STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345051	A. BUILDING _____ B. WING _____	03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANSON HEALTH AND REHABILITATION	405 SOUTH GREENE STREET WADESBORO, NC 28170

(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
E 000	Initial Comments An unannounced recertification survey was conducted on 2/28/22 through 3/3/22. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #DISL11.	E 000		
F 000	INITIAL COMMENTS A recertification survey was conducted from 02/28/22 through 03/03/22. Event ID# DISL11.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on record review, observation and resident and staff interview, the facility failed to assess a resident whether the self-administration of medications was clinically appropriate for 1 of 1 sampled resident who was observed to have medication at bedside (Resident #36). Findings included: 1. Resident # 36 was admitted to the facility on 7/2/21 with multiple diagnoses including emphysema. Resident #36 had a doctor's order dated 11/3/21 for Albuterol sulfate 90 micrograms (mcg) - 2 puff 4 times a day for emphysema. The quarterly Minimum Data Set (MDS) assessment dated 1/9/22 indicated that Resident	F 554	1. Facility failed to assess self-administration of medication clinically appropriate for resident #36. Resident #36 was assessed and educated for self-administration of inhaler completed 3/2/2022. 2. Audit and interviews of residents to determine if any further medications at bedside or any requests to self-administer medications at bedside conducted by Director of Nursing, Wellness Coordinator, and medical records person. Completed 3/2/2022. No further areas of non-compliance noted. Self-administration assessments for those that have been deemed clinically appropriate will be updated quarterly and the care plan updated accordingly.	3/22/22

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

Electronically Signed | 03/15/2022

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F 554	Continued From page 1 #36's cognition was intact. Resident #36 was observed on 3/2/22 at 8:25 AM to have the Albuterol Sulfate inhaler in his room. When interviewed, he stated that he had been administering the Albuterol to himself and kept it in his room for more than a month now. Nurse #2, assigned to Resident #36 was interviewed on 3/2/22 at 12:08 PM. She stated that she was not sure whether Resident #36 was assessed for self- administration, but she knew that he had been self-administering the Albuterol inhaler and was keeping it in his room for a while now, more than a month. The Nurse Unit Manager was interviewed on 3/2/22 at 12:17 PM. She stated that she was not aware and was not informed that Resident #36 had been self-administering his inhaler. She reported that when she was informed on 3/2/22, she had completed the self-administration of medication assessment for Resident #21 and initiated the care plan. The Director of Nursing (DON) was interviewed on 3/2/22 at 4:10 PM. The DON stated that she expected that self-administration of medications assessment was completed, and care plan initiated before the resident could start self-administering medications. She also verified that she was not aware that Resident #36 was administering the Albuterol inhaler to himself. The DON added that she expected nursing to inform the Unit Managers and the MDS Nurse of resident's desire to self-administer medications.	F 554	3. 100% Licensed staff and medication aides will be re-educated by the Director of Nursing and/or Staff Development Coordinator regarding the process for a resident to self-administer medications. Any nurse or medication aide that is on leave will receive the required education prior to starting their assigned shift. Education will be added to new hire orientation. Completed 3/22/2022. Nurse Managers will conduct audits to determine if medications are at the bedside for current residents to ensure medications aren't kept at the bedside for those residents not deemed clinically appropriate. The audit will occur weekly x 12 weeks. Opportunities will be corrected as identified. 4. Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI by Director of Nursing monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. Completed 3/22/2022	
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)	F 686		3/22/22

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F 686	Continued From page 2 §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on record reviews, observations and staff interviews, the facility failed to ensure the alternating pressure reducing air mattress was set according to the resident's weight (Residents #7 and #75). This was for 2 of 6 residents reviewed for pressure ulcers. The findings included: 1) Resident #7 was originally admitted to the facility on 8/11/17 with diagnoses that included diabetes type 2, morbid obesity, and chronic pain. A review of Resident #7's active physician orders revealed an order dated 10/28/21 for an alternating air mattress to aide in wound healing and pressure relief and to check the function every shift. A review of Resident #7's weight history included the following: - On 10/27/21 was 229 pounds (lbs.)	F 686	1. Facility failed to ensure alternating pressure mattresses set according to residents weight for residents #7 and resident #75. Alternating pressure mattress for resident #7 and resident #75 was set to current weight and controls were placed into lock-out mode. Completed 3/2/2022. 2. Audit of all alternating pressure mattresses completed by Administrator and Maintenance Director on 3/2/2000 to ensure weight settings were set to resident s weight. Any alternating pressure mattress found to be out of compliance was set to the appropriate weight and pump unit placed into lock mode to ensure settings cannot be inadvertently changed. Residents with alternating pressure mattress has an order to check function of mattress every shift, including the appropriate weight.	

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F 686	Continued From page 3 - On 11/26/21 was 232 lbs. - On 12/23/21 was 231.2 lbs. - On 1/27/22 was 221.8 lbs. Resident #7's care plan, last reviewed 12/28/21, included a problem area for the potential for skin breakdown secondary to incontinence, impaired mobility, fragile skin due to diabetes, history of unstageable pressure ulcers to the right and left buttocks, right outer ankle and a diabetic ulcer. The interventions included an air mattress. A quarterly Minimum Data Set (MDS) assessment dated 2/16/22 indicated Resident #7 had moderately impaired cognition. She was coded with no pressure ulcers however had a pressure reducing device to the bed. Resident #7's weight on 2/23/22 was 222.2 lbs. On 2/28/22 an observation was made of Resident #7 while she was lying in the bed with her eyes closed. The alternating pressure reducing mattress machine was observed set on 350 lbs. The machine had weight settings from 90 to 660 lbs. and indicated to set according to the resident's weight per lbs. Resident #7 was observed lying in her bed on 3/1/22 at 11:55 AM and the alternating pressure reducing mattress machine was set at 350 lbs. On 3/2/22 at 9:55 AM, Resident #7 was observed lying in bed with her eyes closed. The alternating pressure reducing mattress machine was set at 350 lbs. The treatment nurse was interviewed on 3/2/22 at 10:05 AM and stated the nursing staff were	F 686	completed 3/2/2022. 3. 100% Licensed staff, certified staff, and maintenance director will be educated by Staff Development Coordinator on the appropriate weight settings application for alternating pressure mattresses. Any licensed, certified staff on leave will receive required education prior to starting their shift. Education will be added to new hire orientation. Completed 3/22/2022. Director of Maintenance will set the weight function of the alternating pressure mattress based on the resident□s weight, on the initial set up and place the pump unit into lock mode to ensure compliance. If weight fluctuations noted, weight settings will be reset accordingly and pump re-set to lock mode. Nurse managers and/or maintenance director will audit the alternating pressure mattresses setting weekly x12 weeks to ensure compliance. 4. Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI by Director of Nursing monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. Completed 3/22/2022	

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F 686	Continued From page 4	F 686		

responsible for checking the alternating pressure reducing mattresses every shift to ensure they were functioning properly.

An interview occurred with Nurse #3 on 3/2/22 at 10:10 AM and stated nursing staff were to check the alternating pressure mattress to ensure they were inflated and functioning every shift but didn't change or check the settings for the weight.

An interview was conducted with the maintenance supervisor on 3/2/22 at 10:40 AM and stated when an alternating pressure reducing mattress was ordered, he would put the mattress on the bed and ensure all the ports were hooked up correctly. The resident's weight was obtained from the nurse and entered at that time. The maintenance supervisor stated he made daily rounds only to ensure the CPR (cardio pulmonary resuscitation) settings were functioning.

On 3/2/22 at 2:00 PM, an observation of Resident #7's alternating pressure reducing mattress was observed with the Director of Nursing (DON), as well as a review of Resident #7's weight history. The DON verified the weight setting should not have been 350 lbs. The DON added nursing staff checked the functionality of the mattresses every shift but was unsure if they checked the actual weight settings.

2. Resident # 75 was admitted to the facility on 10/28/21 with multiple diagnoses including Hypertension. The quarterly Minimum Data Set (MDS) assessment dated 2/4/22 indicated that Resident #75 had 4 stage 3 and 1 unstageable pressure ulcers. The assessment indicated that the resident's weight was 113 pounds (lbs.).

Resident #75's care plan dated 2/28/22 was

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F 686	Continued From page 5	F 686		

reviewed. The care plan problem was Resident #75 currently has stage 3 pressure ulcers to his right ankle, right heel, left and right ischium and coccyx. The goals were "the resident will be free from further skin breakdown and his wounds will show signs of improvement/healing". The approaches included air mattress on bed to aid in pressure relief.

Resident #75 was observed in bed on 2/28/22 at 10:30 AM, 3/1/22 at 10:35 AM and on 3/2/22 at 10:05 AM. He had an air mattress in his bed and the machine had a setting selection in lbs. and it was set at 290 lbs.

The Treatment Nurse was interviewed on 3/2/22 at 10:06 AM. She stated that the nurses were responsible for checking the air mattress to ensure it was working and at the correct setting. She reported that the air mattress used by Resident #75 should have been set according to the resident's weight. She observed the air mattress of Resident #75 and verified that the machine was set at 290 lbs.

Nurse # 3, assigned to Resident #75, was interviewed on 3/2/22 at 10:10 AM. She stated that she checked the air mattress daily to ensure the mattress was inflated and functioning properly. She reported that she had not been checking the settings on the machine including the weight setting.

The Director of Nursing (DON) was interviewed on 3/2/22 at 4:10 PM. The DON stated that the Maintenance Director was responsible for the original setting of the air mattress and the nurses were responsible for monitoring the function and the setting daily. The DON verified that the air

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F 686	Continued From page 6 mattress machine should be set according to the resident's weight.	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews and record review, the facility failed to ensure and monitor that a disposable lighter was secured when not in use or left unattended by a resident identified as a safe smoker. This was for 1 (Resident #36) of 3 residents reviewed for accidents. The findings included: Resident #36 was admitted on 7/2/21 with a diagnosis of a Cerebral Vascular Accident. Resident #36's quarterly Minimum Data Set dated 1/9/22 indicated he was cognitively intact and exhibited no behaviors. Review of a smoking risk assessment dated 1/13/22 indicated Resident #36 was a safe independent smoker. Resident #36 was care planned dated 7/2/21 and revised 2/15/22 indicated he used tobacco. Interventions included explaining the smoking policy to him and to explaining to him where the	F 689	1. Facility failed to ensure and monitor that a disposable lighter was secured when not in use or left unattended by a safe smoker, resident #36. Resident #36 was issued a locking security safety box by facility Social Worker on 3/3/2022. Resident #36 educated on keeping lighter in security box when not in use and educated on how to lock the box. Completed 3/3/2022. 2. All residents identified and assessed by nursing and/or social worker, as safe smokers will be issued an individual locking security safety box and educated per Social Worker and/or Administrator to secure their lighters when not in use. Completed 3/15/2022. 3. 100% staff educated by Staff Development Coordinator on safe smokers to be issued a locking security box to secure cigarette lighter when not in	3/22/22

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F 689	Continued From page 7 designated area were located. An observation on 2/28/22 at 3:05 PM was completed. Resident #36 was not in his room. Observed on his bed visible from the hallway was a opened pack of cigarettes and a disposable lighter. An interview was completed on 3/1/22 at 9:25 AM with Nurse #4. She stated residents identified as a safe smoke were allowed to keep their cigarettes and lighter in their possession. Nurse #4 stated she was uncertain if lighters needed to be secured. She stated there were some residents with dementia known to wander into other residents rooms. An interview was completed on 3/1/22 at 9:28 AM with the Maintenance Director. He stated if the resident was a safe smoker, their lighters did not have to be secured. He said the safe smokers were told to keep the lighters in their possession at all times. An observation on 3/1/22 at 9:40 AM was completed. Resident #36 was not in his room. Observed on his bed side table was one cigarette and a disposable lighter. Resident #36 was observed outside smoking in the designated smoking area. An interview was completed on 3/2/22 at 9:50 AM with Nursing Assistant (NA) #3. She stated Resident #36 was a safe smoker and could go smoke whenever he wanted too. She stated he could keep his smoking materials (cigarettes and lighter) in his possession. NA #3 stated she did not think there was a secure place in the rooms to lock up a lighter when it wasn't in use. She	F 689	use. Any staff on leave will receive the required education prior to starting their shift. This education will be added to new hire orientation. Completed 3/22/2022. Department heads will conduct room rounds to ensure cigarette lighters are not visible and left unattended when not in use. These rounds will occur 3 times weekly x 4 weeks, then weekly x4 weeks then monthly x 1 month. Opportunities will be corrected as identified. 4. Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI by the Administrator and/or Director of Nursing monthly for three months. At that time, the QAPI committee will evaluate the effectiveness of the intervention to determine if continued auditing is necessary to maintain compliance.	

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F 689	Continued From page 8	F 689		

stated Resident #36 knows to keep his disposable lighter in his possession at all times and to never leave it out unattended.

An interview was conducted on 3/2/22 at 10:00 AM with NA #2. She stated the nurses complete an assessment to determine if a resident was a safe smoker. NA #2 stated supervised smokers had their smoking materials kept at the nurses station and someone had to go out with them to smoke. If the resident was identified as a safe smoker, they were allowed to keep their smoking materials (cigarettes and lighter) with them. NA #2 further stated the safe smokers had a lock on their nightstand to secure their lighters and were given a key to lock the top drawer.

An interview was completed on 3/2/22 at 12:20 PM with Resident #36. He was sitting in his wheelchair eating lunch. There was no observed cigarettes or lighter out in the open. Resident #36 stated he was told he could keep his lighter and never told he had to keep his lighter locked up in his room when not in use or out of his room. Resident #36 stated he kept his disposable lighter in his pocket but on occasion, he would forget and leave it unsecured when he wasn't in the room. Resident #36 stated he did not have a place to secure his lighter even if he wanted too. He stated his nightstand did not have a lock on it and he had not been provided a box to lock his lighter and cigarettes in. Resident #36 stated some of the rooms in the facility had been renovated and the new nightstand in those rooms had a lock on them. He stated he assumed he would have to wait until his room was remodeled that he would have a new nightstand with a lock on it.

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F 689	Continued From page 9	F 689		

An interview was completed on 3/2/22 at 4:14 PM with the Administrator. She stated safe smoking residents were told to keep their smoking materials (cigarettes and lighter) on their person at all times. She stated the facility had a quarterly meeting with the smoking residents and there had been no problems with the residents keeping their lighters secured. The Administrator stated she understood there was a risk and possibly the safe smoking residents should have a lock box or a new nightstand with a lock to secure smoking items. She stated the plan was to replace the nightstands during the room remodel but there had been delays in the remodeling. She stated if a resident wanted a lock box, the facility would provide it.

An interview was completed on 3/3/22 at 9:29 AM with the Social Worker (SW). She stated they held smoking meetings quarterly and independent smokers could keep their smoking material (cigarettes and lighter) on their person or in a drawer. She stated the items should not be left out visible unattended. If it was discovered that a resident was not compliant with securing a lighter, the facility would meet with that person and discuss the smoking privileges. The SW stated Resident #36 had not been identified as being noncompliant with securing his lighter. She stated to her knowledge, no one person at the facility was actually completing observations rounds to ensure there was no unsecured lighters left out visible. She stated if the floor staff observed Resident #36 leaving his lighter out, they should report it for management to follow up.

Resident #36 was observed sitting in his doorway on 3/3/22 at 10:20 AM. Observed on his bed was a gray colored lock box. He stated he didn't know

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F 689	Continued From page 10 why the lock box was in his room and stated it wasn't there earlier this morning. Resident #36 further stated he was remind to keep his lighter in his pocket yesterday.	F 689		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to provide a physician's ordered diet for 1 of 6 residents (Resident #40) reviewed for nutrition. The findings included: Resident # 40 was admitted to the facility on	F 692	1. Facility failed to provide a physician's ordered diet for resident #40. On 3/1/2022 resident # 40 was provided a regular pureed diet as ordered per the physician. 2. 100% audit of residents prescribed diet orders completed by Dietary Manager on 3/1/2022.	3/22/22

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F 692	Continued From page 11 2/15/2021 with diagnoses that included laryngeal cancer, dysphagia, malnutrition, and frontotemporal dementia. The resident's quarterly Minimum Data Set (MDS) dated 1/5/2022 indicated the resident was severely cognitively impaired, required assistance with meal set up, and received a therapeutic, mechanical soft diet during the assessment period. Resident #40's comprehensive care plan was last updated 2/21/2022 and had a focus for difficulty eating related to side effects from radiation therapy for laryngeal cancer. He required mechanically altered diet, puree with nectar thick liquids. A review of Resident #40's medical record revealed he had a physician's order for regular pureed diet with nectar thick liquids. The order had a start date of 11/3/2021 with no end date. Resident #40's medical record also reveal he was assessed by the Registered Dietician (RD) on 3/1/2022. The RD's assessment read in part, the resident's diet remains regular with puree texture and nectar thickened liquids, ice cream on lunch and dinner tray, and is supplemented with house supplement twice daily. On 3/1/2022 at 1:00 PM Nurse Assistant (NA) #1 was observed delivering a meal tray to Resident #40 that consisted of a hot dog in a bun with mustard and ketchup and a side item of steak fries. The NA provided tray set up and exited the room. The NA then walked out of the room and down the hall to assist meal tray delivery on another hall.	F 692	Tray cards for all modified consistency diets will have the diet high-lited in large print to easily identify prescribed diet. 3. 100% dietary, licensed, certified, and department head staff educated by Staff Development Coordinator on reading tray cards appropriately and the high lighting of the diet order on the tray card. Any staff on leave will receive the required education prior to starting their shift. This education will be added to new hire orientation. Completed 3/22/2022. Dietary manager or designee will audit the trays coming off the line to ensure diets are in compliance daily x30 days, then weekly x 4 weeks, then monthly x 1. Compliance issues will be corrected as identified. 4. Data obtained during audit process will be analyzed for patterns and trends and reported to QAPI by Administrator monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance.	

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	345051	A. BUILDING _____ B. WING _____	03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 692	Continued From page 12 At 1:03 PM on 3/1/2022 an interview was conducted with Nurse #1 who was seated at the nurse's station. When asked what diet was ordered for Resident #40, she stated he was on a pureed diet. When made aware the resident had a hot dog and fries on his meal tray, she notified NA #1 the resident was on a pureed diet. At 1:05 PM observed Nurse #1 and NA #1 remove meal tray from Resident #40. When asked if the resident had a meal tray ticket, NA #1 stated he did. When asked what the meal tray ticket indicated for diet. The NA and Nurse #1 both stated the meal ticked reflected the resident should have received regular puree diet. NA#1 stated it was an oversight, she only saw the word regular. On 3/01/2022 at 2:02 PM and interview was conducted with the Dietary Manager (DM). She stated she was training a new employee on the tray line. She stated the employee only read the first word, regular, and did not read the complete order which read, regular pureed. The DM stated she stepped away from the new employee briefly to plate a renal diet and she must have missed the error. An interview was conducted with the Director of Nursing (DON) on 03/03/2022 at 11:08 AM. She stated she was aware of the incident, and it was her expectation the resident's receive therapeutic diets prescribed by the physician.	F 692		
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		3/22/22

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F 695	Continued From page 13 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, observations and staff interviews, the facility failed to administer oxygen at the prescribed rate for 1 of 3 residents reviewed for respiratory care (Resident #7). The findings included: Resident #7 was originally admitted to the facility on 8/11/17 with diagnoses that included chronic obstructive pulmonary disease (COPD) and congestive heart failure (CHF). A review of the active physician orders included an order dated 10/19/21 for oxygen at 3 liters via nasal cannula continuously. Resident #7's active care plan revealed a problem area, last reviewed 12/28/21, for oxygen therapy secondary to COPD, chronic respiratory therapy and obstructive sleep apnea. The interventions included to administer oxygen per physician orders. A quarterly Minimum Data Set (MDS) assessment dated 2/16/22 indicated Resident #7 had moderately impaired cognition and received oxygen therapy. On 2/28/22 at 12:00 PM, an observation was made of Resident #7 while she was lying in bed.	F 695	1. Facility failed to administer oxygen at prescribed rate for resident #7. Resident #7 had an order for O2 at 3L/minute, O2 setting was adjusted to prescribed rate of 3L by the Director of Nursing on 3/2/2022. 2. On 3/3/2022, 100% of all residents with oxygen, were audited for correct oxygen settings by the Director of Nursing. Any resident with inaccurate settings were corrected immediately. 3. 100% of licensed and certified staff were educated by Staff Development Coordinator on correct oxygen settings and usage. Any licensed or certified staff on leave will receive the required education prior to starting their shift. This education will be added to new hire orientation. Completed 3/22/2022 4. Director of Nursing or Unit Managers will audit all residents on oxygen 3x weekly x 4 weeks, then weekly x 4 weeks, then monthly x 1 month to ensure compliance. Data obtained during the auditing process will be analyzed for patterns and trends and reported to QAPI by Director of Nursing monthly x 3 months to determine if continued auditing is necessary to	

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F 695	Continued From page 14 The oxygen regulator on the concentrator was set at 2 liters flow by nasal cannula when viewed horizontally at eye level. On 3/1/22 at 11:55 AM, an observation was made of Resident #7 which revealed the oxygen regulator on the concentrator was set at 2.5 liters flow by nasal cannula when viewed horizontally at eye level. An observation was made of Resident #7 while she was lying in bed on 3/2/22 at 9:55 AM. The oxygen regulator on the concentrator was set at 2 liters flow by nasal cannula when viewed horizontally at eye level. On 3/2/22 at 2:00 PM, an observation was made of Resident #7 with the Director of Nursing (DON). The DON verified the oxygen regulator on the concentrator was set at 2 liters when viewed horizontally at eye level and adjusted the flow to administer 3 liters of oxygen as ordered.	F 695	ensure compliance.	
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff interview, the facility failed to have a medication error rate of less than 5% as evidenced by 2 medication errors of 26 opportunities resulting in a medication error rate of 7.69% for 1 of 5 residents observed during the medication pass	F 759	1. Nurse #2 was immediately educated by Director of Nursing on the proper administration of metered dose inhalers on 3/2/2022. Resident #36 was assessed per unit manager for self-administration of	3/22/22

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F 759	Continued From page 15	F 759		

(Resident #36).

Findings included:

The facility's policy in administering medications through a metered dose inhaler dated October 2010 read in part "Allow at least one minute between inhalations of the same medication and, at least 2 minutes between inhalations of different medications".

The manufacturer's instruction for Albuterol Sulfate inhalation indicated "if your doctor has told you to use more sprays, wait at least one minute and shake the inhaler again".

1 a. Resident #36 was admitted to the facility on 7/2/21 with multiple diagnoses including emphysema.

Resident #36 had a doctor's order dated 11/3/21 for Albuterol Sulfate 90 micrograms (mcg) - 2 puffs 4 times a day for emphysema.

Resident #36 was observed on 3/2/22 at 8:25 AM during the medication pass. Resident #36 was observed to self- administer 2 puffs of the Albuterol with 5 seconds in between puffs, in front of Nurse #2. Nurse #2 was not observed to give instruction to Resident #36 on how to administer the Albuterol.

Nurse #2 was interviewed on 3/2/22 at 9:15 AM. She stated that the facility's policy in administering medications through a metered dose inhaler was to wait 10 minutes or 15 minutes between puffs, but she was not sure.

The Director of Nursing (DON) was interviewed

metered dose inhaler and educated by unit manager on waiting 1 minute between puffs, and to wait 2 minutes between different ordered inhalers with satisfactory return demonstration noted. Completed 3/2/2022.

2. Audit completed by unit managers to identify all residents ordered metered dose inhalers completed 3/4/2022.

3. 100% education of licensed nurses and medication aides by Staff Development Coordinator on the proper administration of metered dose inhalers to emphasis providing 1 minute spacing between inhalations of same medication and to provide 2 minutes spacing between different medications. Any licensed staff on leave will receive required education prior to their shift. This education will be enhanced for new hire orientation. Completed 3/22/2022.

4.Director of Nursing, Unit Managers, and Staff Development Coordinator will complete observed administration audits of 3 residents receiving metered dose inhalers 3 times weekly x 4weeks, then weekly times 4 weeks, then monthly x 1 month to ensure compliance.
Data obtained during the auditing process will be analyzed for patterns and trends and reported to QAPI per Director of Nursing monthly x 3 months to determine if continued auditing is necessary to ensure compliance.

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F 759	Continued From page 16	F 759		

on 3/3/22 at 11:10 AM. The DON stated that she expected the nurses to follow the facility's policy in administering medications through a metered dose inhaler. She stated that the facility's policy was to wait at least a minute between puffs of same medication and 2 minutes between puffs of different medications.

1 b. Resident #36 was admitted to the facility on 7/2/21 with multiple diagnoses including emphysema.

Resident #36 had a doctor's order dated 11/3/21 for Anoro Ellipta - 1 puff daily for emphysema.

Resident #36 was observed on 3/2/22 at 8:25 AM during the medication pass. Resident #36 was observed to self- administer 2 puffs of the Albuterol in front of Nurse #2. After 10 seconds, Nurse #2 was observed to administer 1 puff of Anoro Ellipta to the resident.

Nurse #2 was interviewed on 3/2/22 at 9:15 AM. She stated that the facility's policy in administering medications through a metered dose inhaler was to wait 10 minutes or 15 minutes between puffs, but she was not sure.

The Director of Nursing (DON) was interviewed on 3/3/22 at 11:10 AM. The DON stated that she expected the nurses to follow the facility's policy in administering medications through a metered dose inhaler. She stated that the facility's policy was to wait at least a minute between puffs of same medication and 2 minutes between puffs of different medications.