Exhibit A

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

PRINTED: 11/08/2018
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
	335425	A. BUILDING _____ B. WING _____	C 04/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBANY COUNTY NURSING HOME	780 ALBANY SHAKER ROAD ALBANY, NY 12211

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F 678 SS=E	Cardio-Pulmonary Resuscitation (CPR) CFR(s): 483.24(a)(3) §483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. This REQUIREMENT is not met as evidenced by: Based on record review and interview during an abbreviated survey (Case #NY00216244), the facility did not ensure personnels ability to provide emergency basic life support, including cardiopulmonary resuscitation (CPR), to residents requiring such care prior to the arrival of emergency medical personnel in accordance with the resident's advance directives and subject to related physician orders for one (Resident #1) of four residents reviewed. Specifically, the facility did not ensure Resident #1's advance directive status was known during a significant change in the resident's respiratory condition on 3/1/18. This is evidenced by: Refer to F684 Resident #1: The resident was readmitted to the facility on 11/10/17, with a diagnoses of chronic obstructive pulmonary disease, dementia without behavioral disturbance, and hypertensive heart disease without heart failure. The Minimum Data Set (MDS) dated 2/15/18, assessed the resident with severe cognitive impairment. The facility's Advanced Directive Policy and Procedure (P&P) dated 6/2017, documented that	F 678		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 11/07/2018

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 678	Continued From page 1 the MOLST (Medical Orders for Life Sustaining Treatment) form is a short summary of the resident's treatment preferences with a physician's order for care that is easy to read in an emergency situation. The medical orders must be followed by all health care professionals. CPR (cardio pulmonary resuscitation) restores cardiac function or supports ventilation in the event of a cardiac or respiratory arrest. If the resident/representative chooses CPR, the nurse will ensure that the resident's identification bracelet, doorway name plate, and medical record spine will be blue, and "full code" order will be obtained. The facility P&P for "Code E Rapid Response" revised 6/2017, documented that "Code E" is utilized to designate a Medical Emergency. A "Rapid Response" is utilized when a Medical Emergency may be imminent based upon nursing assessments. The purpose of the P&P documented to provide for immediate Medical and Nursing response for residents when a medical emergency arises. The Procedure documented: 1) Announce a Code E, validate code status. 2) Stay with victim. The resident's Medical Orders for Life-Sustaining Treatment (MOLST) dated 5/9/17, documented to attempt Cardio-Pulmonary Resuscitation (CPR) when the resident has no pulse and/or is not breathing, The physician's order dated 11/10/17, renewed on 2/12/18, documented the resident's Advanced Directive status was a full code. The Comprehensive Care Plan (CCP) for Advanced Directives updated 2/13/18,	F 678		

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F 678	Continued From page 2 documented the resident's current code status is full code, with HCP (health care proxy) and MOLST on file. The Nursing Progress Note written by the Registered Nurse Supervisor (RN #1) on 3/1/18 at 6:04 pm, documented the resident was noted to have a fever of "103.4" tympanic (taken via the ear). Tylenol 650 mg given per prn (as needed) order. Lungs congested with expiratory wheeze (high-pitched whistling sound made while breathing out). O2 SAT "81%" on room air; Oxygen started at 2 liters via nasal cannula. Nebulizer treatments (breathing treatments) given per order. Pulse between "180 and 220." MD (Medical Doctor) #1 made aware of above. The note did not include the resident's rate of respirations. The Weights and Vitals Summary dated 3/1/18 at 6:10 pm, documented: Pulse 180 bpm (beats per minute); (normal is 60-100); Respirations 40 breaths/minute (normal is 12-22); Temperature 103.4 (tympanic) (normal is 97-99). The summary did not include a blood pressure. The EMS Patient Care Record (PCR) dated 3/1/18, documented that EMS arrived in the resident's room at "6:45 pm." Patient was unresponsive and a family member was hysterical in the room screaming and crying. Facility staff were not in the resident's room. There was no report from facility staff. Patient found lying in hospital bed "unresponsive in obvious respiratory failure, near respiratory arrest." Hot, diaphoretic (sweating excessively), pale, accessory muscles (muscles of the neck, back, and abdomen that assist with respiration) used with breathing, decreased breath sounds on	F 678		

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F 678	Continued From page 3 left and right, increased respiratory effort, and unresponsive. At 6:46 pm, non-patent (obstructed) airway in need of immediate airway support/control and the patient was bagged (artificial ventilation performed with a respirator bag). The patient remained unresponsive and at 7:07 pm was intubated. Physician's order dated 3/1/18 at 7:17 pm, documented emergency room transfer for respiratory distress. The Hospital Chart Report Visit documented the resident arrived on 3/1/18 at 7:40 pm with patient complaint of "respiratory arrest." During an interview on 4/10/18 at 3:40 pm, LPN #1 stated she did not know the resident was a full code. She wasn't familiar with the resident and stated RN #1 might have checked. LPN #1 is CPR certified. She stated she was not able to recognize respiratory distress, respiratory failure, or respiratory arrest. "LPNs do not assess." During an interview on 4/12/18 at 3:40 pm, RN #1 was able to identify a resident who is a full code; Blue wrist band, blue band on door, blue band on chart. RN #1 stated, "We check DNRs twice a day. You don't want to start CPR on someone who is a DNR." When asked if she realized the resident was a full code, she stated, "Not until making copies of the paperwork for EMS." During an interview on 4/12/18 at 5:15 pm, the Director of Nursing (DON) stated that "Staff should know the resident's code status. That's why we have a system in place."	F 678		
F 684	Quality of Care	F 684		

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F 684 SS=E	Continued From page 4 CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review and interviews during an abbreviated survey (Case #NY00216244), the facility did not ensure that a resident received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan and the resident's choices for one (Resident #1) of three residents reviewed. Specifically, for Resident #1, the facility did not promptly identify and intervene for an emergent change in the resident's condition resulting in the family calling 911 to transport the resident to the hospital. The Hospital Chart Report Visit documented respiratory arrest. This is evidenced by: Resident #1: The resident was readmitted to the facility on 11/10/17, with a diagnosis of chronic obstructive pulmonary disease (COPD), dementia without behavioral disturbance, and hypertensive heart disease without heart failure. The Minimum Data Set (MDS) dated 2/15/18, assessed the resident with severe cognitive impairment. The facility guide (undated) titled "Change in	F 684		

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F 684	Continued From page 5 Condition - Identify, Communicate and Manage" documented: Always assess vital signs before calling the physician service with a change in condition. Normal values documented; Pulse 60-100, blood pressure (90/60 - 120/80), oxygen saturation level (O2 SAT) 95 - 100%, respiratory rate 12-22, temperature 97-99 degrees F. Contact physician services for any changes in condition of the resident. Example - new onset of symptoms/exacerbations. Timely communication is key to this treatment modality and needed to determine the next step in treating conditions effectively and safely. Change in condition is any alteration from an individual's usual healthy or baseline status. The change may illustrate signs of acute distress or evidence of an increase in symptoms of an existing chronic disease. Goal is to recognize a change in condition to initiate clinical action, determine clinical interventions based on the advance care plan and avoid potential complications of illness. Additional signs to look for included difficulty breathing and abnormal vital signs. Avoid delays to report a change in condition. SBAR (Situation -What is going on with the resident? Background - What is the clinical background or context? Assessment - What is the problem? and Recommendations and Request - What would I do to correct it?) The facility policy and procedure (P&P) for the "Notification of Significant Changes" revised 8/2017, documented that residents identified with a significant change receive appropriate intervention. The procedure in case of an extreme emergency documented the nurse may use clinical judgement and send a resident to the	F 684		

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F 684	Continued From page 6 emergency room prior to receiving a physician order. The facility Advanced Directive P&P dated 6/2017, documented the MOLST (Medical Orders for Life Sustaining Treatment) form is a short summary of the resident's treatment preferences and a physician's order for care in an emergency situation. These valid medical orders must be followed by all health care professionals. CPR (cardio-pulmonary resuscitation) means to restore cardiac function or to support ventilation in the event of a cardiac or respiratory arrest. The Oxygen Therapy P&P revised 6/2017, documented that an RN (registered nurse) may apply oxygen or increase current (oxygen) flow per their nursing judgment. The facility P&P for "Code E Rapid Response" revised 6/2017, documented that "Code E" is utilized to designate a Medical Emergency. A "Rapid Response" is utilized when a Medical Emergency may be imminent based upon nursing assessments. The P&P documented to provide for immediate Medical and Nursing response for residents when a medical emergency arises. It documented: 1) Announce a Code E, validate code status. 2) Stay with victim. The resident's Medical Orders for Life-Sustaining Treatment (MOLST) dated 5/9/17, documented when the resident has no pulse and/or is not breathing, attempt Cardio-Pulmonary Resuscitation (CPR). The physician's order dated 11/10/17, renewed on 2/12/18, documented the resident's Advanced Directive status was a full code.	F 684		

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F 684	Continued From page 7 The Comprehensive Care Plan (CCP) for Advanced Directives updated 2/13/18, documented the resident's current code status is full code. The Comprehensive Care Plan (CCP) for Risk for Altered Nutrition Status updated 2/14/18, documented a goal for the resident to have clear lungs with no signs and symptoms of aspiration with an intervention to monitor for shortness of breath, choking, labored respirations, and lung congestion. An Employee Statement written by LPN #1, on 3/1/18, documented that between approximately 5:30 - 6:00 pm, a CNA (certified nursing assistant) noticed the resident felt warm to touch and had a temperature of 101.9 F. Tylenol 650 mg and a Duoneb (breathing treatment) was given for wheezing. The Registered Nurse Supervisor (RN #1) arrived on the unit. A physician's order dated 3/1/18 at 5:54 pm, documented for the resident to be given Levaquin 250 mg (antibiotic) 2 tabs, by mouth now, for 1 day, for elevated temperature and respiratory congestion. The Nursing Progress Note written by the Registered Nurse Supervisor (RN #1) on 3/1/18 at 6:04 pm, documented the resident had a fever of "103.4" tympanic (ear). Tylenol 650 mg given. Lungs congested with expiratory wheeze (high-pitched whistling sound made while breathing out). O2 SAT "81%" on room air. Oxygen started at 2 liters via nasal cannula. Nebulizer treatments given. Pulse between 180 and 220. MD (Medical Doctor) #1 made aware.	F 684		

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F 684	Continued From page 8 Order received for Levaquin (antibiotic) 500 mg now. The possibility of the resident's family wanting the resident to go to the hospital was discussed with the MD. The MD stated it was okay and to send the resident out if we are unable to get the resident to take the antibiotic. The Weights and Vitals Summary dated 3/1/18 at 6:10 pm, documented: Pulse 180 bpm (beats per minute); (normal is 60-100) ; Respirations 40 breaths/minute (normal is 12-22); Temperature 103.4 (tympanic) (normal is 97-99). The summary did not document a blood pressure. The resident's medical record did not include an SBAR (per facility policy) for the resident's change (decline) in condition. The Employee Statement written by RN #1, on 3/1/18, documented RN #1 called the resident's daughter and left a message that the resident was sick. RN #1 left the unit to attend to another situation at approximately 6:15 pm. The Employee Statement written by LPN #1, on 3/6/18, documented the supervisor left the unit. LPN #1 went back into the resident's room to check on him less than 10 minutes later, and noted the resident's breathing had become more rapid. O2 was increased to 5 liters and the supervisor was paged. RN #1 did not answer right away. The resident's daughter arrived on the unit and went directly into the resident's room. The EMS (Emergency Medical Services) Pre-hospital Care Report (PCR) dated 3/1/18, documented EMS received a call regarding the resident's breathing problems from a family member at 6:34 pm.	F 684		

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F 684	Continued From page 9 The Employee Statement written by RN #1, on 3/1/18, documented RN #1 left the unit to go to another unit to check on another situation. RN #1 was on the telephone on another unit when she heard a page for her to call Unit 5HR. As she finished the telephone call, maybe "5" minutes later, there was another page for her to call 5HR "STAT (right away). This occurred about "6:35 pm - 6:40 pm." RN #1 called the unit and was told the resident's daughter was there and was screaming. The resident's daughter had called 911. EMS arrived at about "6:45 pm." The EMS Patient Care Record (PCR) dated 3/1/18, documented that the EMS arrived in the resident's room at "6:45 pm." Patient was unresponsive and a family member was hysterical in the room screaming and crying. Facility staff were not in the resident's room. There was no report from facility staff. Patient found lying in hospital bed "unresponsive in obvious respiratory failure, near respiratory arrest." Hot, diaphoretic (sweating excessively), pale, accessory muscles (muscles of the neck, back, and abdomen that assist with respiration) used with breathing, decreased breath sounds on left and right, increased respiratory effort, and unresponsive. At 6:46 pm, non-patent (obstructed) airway in need of immediate airway support/control and the patient was bagged (artificial ventilation performed with a respirator bag). The patient remained unresponsive and at 7:07 pm was intubated. The Hospital Chart Report Visit documented the resident arrived on 3/1/18 at 7:40 pm, with patient complaint of "respiratory arrest."	F 684		

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F 684	Continued From page 10 During an interview on 4/5/18 at 3:11 pm, RN #1 stated she was called to unit 5HR between 4:15 pm and 4:30 pm by LPN #1 stating the resident's temperature was "101." She went to the unit, got vitals, but had trouble getting the blood pressure. The temperature was "103 something." The O2 SAT was "82%" on room air. Pulse was "220" (via finger device). The resident's hands were shaking, hands were all over the place, which was his norm. She could not get a blood pressure. She left the room and told LPN #1 to start oxygen. LPN #1 had given Tylenol. RN #1 called the MD who gave an order for antibiotics. RN #1 asked the MD (#1) if he wanted the resident sent out to the hospital and was instructed to send the resident to the hospital per family request or if they couldn't get the antibiotic into him. LPN #1 gave the antibiotic. RN #1 completed documentation, and left the unit. While on the other unit, RN #1 heard an overhead page to call 5HR, and realized her radio was not working. She then got a page to call unit 5HR STAT. RN #1 called the unit and was told the resident's daughter was there. The resident's daughter was screaming, crying and had called 911. RN #1 was not given information about the resident's condition during the call. RN #1 went to the unit, walked into the resident's room, the resident's daughter stopped her, called her a few choice words" and refused to let her in (resident's room). The curtain was partially closed and only the resident's feet and the daughter could be seen. The resident was "gasping" and there was a significant change in his respiratory status." She texted MD #1 to tell him the resident was going to the hospital. During an interview on 4/10/18 at 3:40 pm, LPN #1 stated the resident's temperature was "101.9"	F 684		

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F 684	Continued From page 11	F 684		

when she gave Tylenol. LPN #1 gave the scheduled nebulizer treatment a little early because the resident was wheezing. LPN #1 stated the resident was breathing heavy, but did not seem to be in distress. She did not call the Supervisor because as she was signing for the medications, the Supervisor (RN #1) came onto the unit for rounds, around suppertime. RN #1 rechecked the resident's temperature and it was "103." RN #1 gave instructions to put the resident on oxygen after the breathing treatment for an O2 SAT in the 80's. RN #1 called MD #1 who ordered Levaquin (antibiotic). LPN #1 was not sure if the MD wanted the resident to go to the hospital. LPN #1 got cool wash cloths and wiped the resident down. RN #1 left the unit and came back with the antibiotic. LPN #1 gave the antibiotic (time unknown) and left the resident's room. RN #1 left the unit. About 10 minutes later, when the LPN went back into the resident's room, the resident was breathing heavier than normal and faster. LPN #1 increased the resident's oxygen because she thought it would help him, but did not recall the number of liters the oxygen was increased to. The O2 SAT or other vitals were not checked. The resident was wiped down with cool cloths. The LPN left the room to page RN #1. RN #1 did not call back (answer the page). The RN was not paged stat (immediately). In regard to calling a Code E, the LPN stated, "I can't do anything without going through the Supervisor. We have to let them know." Shortly after the Supervisor was paged, the daughter arrived on the unit. The daughter went into the resident's room and started screaming and that is when I paged the Supervisor stat. LPN #1 was behind the desk when the daughter arrived. Regarding whose responsible for monitoring the resident for respiratory distress, the LPN stated

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F 684	Continued From page 12 she can't stay in the resident's room. The LPN stated that she has to do everybody's meds and their pain pills. After the Supervisor was paged stat, she came to the unit. The resident's daughter was in the resident's room and would not let RN #1 in the room. LPN #1 was at the desk when RN #1 arrived on the unit. During an interview on 4/12/18 at 3:40 pm, RN #1 stated when the resident was having "slight respiratory distress" per her assessment note, she meant that he had a cough and congestion. RN #1 stated she thought the resident's respirations were 24-28 breaths/min. RN #1 tried to get an apical pulse (placing a stethoscope on the heart) but was unable to get an accurate one because the resident was fighting/pushing her away. RN #1 believed the resident's change in condition was urgent, but did not know if the urgency was expressed to the MD. RN #1 stated when asked if she gave any specific instructions for monitoring the resident to LPN #1 that "I might have said to keep an eye on him. LPN #1 knew something was going on in there. She gave him the antibiotic." RN #1 did not believe there was a written protocol for full code or change in condition. The LPN should have "gotten a hold of an RN." After the stat page the RN went to the unit and the resident's "breathing was much worse." RN #1 was not aware that LPN #1 had increased the O2 to 5 liters. When asked if she realized the resident was a full code, she stated, "Not until making copies of the paperwork for EMS." During an interview on 4/12/18 at 4:15 pm, CNA #1 stated the resident was restless ("fidgety in the recliner"). She decided to put him to bed and when she took his shirt off, she noticed that he	F 684		

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	335425	A. BUILDING _____ B. WING _____	C 04/26/2018

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F 684	Continued From page 13	F 684		

felt hot. The resident's temperature was "101.9." The resident's temperature was reported to LPN #1. RN #1 showed up on the unit. CNA #1 said she did not stay in the resident's room. LPN #1 did not ask her to check on the resident. She stated that when she found that he was hot, she told the LPN, and the LPN told the Supervisor. LPN #1 was at the desk when the resident's daughter came in. CNA #1 was in the lounge and heard yelling coming from the resident's room. CNA #1 went into the resident's room, the curtain was partially closed and looked around the curtain. The daughter was sitting on the bed on her cellphone. The resident was sitting in an upward position. The daughter was screaming "at the top of her lungs" to someone on the phone.

During an interview on 4/12/18 at 5:15 pm, the Director of Nursing (DON) stated LPNs cannot assess residents. LPN's can initiate oxygen if a resident is having a respiratory issue. She stated, "If they come upon a resident and the O2 SAT is low, they then call the RN for the change in condition, so that an assessment can be done." For a change in condition, staff are supposed to take vitals and report to the nurse. The LPNs and RNs receive SBAR training. Code E is for assistance with any type of medical emergency. The DON stated that to her knowledge, a Code E was not called on 3/1/18. If the LPN called a Code E, it "certainly" would have gotten staff to her sooner. Staff should know the code status. That's why we have a system in place."

During an interview on 4/17/18 at 10:25 am, Medical Doctor (MD) #1 stated the resident's temperature was "101.3" and heart rate was around "100 - 120." Tylenol, oxygen, one dose of Levaquin (antibiotic) were ordered with

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F 684	Continued From page 14 instructions to call the resident's family regarding their preferred hospital to send the resident out to. MD #1 was not aware the resident's temperature was "103.4 F" until afterwards. One dose of the Levaquin was ordered to start until the family was called. The MD was not aware that the resident's condition worsened until informed that the family called 911. The MD stated that when the RN was attending to another situation, a Code E should have been called. Staff should have prepared to start CPR if the resident was a full code. During an interview on 4/18/18 at 2:06 pm, with the Respiratory Therapist/Director (RT #1) stated for oxygen administration during respiratory distress, the respiratory rate, heart rate, and O2 SATs need to be checked and the resident needs to be evaluated. Each situation has its own set of variables. From the Respiratory Therapist's perspective, if the resident was in respiratory distress, he would check an O2 SAT. When a resident is found in respiratory distress the Supervisor should be called. During an interview on 4/18/18 at 2:55 pm, with the Medical Director (MD #2) regarding the staff's response when the resident was found in respiratory distress, MD #2 stated "As a physician, I would have expected the code to be called. Then they'd get a rapid response team." The SBAR form is a good guide for RNs and LPNs to use and helps the MD a lot. MD #2 stated that when the resident's temperature is "103.4", there is no accurate heart rate, and no blood pressure, that's where the Code E comes in. The situation would have gone more smoothly had staff called a Code E.	F 684		

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F 684	Continued From page 15 10 NYCRR 415.12	F 684		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on record review and interview during an abbreviated survey (Case # NY00216244), the facility did not ensure that a resident who needs respiratory care is provided such care, consistent with professional standards of practice for one (Resident #1) of four residents reviewed. Specifically, on 3/1/18, the physician order for Resident #1 to receive 2 liters of oxygen was not transcribed onto the electronic Physician Order Entry system, the resident's respiratory status was not monitored, and there was no documentation of the oxygen therapy. This is evidenced by: Refer to F684 Resident #1: The resident was readmitted to the facility on 11/10/17, with a diagnosis of chronic obstructive pulmonary disease (COPD), dementia without behavioral disturbance, and hypertensive heart disease without heart failure. The Minimum Data	F 695		

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F 695	Continued From page 16 Set (MDS) dated 2/15/18, assessed the resident with severe cognitive impairment. The facility's policy and procedure (P&P) for Oxygen Therapy revised 6/2017, documented oxygen will be administered by physician order or in emergency situations per nursing judgment. The oxygen order must include: type of administration (nasal cannula or face mask), number of liters per minute, continuous or PRN (as needed) administration, indications for use, specific parameters if the flow rate is determined by the resident's blood oxygen, as determined by the pulse oximeter. The Registered Nurse (RN) may apply oxygen or increase current flow per their nursing judgment. Oxygen therapy will be documented on the resident's TAR (treatment administration record) each shift by the licensed nurse. When a pulse oximeter is used, the oxygen saturation (O2 SAT) will be documented on the TAR and or nursing notes. The Nursing Progress Note written by the Registered Nurse Supervisor (RN #1) on 3/1/18 at 6:04 pm, documented the resident was noted to have a fever of "103.4" tympanic. Tylenol 650 mg given per prn (as needed) order. Lungs congested with expiratory wheeze (high-pitched whistling sound made while breathing out). O2 SAT "81%" on room air; oxygen started at 2 liters via nasal cannula. Nebulizer treatments (breathing treatments) given per order. Pulse between "180 and 220." MD (#1) made aware of above. The respirations were not documented in the note. The Weights and Vitals Summary dated 3/1/18 at 6:10 pm documented the following: pulse "180 bpm (beats per minute); respirations "40"	F 695		

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F 695	Continued From page 17 breaths/minute; temperature "103.4" (tympanic). The was no documented physician order for the oxygen that included the oxygen delivery system (nasal cannula or face mask), parameters for administration (continuous or intermittent), equipment settings for the prescribed flow rates, and monitoring of O2 SATs. There was no documentation of the oxygen therapy on the TAR. The medical record did not reflect ongoing assessment of the resident's respiratory status and response to the oxygen therapy. During an interview on 4/10/18 at 3:40 pm, Licensed Practical Nurse (LPN) #1 stated RN #1 left the unit after she assessed the resident for a change in condition. LPN #1 went back into the resident's room about 10 minutes later. The resident was "breathing heavier than normal and faster." She increased the oxygen, but could not recall the number of liters. She stated, "I did it because I thought it would help him." She did not check the O2 SAT and did not check any other vitals. During an interview on 4/12/18 at 3:40 pm, RN #1 stated there are no standing orders for oxygen. The MD will order oxygen and tell the nurse what he wants the rate to be. She stated, "With all of the excitement, I didn't enter an order for it." After she was paged stat and went to the unit, the resident's "breathing was much worse." LPNs can check the O2 SAT. She was not aware that LPN #1 had increased the O2 to 5 liters. LPN #1 should have gotten permission to increase the oxygen. There is an oxygen policy that states	F 695		

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F 695	Continued From page 18 nurses need to follow the MD's order. During an interview on 4/12/18 at 5:15 pm, the Director of Nursing (DON) stated LPNs cannot assess residents. LPNs can initiate oxygen if a resident is having a respiratory issue. If they come upon a resident and the O2 SAT is low, they then call the RN for the change in condition, so that an assessment can be done. LPNs can check the O2 SAT; every unit has 2 devices. CNAs can also use them. Regarding the LPN not checking the resident's O2 SAT, she picked up the Oxygen policy and stated, "This is our policy and staff are trained when changes are made to it." For a change in condition, staff are supposed to take vitals. They should be reporting to the nurse. The nurse enters the vitals into the computer system. There are no standing orders for oxygen; there should have been an order. Sometimes the MD gives parameters to maintain the O2 SAT. She stated, "We have to monitor O2 SATs." The nurse can obtain an O2 SAT. During an interview on 4/18/18 at 2:06 pm, with the Respiratory Therapist/Director (RT #1) stated for oxygen adminstration during respiratory distress, the respiratory rate, heart rate, and O2 SATs need to be checked and the resident needs to be evaluated. Each situation has its own set of variables. From the Respiratory Therapist's perspective, if the resident was in respiratory distress, he would check an O2 SAT. When a resident is found in respiratory distress the Supervisor should be called. 10 NYCRR 415.12(k)(6)	F 695		