STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345168	A. BUILDING ______ B. WING ______	C 03/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MACGREGOR DOWNS HEALTH AND REHABILITATION	**2910 MACGREGOR DOWNS ROAD GREENVILLE, NC 27834**

(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
F 000	INITIAL COMMENTS A Complaint investigation was conducted from 3/16/2021 through 3/22/2021. Event ID# 0C2K11. 2 of 30 complaint allegations were substantiated resulting in deficiencies.	F 000		
F 553 SS=D	Right to Participate in Planning Care CFR(s): 483.10(c)(2)(3) §483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iii) The right to be informed, in advance, of changes to the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. §483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's	F 553		4/14/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 04/01/2021

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 553	Continued From page 1 strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. This REQUIREMENT is not met as evidenced by: Based on record review and resident and staff interviews, the facility failed to invite to and conduct one of three resident's reviewed care plan meetings. (Resident #5) Findings included: Resident #5 was admitted to the facility 09/02/2020 with diagnoses including Parkinson's disease and acute embolism and thrombus of lower extremity. A Quarterly Minimum Data Set (MDS) dated 01/12/2021 revealed Resident #5 had mild cognitive impairment with clear speech and minimal difficulty hearing. He was always able to understand and was usually understood. A review of the current care plan for Resident #5 indicated it was reviewed and revised on 01/26/2021. On 03/17/2021 at 9:34 AM an interview with Resident #5 indicated he had not been invited to or attended a care plan meeting. He stated it was very important to him to be involved in decision making and he would have attended a care plan meeting if he had been invited. A review of Resident #5's medical record revealed no documentation a care plan meeting had occurred. On 03/17/2021 at 9:45 AM an interview with MDS	F 553	Please accept this Plan of Correction as MacGregor Downs Health and Rehabilitation□s Center□s credible allegation of compliance for the alleged deficiency cited. Submission and implementation of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. The Plan of Correction is submitted to meet requirements established by Federal and State laws, which requires an acceptable Plan of Correction as a condition of continued certification. The resident, wife and daughter were invited and attended a care plan meeting on 3/29/21. The Director of care management will conduct an audit to identify any current resident that had a comprehensive or quarterly MDS completed over the last 30 days. The Director of social services will ensure that the residents and responsible parties were invited to the scheduled care plan meeting. If a care plan meeting was not conducted, the Director of social services will initiate a care plan meeting for these residents and families. The Director of Care Management will conduct in-service training to the interdisciplinary team which includes therapy team leader, social services, MDS	

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F 553	Continued From page 2 nurse #1 indicated she was responsible for arranging care plan meetings. She stated it was the social worker's (SW) responsibility to invite residents. MDS nurse #1 stated Resident #5 had been due for a care plan meeting on 01/12/2021 and it had been on the schedule. She went on to say Resident #5 had not had this care plan meeting and it must have gotten missed. On 03/18/2021 at 11:59 AM a telephone interview with SW #1 indicated although she mailed an invitation to Resident #5's representative, she had not invited Resident #5 to participate in his care plan meeting scheduled for 01/12/2021. On 03/17/2021 at 12:26 PM an interview with the administrator indicated the facility was conducting care plan meetings as usual except families participated via video call. He stated he did not know why Resident #5 was not invited to attend his care plan meeting or why it was not conducted.	F 553	coordinators, Director of nursing, assistant director of nursing, unit managers, activities department, dietary department, Staff development coordinator and the Administrator on the care plan meeting process. This education will include the resident has the right to participate in the development and implementation of his or her person-centered care plan and to facilitate the inclusion of the resident representative. The social services department will invite the family and or resident to the care plan meetings with documented evidence of the invitation. Care plan attendance signature sheets will used as a source document for each meeting to indicate if the resident participated, or was unable to participate due to medical condition or declined. Care plan attendance signature sheets will be used as a source document to indicate if the family attended or declined the meeting. The care plan attendance sheets will be maintained by the MDS department. This education will be completed by 4/14/2021 The Director of Care Management is responsible for oversight and monitoring this process for 5 sample resident□s weekly for four weeks and then 5 sample resident□s monthly for 2 months to ensure that the resident and the resident representative invitation to the care plan meeting was provided and to validate the signature sheets are present for the care plan meeting. Results of the monitoring will be taken to QAPI monthly and discussed by the QAPI committee for 3	

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F 553	Continued From page 3	F 553	months, or until deemed unnecessary by the QAPI Committee.	
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information	F 585		4/14/21

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F 585	Continued From page 4 of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a	F 585		

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F 585	Continued From page 5 summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on resident interviews, family interviews, staff interviews, and record review the facility failed to resolve grievances for 1 of 1 resident reviewed for grievances (Resident #3). The findings included: Resident #3 was admitted to the facility on 10/1/20. He discharged to the community on 1/31/21. The Minimum Data Set (MDS) assessment dated 12/24/20, a quarterly assessment revealed Resident #3 was cognitively intact. An interview was conducted with Resident #3 ' s family member on 3/16/20 at 3:45 PM who stated she had filed a grievance with the facility and received no response. The family member	F 585	Please accept this Plan of Correction as MacGregor Downs Health and Rehabilitation□s Center□s credible allegation of compliance for the alleged deficiency cited. Submission and implementation of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. The Plan of Correction is submitted to meet requirements established by Federal and State laws, which requires an acceptable Plan of Correction as a condition of continued certification. Resident #3 was successfully discharged home on 1/31/2021, and is no longer a resident at the facility. All current residents have received the	

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F 585	Continued From page 6 reported she filed the grievance orally with the Director of Nursing. A review of a grievance reports from October 2020 through March 2021 revealed no grievance report filed on Resident #3 ' s behalf. An interview was conducted with the Director of Nursing (DON) on 3/16/21 at 4:09 PM who stated she was advised by Resident # 3 ' s family member that Resident #3 felt disrespected by a nurse aide. She stated she spoke with Resident #3 and he advised that he did feel disrespected. The DON spoke with the nurse aide who stated she was joking and apologized to the resident. She stated she felt the matter was resolved but never followed up with the family member. The DON stated a grievance form should have been completed. During an interview with the Administrator on 3/16/21 at 4:25 PM, he stated that he was aware of the concern voiced by Resident #3 ' s responsible party. He reported he may have spoken with the responsible party but could not recall. The Administrator stated he should have documented the contact. The Administrator further stated staff members had been contacting residents ' family members weekly and when a concern was voiced the facility was working to correct them. He indicated that if the concern was easily resolved a grievance was not completed. He indicated a grievance form should have been completed for tracking.	F 585	facility written concern policy and procedure upon admission. All family members of current residents will be contacted on the weekly communication call on 4/8/21 and 4/9/21, and will be asked if they have any concerns which need to be addressed. The response will be logged on the communication call log. Any concerns identified will be processed through the Facility concern procedure. All staff will be inserviced by each Department Head on the existing concern policy and procedure. All concerns should be documented, investigated, and entered on the concern log, with a written decision discussed and/or mailed to the resident or family member submitting the concern. The concern log will be monitored 3 times each week by the facility Social Workers, and discussed in the morning meetings three times per week for 3 months. Results will be reviewed in the monthly QAPI meeting for 3 months, or until deemed unnecessary by the QAPI Committee.	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments.	F 641		4/14/21

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F 641	Continued From page 7 The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to accurately code an Admission Minimum Data Set (MDS) for functional limitations in range of motion for 1 of 8 residents (Resident #1) reviewed for MDS accuracy. Findings included: Resident #1 was admitted to the facility on 9/28/2020 with diagnoses which included Parkinson's, spinal stenosis (the narrowing of the spaces within the spine, which eventually results in pressure on the spinal cord or nerve roots) , osteoarthritis, scoliosis (abnormal curvature of the spine) and chronic back pain. An Admission Minimum Data Set (MDS) dated 10/5/2021 indicated Resident #1 was moderately cognitive impaired, able to make his needs know, and able to understand others. The MDS revealed Resident #1 required extensive to assistance with all activities of daily living (ADL)) except was independent with meals. The MDS indicated Resident #1 did not have impairments of the upper and lower extremity. The MDS indicated Resident #1 required maximal assistance to transfer from a sitting to standing position. Resident #1 did not attempt to ambulate during the 7-day assessment look back period. A care plan initiated on 9/28/2020 indicated Resident #1 was at risk for falls due to bilateral foot drop (the inability to raise the front part of the foot due to weakness or paralysis of the muscles that lift the foot), pain, impaired balance, gait, and	F 641	Please accept this Plan of Correction as MacGregor Downs Health and Rehabilitation□s Center□s credible allegation of compliance for the alleged deficiency cited. Submission and implementation of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. The Plan of Correction is submitted to meet requirements established by Federal and State laws, which requires an acceptable Plan of Correction as a condition of continued certification. Resident # 1 Admission MDS assessment with ARD of 10/5/2020 was modified on 3/31/2021 by the Director of care management to reflect Section G0400 was coded to reflect the impairment of his extremities. Director of Care Management will review current residents with Admission assessments over the last 30 days for accuracy of coding of Section G0400. Assessments with errors identified will be corrected as appropriate by the Director of care management or MDS coordinators. Audit will be completed by 4/14 /2021 Director of Care Management to conduct in-service education with Facility Administrator, Director of Nursing, and MDS Coordinators in relation to MDS accuracy for Section G 0400 on 4/14/2021	

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F 641	Continued From page 8 mobility. The interventions included to make sure Resident #1 wore appropriate footwear when ambulating or mobilizing in a wheelchair. An interview with the Therapist Director on 3/17/2021 at 11:00 am revealed Resident #1 was admitted to the facility with bilateral foot drop. During an interview on 3/19/2021 at 2:20 pm with MDS Nurse #1, she stated since Resident #1 was admitted to the facility with foot drop, it should have been captured on the Admission MDS as an impairment of the lower extremities. On 3/19/2021 at 2:38 pm during a conversation with the Administrator, he stated the Admission MDS should have been coded to reflect Resident #1's bilateral foot drop.	F 641	utilizing the RAI manual as the source document for training. The Director of Care Management is responsible for auditing the accuracy of Section G0400 on 5 comprehensive MDS□s weekly times four weeks and then 5 comprehensive MDS□s monthly for 2 months. Results of the monitoring will be taken to QAPI monthly and discussed by the QAPI committee, until deemed unnecessary by the QAPI Committee.	