11 with diagnoses to include Chronic Airway Obstruction, Anemia, Anxiety, Depression, Congestive Heart Failure and Pneumonia. The resident had a procedure for an AV fistula in January 2011, but it was not accessed since placement. The resident was on comfort measures and expired at the facility on 05/19/11.</p> <p>An interview with Resident #3's Power of Attorney (POA), on 06/14/11 at 1:30 PM, revealed the resident had a procedure for an AV fistula in his/her right arm in January 2011. The fistula was not accessed for dialysis and the facility was provided instructions for no blood pressures or laboratory procedures in the resident's right arm. The POA revealed, on 05/19/11, she noticed bruising on the resident's right arm in the area where the fistula was located and reported the bruising to Licensed Practical Nurse (LPN) #4. Resident #3's POA stated she took pictures of the bruised area and showed it to the Assistant Director of Nursing (ADON) a couple of days after the resident expired and requested an investigation to be completed. She felt the bruising could be attributed to blood pressures being obtained in that arm.</p> <p>An interview with LPN #4, on 06/15/11 at 4:45 PM, revealed she recalled Resident #3's POA informed her, on 05/19/11, prior to the resident's death, of bruising on the resident's right arm above the AV fistula. LPN #4 stated vital signs were being obtained every three or four hours on</p>	F 226		
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F 226	Continued From page 6 the resident. She described the bruising to be the size of a 50 cent piece and was located above the AV fistula on the right arm. LPN #4 stated she did not know the source of the bruising but Resident #3 had multiple areas of bruising and thought the bruised areas could be from a recent hospital stay. She revealed she did not complete an incident report even though she was not sure of the source of the bruising. An interview with the Assistant Director of Nursing (ADON), on 06/15/11 at 5:15 PM, revealed Resident #3's POA made her aware of the bruising on Resident #3's right arm a couple of days after his/her death and the POA requested an investigation be completed to determine the cause of the bruising. The ADON confirmed that the POA showed her pictures of Resident #3's bruised right arm and wanted her to notify the Director of Nursing (DON). She notified the Director of Nursing but did not recall anything further about it. An interview with the DON, on 06/15/11 at 5:45 PM, revealed the ADON notified her about the POA's report of bruising and the request for an investigation. The DON stated she questioned LPN #2 and LPN #4 about the bruising; however, she could provide no documented evidence of an investigation. Interviews with LPN #2 and LPN #4, on 06/15/11 at 7:30 AM and 7:40 AM, revealed they did not recall that the DON had discussed with them or requested statements from them related to the bruising on Resident #3's right arm.	F 226			
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS	F 281			

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F 281	<p>Continued From page 7</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interviews, it was determined the facility failed to ensure services provided by the facility met professional standards of quality related to the administration of oxygen (O2) for one resident (#3), in the selected sample of five. O2 was administered to Resident #3 at 5 liters per nasal cannula (5 L/NC); however, there was no evidence of a physician's order for the O2 to be administered at 5 liters.</p> <p>Findings include:</p> <p>A review of the facility's policy titled "Oxygen Administration", dated December 1999 and revised October 2009, revealed "a physician's order must be obtained prior to the administration of O2 and all orders for O2 therapy must include liter flow or concentration".</p> <p>A closed record review revealed Resident #3 was admitted to the facility on 03/01/11 with diagnoses to include Chronic Airway Obstruction, Anemia, Anxiety, Depression, Congestive Heart Failure and Pneumonia. The resident was on comfort measures and expired at the facility on 05/19/11.</p> <p>Review of nurses' notes, dated 05/06/11 at 1:00 PM, 05/07/11 at 1:00 PM, 05/08/11 at 10:00 AM, 05/09/11 at 1:00 PM, 05/10/11 at 11:00 AM, 05/11/11 at 7:00 AM, 05/12/11 at 7:00 AM,</p>	F 281	<p>F281 SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <ol style="list-style-type: none"> 1. Resident #3 no longer resides at center. 2. All residents receiving oxygen have been reviewed by DON to ensure oxygen is administered per physician orders. 3. Licensed nurses were re-educated on 6/20/11 by DON regarding requirement to ensure that oxygen is administered as ordered by physician. 4. DON will review all resident receiving oxygen 3 times per week for 2 weeks, then weekly for 4 weeks, then monthly to ensure oxygen is administered as ordered by physician. Results of audits will be forwarded to monthly QA committee for review and further recommendations. 	7/15/11

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F 281	<p>Continued From page 8</p> <p>05/13/11 at 10:35 AM, 05/14/11 at 10:00 AM, 05/15/11 at 9:50 AM, 05/16/11 at 7:00 AM, 05/17/11 at 8:30 AM, 05/18/11 at 11:00 AM and 05/19/11 at 10:00 AM, revealed the resident received O2 at 5 L/NC.</p> <p>A review of a physician's order, signed on 05/07/11, revealed O2 at 2 L/NC to be administered for Resident #3.</p> <p>An interview with the Director of Nursing (DON), on 06/15/11 at 6:50 PM, revealed she was unable to verify a physician's order for O2 at 5 L/NC for this resident. The DON stated she thought a nurse received the order from the hospital but could not verify this information.</p>	F 281		
F 328 SS=D	<p>483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, record review and interviews, it was determined the facility failed to ensure three residents, (#1, #2 and #5), in the selected sample of five, received proper care and</p>	F 328		

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F 328	<p>Continued From page 9</p> <p>treatment related to oxygen (O2) hydration not maintained and unqualified staff who administered O2 therapy. Certified Nurse Aides (CNAs) were observed setting an O2 regulator for Resident #1. Observations revealed O2 was administered to Resident #5 with the hydration container empty. Resident #2 stated he/she had to take his/her O2 off frequently due to the hydration container on the O2 concentrator being empty.</p> <p>Findings include:</p> <p>1. A review of the facility policy for "Oxygen (O2) Administration", dated 12/1999 and revised January 2006 and October 2009, revealed "Prefilled humidifier with sterile water or refillable humidifier with distilled water".</p> <p>A record review revealed Resident #2 was admitted to the facility on 04/12/11 with diagnoses to include Anemia, Chronic Airway Obstruction and Chronic Respiratory Failure.</p> <p>An observation, on 06/15/11 at 7:45 AM, revealed Resident #2 was in bed with O2 per nasal cannula at 2 liters (2/L). An interview at the time revealed the resident required O2 continuously, but frequently had to "take it off" due to the hydration container being empty and causing his/her nose to become "bone dry" and very uncomfortable.</p> <p>2. A record review revealed Resident #5 was admitted to the facility on 06/27/10 with diagnoses to include Cerebral Vascular Accident (CVA), Dementia and Hemiparesis. A review of a physician's order, dated 06/01/11, revealed O2</p>	F 328	<p>F328 TREATMENT/CARE FOR SPECIAL NEEDS</p> <ol style="list-style-type: none"> 1. Resident #1 is receiving oxygen as ordered by physician. Resident #5 and #2 are receiving hydration on oxygen container per prefilled humidifier. 2. All residents receiving oxygen reviewed to ensure oxygen concentrators have filled humidifer present. CNA #2 and #3 were re-educated by DON on 6/15/11 regarding the requirement that oxygen regulators may only be set by licensed nurse. 3. Licensed nurses re-educated on 6/20/11 by DON regarding requirement to monitor oxygen containers to ensure hydration containers on oxygen are changed before empty. Nursing assistants were re-educated by DON on 6/15/11 regarding the requirement that oxygen regulators may only be set by licensed nurse. 4. DON will observe humidifier bottles on oxygen concentrators weekly to ensure containers are not empty. DON will observe 5 transfers of residents receiving oxygen weekly X 4 weeks, then one weekly to ensure nursing assistants do not set oxygen regulators. Results of audits will be forwarded to monthly QA committee for review and further recommendations. 	7/15/11
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/28/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185252	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/15/2011
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NAME OF PROVIDER OR SUPPLIER SHADY LAWN NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 2582 CERULEAN RD. CADIZ, KY 42211
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 328	<p>Continued From page 10 per nasal cannula.</p> <p>Observations, on 06/15/11 at 8:00 AM, 10:05 AM and 2:35 PM, revealed Resident #5 was in bed, his/her eyes closed with O2 at 2/L per nasal cannula. The hydration container was empty during each observation.</p> <p>3. A record review revealed Resident #1 was admitted to the facility on 03/30/11 with diagnoses to include Acute and Chronic Respiratory Failure, Chronic Airway Obstruction and Congestive Heart Failure. The resident was alert and able to make his/her needs known.</p> <p>An observation, on 06/15/11 at 10:15 AM, revealed Resident #1 was assisted to the wheel chair from the bed by CNA #2 and CNA #3. CNA #3 changed the resident's O2 from the concentrator to a portable O2 tank located on the back of the wheel chair and set the O2 regulator at 5 liters (5/L).</p> <p>Interviews, on 06/15/11 at 10:25 AM, with CNA #2 and CNA #3 revealed they set the O2 regulators when transferring residents that required O2 therapy.</p> <p>An interview with the Director of Nursing (DON), on 06/15/11 at 5:45 PM, revealed hydration containers for O2 therapy was for the resident's comfort and without the hydration containers O2 therapy could cause dry membranes. Nurses were responsible to ensure the hydration containers functioned properly and should replace them when empty. The DON also stated CNAs should not set the regulators on the residents' O2 concentrators or cylinders and the</p>	F 328		
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185252	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/15/2011
NAME OF PROVIDER OR SUPPLIER SHADY LAWN NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2582 CERULEAN RD. CADIZ, KY 42211		
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F 328	Continued From page 11 nurses were responsible to set the regulators.	F 328			