STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345159	A. BUILDING _____ B. WING _____	C 03/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLNTON REHABILITATION CENTER	1410 EAST GASTON STREET LINCOLNTON, NC 28092

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E 001 SS=C	Establishment of the Emergency Program (EP) CFR(s): 483.73 The [facility, except for Transplant Center] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements: *[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. *[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to have an Emergency Preparedness plan (EP). The EP plan did not include procedures for tracking of staff and patients, emergency officials contact information. The plan failed to have policies and procedures for sheltering in place. The plan did not have an emergency prep training program, and the plan did not address names or contact information for staff, resident physicians, or other facilities.	E 001	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all state and federal regulations the center has taken or will take the actions set forth in the following plan of corrections constitutes the center's allegation of compliance. All alleged	4/19/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/13/2018

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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E 001	Continued From page 1 The findings included: 1. A. Review of the EP manual revealed the manual did not include a procedure for tracking staff and residents. B. Review of the EP plan revealed there were no policies and procedures for sheltering in place for residents, staff and volunteers. C. Review of the EP plan revealed there was no contact information for emergency officials: federal, state, tribal, regional, or local emergency preparedness staff, State Licensing and Certification Agency, The office of the State Long-Term Care Ombudsman, and other sources of assistance. D. Review of the EP plan revealed there were no emergency prep training program for existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. Provide EP training at least annually. Maintain documentation of training. Demonstrate staff knowledge of emergency procedures. E. Review of the EP plan revealed there were no names and contact information in the plan for resident physician's, staff, other long term care facilities, and volunteers. An interview conducted on 03/22/18 at 4:00 PM with the Administrator revealed he worked on completing the facility EP manual by the templates he was sent from the corporate office. He agreed that the above items were missing from the EP plan and should have been included.	E 001	deficiencies cited have been or will be completed by the dates indicated. Interventions for the affected resident(s): No resident's were affected by the alleged deficient practice. Interventions for residents identified as having the potential to be affected: New Emergency Preparedness Manuals were being updated at the corporate office to ensure that all manuals were uniform and contained the new regulatory requirements. During this process, the facility failed to update the current manual(s) with the new regulations until the new manuals arrived. The new updated Emergency Preparedness Manuals with the updated information to include the cited areas of: the procedure for tracking staff and residents, policies and procedures for sheltering in place for resident, staff and volunteers, contact information for emergency officials, emergency prep training program, and names and contact information for resident physicians, staff, other long term care facilities, and volunteers was implemented on 4/16/2018. Systemic Change: Facility staff will be educated by Administrator/Designee on the updates to the Emergency Preparedness Manual on or by 4/19/18. When updates occur the Administrator/Maintenance Director will	

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E 001	Continued From page 2	E 001	place temporary communication in the existing Emergency Preparedness Manual until permanent updates are completed. The updates will be communicated to staff prior to /at the time that the updates are implement. Monitoring of the change to sustain system compliance ongoing: Review of the Emergency Manual will be completed by the Safety Committee monthly to ensure compliance. All Updates will be tracked and forwarded to the QAPI committee.	
F 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation. Event ID#: 4NKR11.	F 000		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine.	F 636		4/19/18

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F 636	Continued From page 3 (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility	F 636		

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F 636	Continued From page 4 following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to complete Care Area Assessments that addressed the underlying causes and contributing factors for psychotropic medication use and hearing loss for 2 of 36 sampled residents (Resident #33 and Resident #45). The findings included: Resident #33 was admitted to the facility on 05/31/13 with current diagnoses of Alzheimer's disease, dementia, anxiety, depression, and psychotic disorder. Review of the annual Minimum Data Set dated 08/15/17 revealed Resident #33 was severely cognitively impaired and received antipsychotics, antidepressants, and antianxiety medications during the assessment period. Review of the Care Area Assessment (CAA) for psychotropic medication use revealed there was no description of how the psychotropic medications affected Resident #33's day to day activities. The CAA did not indicate if Resident #33 was receiving psychiatric services, had behaviors, or if gradual dose reduction's had been attempted. An interview conducted with the MDS Nurse revealed she writes the psychotropic Medication CAA to meet all the bullets, lists their medications and diagnoses. She stated she didn't realize she should write the CAA as to how the medications	F 636	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all state and federal regulations the center has taken or will take the actions set forth in the following plan of corrections constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. Interventions for the affected resident(s): The MDS Nurse A, responsible for completing the long term resident assessments, did not understand what documentation was needed to reflect a completed Care Area Assessment (CAA□s) and how the completion of the CAA□s helps to create a more person centered individualized careplan. MDS Nurse A was provided with education on documentation that supports completion of CAA□s and creation of the individualized careplan.¿ This education was done on April 10th, 2018 by the Director of Nursing and or his/her designee Interventions for residents identified as	

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F 636	Continued From page 5 affected Resident #33's day to day activities. 2. Resident #45 was admitted to the facility on 01/18/18. The admission Minimum Data Set (MDS)dated 01/31/18 coded him with intact cognition and having moderate difficulty hearing with the use of hearing aids. Review of the Care Area Assessments (CAA) completed 01/31/18 which addressed communication revealed there was no description of Resident #45's hearing loss or the effectiveness of the hearing aids for improving his day to day routine and care needs. The only mention of the hearing aids was that there would be a care plan developed due to hearing loss and the use of bilateral hearing aids. Interview on 03/21/18 at 3:29 PM with the Resident Care Specialist who completed the MDS revealed she addressed each item on the CAA sheet that was checked to make sure each item was addressed. She stated that she she wrote that Resident #45 wore hearing aids, she should have addressed who the hearing aides affected his daily routines.	F 636	having the potential to be affected: On April 10, 2018 education was completed by the Clinical Process Analyst for Care Area Assessment (CAA) completion using appendix C of the Resident Assessment Instrument (RAI) manual as a reference. Education provided included both Minimum Data Set (MDS) nurses and Director of Nursing (DON). Systemic Change: As of April 11, 2018 and moving forward, Care Area Assessments completed by the second Minimum Data Set (MDS) nurse will be reviewed by the lead Minimum Data Set (MDS) nurse for completion prior to submission to Centers for Medicare & Medicaid Services (CMS). A random audit of 3 comprehensive assessments CAA's will be reviewed by the DON/Designee monthly x 3 months. Monitoring of the change to sustain system compliance ongoing: For a minimum of 3 months, the DON/designee will report audit results to the Quality Assurance and Performance Committee. The Quality Assurance and Performance Committee will review the audits to make recommendations to ensure compliance is on going and determine the need for further ongoing auditing. Results will be tracked and trended and submitted to the QAA committee. Based on the information	

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F 636	Continued From page 6	F 636	received, the QAPI Committee will determine the need for ongoing auditing.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the	F 656		4/19/18

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F 656	Continued From page 7 community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to develop comprehensive care plans for 2 of 36 sampled residents reviewed for care plans in the care areas of hearing (Resident #45), and dental (Resident #45 and Resident #51). The findings included: 1. Resident #45 was admitted to the facility on 01/18/18. The admission Minimum Data Set (MDS)dated 01/31/18 coded him with intact cognition and having moderate difficulty hearing with the use of hearing aids. He was also coded with having obvious or likely cavity or broken natural teeth. a. Review of the Care Area Assessments (CAA) completed 01/31/18 which addressed communication revealed Resident #45 wore bilateral hearing aids. The CAA stated a care plan would be developed due to hearing loss and the use of bilateral hearing aids. Review of the Care Plans developed 01/28/18 revealed there was no care plan developed for communication deficits or hearing loss. The use of the bilateral hearing aids was not mentioned in any care plan.	F 656	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all state and federal regulations the center has taken or will take the actions set forth in the following plan of corrections constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. The MDS Nurse A, responsible for completing the long term residents Care Area Assessments (CAA□s) did not understand how the completion of the CAA□s helps to create a more person centered individualized careplan. MDS Nurse A was provided with education on documentation that supports completion of CAA□s and creation of the individualized careplan.¿ This education was done on April 10th, 2018 by the Director of Nursing and or his/her designee. Interventions for the affected resident(s): The Comprehesive Care Plans in the area	

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F 656	Continued From page 8 Interview on 03/21/18 at 3:29 PM with the Resident Care Specialist who completed the MDS and care plans revealed she could not locate a care plan which addressed his hearing loss and use of hearing aids and offered no explanation. b. Review of the CAA completed 01/31/18 for dental needs addressed that the resident had no visible teeth but had several teeth that could be felt at the gum line. He denied gum, mouth, or tooth fragment pain or discomfort. The CAA stated a care plan for dental would be developed. Review of the Care Plans developed 01/28/18 revealed no dental care plan and there was nothing noted about dental needs in any other care plan developed. Interview on 03/21/18 at 3:39 PM with the Resident Care Specialized (MDS Coordinator) who completed this care plan revealed that she normally did not develop a dental care plan but addressed dental needs under the care plan for activities of daily living skills (ADL). She offered no explanation as to why there was no mention of dental needs under the ADL care plan. 2. Resident #51 was admitted 11/30/17 and had diagnoses including anemia, hypertension (high blood pressure), depression, and anorexia. The admission Minimum Data Set (MDS) dated 12/22/17 coded her with moderately impaired cognition and having obvious or likely cavity or broken teeth.	F 656	of hearing for Resident #45 and dental for Resident #45 and Resident #51 were implemented the day the deficient practice was found on March 22, 2018. Interventions for residents identified as having the potential to be affected: Current resident careplans were audited 100% by the MDS nurse and corrected with appropraite dental and hearing careplans by 4/19/18. As of April 11, 2018 and moving forward, Care Area Assessments completed by the second Minimum Data Set (MDS) nurse will be reviewed by the lead Minimum Data Set (MDS) nurse to ensure Care Plans have been implemented for Care Area Assessment□s (CAA□s) prior to submission to Centers for Medicare & Medicaid Services (CMS). Systemic Change: Education was completed by the Clinical Process Analyst that in the event the decision is made to proceed to plan of care, based on the analysis of the Care Area Assessment (CAA), an individualized Care Plan must be implemented for that Care Area Assessment (CAA). Education was completed to both Minimum Data Set (MDS) nurses and Director of Nursing (DON) on 4/10/18. A random audit of 3 Care Area Assessments will be reviewed for the implementation of a Care Plan by the Director of Nursing/Designee monthly x 3 months.	

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F 656	Continued From page 9 Review of the Care Area Assessment (CAA) completed 12/22/17 which addressed dental care revealed that Resident #51 had a few broken teeth in the upper back part of her mouth and many broken and chipped teeth at the bottom front of her mouth. The CAA stated a care plan would be developed for dental care. Review of the care plan last updated 1/30/18 revealed there was no care plan developed for dental care and there was nothing noted about dental needs in any other care plan developed. An interview with the MDS Coordinator was conducted 3/21/18 at 4:00 pm. The MDS Coordinator stated she normally did not develop a dental care plan but addressed dental needs under the care plan for activities of daily living skills (ADL). She offered no explanation as to why there was no mention of dental needs under the ADL care plan. An interview with the Director of Nursing (DON) on 3/22/18 at 3:30 pm revealed it was her expectation that when a resident had dental care needs there would be a dental care plan in place.	F 656	Monitoring of the change to sustain system compliance ongoing: Monthly for a minium of 3 months, the DON will report audit results to the Quality Assurance and Performance Committee. The Quality Assurance and Performance Committee will review the audits to make recommendations to ensure compliance is on going and determine the need for further ongoing auditing.	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the	F 658	The statements included are not an	4/19/18

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F 658	Continued From page 10 facility failed to provide an ordered nutritional supplement for 1 of 5 (Resident #11) residents reviewed for nutrition. Findings included: Resident #11 was admitted to the facility 6/7/10 and had diagnoses including hypertension (high blood pressure), diabetes, anxiety, and depression. The quarterly Minimum Data Set (MDS) dated 1/8/18 revealed that Resident #11 was severely impaired for cognition and was totally dependent for eating. The care plan last updated 1/8/18 revealed Resident #11 was at risk for nutrition problems and dehydration related to combative behaviors and that Resident #11 was at risk for weight loss due to receiving a mechanically altered diet. A review of Resident #11's weights from 12/26/17 through 3/7/18 revealed her weight had steadily decreased from 136 pounds to 127 pounds. A Registered Dietician (RD) saw Resident #11 on 2/5/18 for severe weight loss and recommended increasing the ordered house supplement (a liquid nutritional supplement designed to promote weight gain) from 1 to 2 times a day. A physician's order was written for Resident #11 on 2/5/18 to discontinue the current order of house supplement 4 ounces once a day and to increase the house supplement to 4 ounces twice a day. The physician's order for the increase in house	F 658	admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all state and federal regulations the center has taken or will take the actions set forth in the following plan of corrections constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. Interventions for the affected resident(s): The order for the nutritional supplement for resident #11 was inadvertently entered into the electronic orders incorrectly . The DON follow up with the Registered Dietician who re-evaluated the resident and issued an order to restart the nutritional supplement at 4oz three times a day indefinitely on 3/29/18. The DON verified the order was entered correctly and the supplement was being received as ordered. Interventions for residents identified as having the potential to be affected: All residents with orders for nutritional supplements were reviewed/audited to ensure supplements were being received as ordered. The reviews were performed by DON/designee and were completed on _4/2/18. Systemic Change:	

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F 658	Continued From page 11 supplement was placed in the computer on 2/5/18 by nursing staff. There was documentation on Resident #11's Medication Administration Record (MAR) that the resident received the house supplement twice a day as ordered and typically consumed 100% from 2/5/18 through 3/7/18. The MAR showed the order for house supplement as being discontinued 3/7/18. There was no order from the Physician to discontinue the house supplement. Resident #11 did not receive the ordered house supplement after 3/7/18 according to her MAR. An interview was conducted with the Unit Manager 3/22/18 at 2:30 pm. The Unit Manager stated she was not sure why Resident #11 did not receive the house supplement after 3/7/18 since there was no physician's order to discontinue the supplement. An interview was conducted with the Director of Nursing (DON) on 3/22/18 at 2:40 pm. The DON stated that when nursing staff put orders in the computer for nutritional supplements the computer automatically put a stop date on the supplements for 30 days after the order was placed in the computer. The DON stated it was possible to override the 30 day limit the computer placed on nutritional supplements but nursing staff was not aware of the need to override the 30 day limit. The DON stated Resident #11 should have received house supplement as ordered by the Physician.	F 658	New nutritional supplement orders are to be reviewed by the clinical team in the clinical morning meeting to ensure nutritional supplement orders are entered correctly. Education of this process was done with the licensed nurses by the DON/SDC/designee by 4/11/19. New nutritional supplement orders will be reviewed in clinical meetings to verify that residents are receiving supplements as ordered. Inaccuracies will be tracked and trended with re-education provided as necessary. All house supplement orders will be audited 5 days a week for 2 months, then 2 x week for 1 month. Monitoring of the change to sustain system compliance ongoing: Monthly for a minimum of 3 months, the DON will report audit results to the Quality Assurance and Performance Committee. The Quality Assurance and Performance Committee will review the audits to make recommendations to ensure compliance is on going and determine the need for further ongoing auditing.	
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.	F 695		4/19/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345159	A. BUILDING _____ B. WING _____	C 03/22/2018

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F 695	Continued From page 12 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 observations, record reviews, and staff interviews, the facility failed to provide respiratory care for 1 of 3 sampled residents (Resident #1) according to physician's orders. The findings included: Resident #1 was re-admitted to the facility on 3/7/18 with diagnoses which included acute respiratory failure with hypoxia, cerebrovascular accident (CVA), and dementia. The physician orders on admission indicated oxygen at 3 liters per minute continuously. Observations were made of Resident #1 on 3/19/18 at 11:50 AM resting in bed with oxygen in place via a nasal cannula through a concentrator with setting at 1 liter per minute, and at 2:34 PM while sitting up in wheelchair with oxygen through a portable tank with setting at 2 liters per minute. A subsequent observation was made of Resident #1 on 3/21/18 at 10:14 AM sitting up in wheelchair with oxygen in place via a nasal cannula through a portable tank with setting at 4 liters per minute. An interview was conducted with Nurse Aid (NA) #4 and she reported she had never seen Resident #1 touch the settings on the oxygen	F 695	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all state and federal regulations the center has taken or will take the actions set forth in the following plan of corrections constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. Interventions for the affected resident(s): Nurses were not being notified to verify Oxygen settings for residents specifically when the delivery of oxygen is transferred from one source to another, and or when the oxygen source is moved. The oxygen setting was immediately verified to the ordered setting of 3 liters oxygen 3/21/18. Interventions for residents identified as having the potential to be affected: All resident receiving oxygen were audited for correct settings according to their	

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F 695	Continued From page 13 concentrator or portable tank. In an interview with nurse #2 on 3/21/18 at 10:30 AM, she indicated Resident #1 did not have the fine motor skills to adjust the oxygen setting on the concentrator or the portable tank. She checked the Medication Administration Record (MAR) at this time and reported that Resident #1 should receive oxygen at 3 liters per minute. She did not know why the oxygen would be on the wrong setting but did know that a NA had just brought Resident #1 back from the shower and connected the oxygen tubing to the portable tank on the wheelchair. During a telephone interview with NA #3 on 3/22/18 at 2:29 PM, she revealed she had returned from the shower with Resident #1 and connected the oxygen tubing to the portable tank, from the concentrator, which was the usual practice. She never adjusted the settings on the concentrators but would make sure the portable tanks were on the correct settings according to the indicators on the concentrators. If not sure of what the setting should be, she would ask the nurse. The indicator on the oxygen concentrator for Resident #1 was on 4 liters when she connected the tubing to the portable tank so she put the setting at 4 liters. She did not ask the nurse what the setting should be. An interview was conducted on 3/22/18 at 11:10 AM with the Nurse Practitioner (NP) in which she revealed her expectation was that if oxygen was to be titrated, it would be indicated in the oxygen order. If not specified to be titrated, the oxygen should be at the same level all the time. The NP further indicated that with a diagnosis of acute	F 695	physicians orders and oxygen tanks or concentrators were visually checked for accuracy by 3/30/18. Systemic Change: All nurses were educated regarding checking Oxygen sources for correct settings when residents are transferred from one source to another and randomly throughout their shifts to maintain compliance. The nursing assistants were educated on notifying the nurse when sources of O2 are switched and to confirm what the setting is ordered to be. Education was completed by DON/SDC/designee by 4/12/18. Observations of 5 residents receiving oxygen will be randomly audited/observed by the DON/Designee to verify correct O2 settings will be completed 5 days a week for 8 weeks, then 3 times a week for 1 month. Monitoring of the change to sustain system compliance ongoing: Monthly for a minimum of 3 months, the DON will report audit results to the Quality Assurance and Performance Committee. The Quality Assurance and Performance Committee will review the audits to make recommendations to ensure compliance is on going and determine the need for further ongoing auditing.	

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F 695	Continued From page 14 respiratory failure with hypoxia, she would expect oxygen should be delivered at a consistent level. On 3/22/18 at 12:05 PM in an interview with the Director of Nursing (DON), she reported she expected residents to be on the oxygen level ordered by the physician, and if assessed to not need the current level, staff should notify the Medical Director (MD) for orders to wean the oxygen down.	F 695		