STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345242	A. BUILDING _____ B. WING _____	11/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOUNTAINS AT THE ALBEMARLE	200 TRADE STREET TARBORO, NC 27886

(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 11/07/22 through 11/10/22. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #H18T11.	E 000		
F 000	INITIAL COMMENTS A recertification survey was conducted from 11/07/22 through 11/10/22. Event ID# H18T11.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her	F 550		12/8/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/29/2022

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 550	Continued From page 1 rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on record review, observation, staff and resident interviews, the facility failed to provide incontinence care causing the resident to feel uncomfortable and wished he was dry for 1 of 1 resident (Resident #9) reviewed for Activities of Daily Living (ADL) care. Findings included: Resident #9 was admitted to the facility on 8-31-22 The significant change Minimum Data Set (MDS) dated 9-14-22 revealed Resident #9 was cognitively intact with no behaviors and required extensive assistance with one person for bed mobility, transfers, dressing, personal hygiene and total assistance with one person for toileting and bathing. The MDS also documented Resident #9 for receiving hospice services. Resident #9's care plan dated 10-3-22 revealed a goal that Resident #9 would be cared for with	F 550	This plan of correction is submitted as required under State and/or Federal law. The submission of this Plan of Correction does not constitute an admission on the part of the Community as to the accuracy of the surveyors findings or the conclusions drawn therefrom. Submission of this Plan of Correction also does not constitute an admission that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to the Communitys policies and procedures should be considered subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence, corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The Community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community	

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F 550	Continued From page 2 dignity. The interventions included provide resident with supportive care and services to promote a sense of safety, well-being and positive self-image. Resident #9 was observed and interviewed on 11-7-22 at 9:55am. Resident #9's under pad was observed to have a large brown stain with a dark yellow ring around the outside of the brown stain. The resident explained he had spilled his nutritional drink earlier that morning (11-7-22) and had urinated on himself. He explained he had told his nursing assistant (NA) #1 but said the NA had told him he had to wait until after breakfast. Resident #9 stated he felt "uncomfortable being wet and I wish I was dry." The resident put his call light on for the NA to return. NA #1 was interviewed on 11-7-22 at 10:02am. NA #1 entered Resident #9's room and explained she was aware the resident had spilled his nutritional drink and had urinated. She stated she had already told Resident #9 she would clean him after breakfast and left the room. A further interview occurred with NA #1 on 11-7-22 at 12:45pm. The NA explained she was informed by Resident #9 he had urinated and spilled his nutritional drink when she brought him his breakfast tray around 9:15am. She stated she had informed Resident #9 she could not provide care to him right then because she was passing breakfast trays and said she told the resident she would clean him up after breakfast. NA #1 stated she was sure Resident #9 was uncomfortable and did not like eating breakfast while he was wet but said she did not know what else she could have done but to tell the resident he would have to wait for care. The NA explained she had	F 550	or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies. Incontinence care was provided to Resident #9 on 11/7/22. Inservice with all nursing staff beginning on 11/7/22 to be completed by 12/8/22 by Director of Nursing and/or her designee on the importance of treating a resident with dignity by ensuring they are provided incontinence care in a timely manner and that they are not left soiled during a meal. New hires will receive training during orientation as well as contract staff on first date of employment. Residents who require assistance with incontinent care will be randomly audited by Director of Nursing or designee weekly x 4 weeks and monthly x 2 months to ensure incontinent care is provided in a timely manner with dignity and residents are not left soiled during a meal. Findings of Incontinence Care/Dignity audits will be presented to the QAPI Committee by the DON monthly for three months with any changes to plan made as needed.	

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F 550	Continued From page 3 provided care to Resident #9 around 10:20am (11-7-22) so the resident had waited for incontinence care for an hour. The Director of Nursing (DON) was interviewed on 11-8-22 at 12:46pm. The DON explained the process would have been for NA #1 to finish passing the breakfast trays and then return to Resident #9 and provide him care. She stated she would not expect the resident to wait an hour before receiving care especially if he had urinated. The DON stated she expected staff to provide incontinence care to the residents as soon as possible or ask for assistance. During an interview with the Administrator on 11-10-22 at 12:45pm, the Administrator stated she would expect the residents to receive incontinence care as soon as possible. She stated Resident #9 should have had incontinence care provided as soon as all the breakfast trays were passed.	F 550		
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property,	F 604		12/8/22

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F 604	Continued From page 4 and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff, resident representative and Physician interviews the facility utilized a bilateral bolster cover (4-cylinder shaped cushions each measuring 3 inches high, and 31 inches long attached to a 36-inch vinyl cover) on Resident #3's bed without considering them as a restraint and without a medical diagnosis for 1 of 1 resident reviewed for physical restraints. Findings included: The facility's restraint policy and procedure dated 10-15-18 was reviewed and revealed in part the decision to apply a restraint is based upon assessment of the resident's condition and must treat a specific medical condition. Falls are not a specific medical condition. Resident #3 was admitted to the facility on	F 604	Request for therapy evaluation of bolster on Resident #3□s bed was made on 11/9/22. Therapy Evaluation occurred by PT on 11/10/22. Orders were received for bolster as restraint from MD on 11/10/22 for her diagnosis of abnormalities of gait and mobility/lack of coordination. Inservice with all nursing staff beginning on 11/7/22 to be completed by 12/8/22 by Director of Nursing and/or her designee on policy/procedures for use of restraint in community. New hires will receive training during orientation as well as contract staff on first date of employment. 100% audit of all residents will be conducted by DON and/or designee on 11/9/22 to ensure that any resident with a device that could be considered a	

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F 604	Continued From page 5 10-5-21 with a diagnosis of Alzheimer's disease. A Physician order dated 2-8-22 revealed an order for Resident #3 to always have a bolster cover to the bed. The order did not include a medical necessity for the bolster cover. Resident #3's care plan dated 8-10-22 revealed a goal that the risk for falls and injury would be minimized. The interventions were in part wing mattress. The annual Minimum Data Set (MDS) dated 10-14-22 revealed Resident #3 was severely cognitively impaired with no documentation of mood or behavior issues. Resident #3 was documented for two or more falls since prior admission, but she was not documented for restraints. A fall evaluation was completed on 10-18-22 for Resident #3 and revealed Resident #3 was at risk for falls. Review of Resident #3's electronic medical record revealed no assessment or evaluation for the resident to have a bolster cover on her bed. Observation of Resident #3's room on 11-7-22 at 10:33 revealed the resident had a fall mat next to her bed and bolsters located bilaterally on her bed. A telephone interview occurred on 11-7-22 at 3:15pm with Resident #3's legal representative. The legal representative stated the facility had explained to her the bolsters on Resident #3's bed were present to keep the resident from rolling out of bed. The legal representative stated she	F 604	restraint followed all policies and procedures in place for restraints in community. No other restraints were found in community. All residents will be residents audited by DON or designee for restraint use weekly x 4 weeks and monthly x 2 months to ensure restraint policies and procedures are followed. Findings of Restraint audits will be presented to the QAPI Committee by Administrator monthly for three months with any changes to plan made as needed.	

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F 604	Continued From page 6	F 604		

did not live in the area, so she was not aware if the bolsters had restricted Resident #3's movements.

Resident #3 was observed in bed on 11-9-22 at 8:07am. The resident's bed was observed to be in the low position with a fall mat next to the bed. The bed was observed to have bilateral bolsters present and Resident #3 was observed to have her body up against the right bolster preventing her from rolling onto her right side.

An interview with Nursing Assistant (NA) #2 occurred on 11-9-22 at 8:25am. NA #2 discussed Resident #3's mobility out of bed and stated the resident was able to get out of bed on her own but explained the resident would fall due to the inability to walk. NA #2 explained the bolsters placed on Resident #3's bed had been placed there to keep the resident from falling out of bed. She stated with the bolsters present the resident was unable to get out of bed on her own.

During an interview with Nurse #2 on 11-9-22 at 8:29am, the nurse discussed Resident #3 and explained the resident was able to get out of bed but stated she would fall due to not being able to walk anymore. Nurse #2 stated the bolsters were placed on the bed to keep the resident from falling out of bed but then said Resident #3 would scoot to the end of the bed and try to climb over the foot board of the bed to try and get out of the bed. The nurse explained that was why there was a fall mat present next to the bed. The nurse stated she was unaware if an assessment or evaluation was completed prior to placing the bolsters on the bed.

The facility's Rehabilitation Director was

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interviewed on 11-9-22 at 9:18am. The Rehabilitation Director explained rehab had not completed an assessment or evaluation on Resident #3 for the bolsters on her bed. She stated the resident was on hospice and rehab would not have completed an assessment on a hospice resident.

A telephone interview occurred on 11-9-22 at 10:41am with Resident #3's hospice nurse. The hospice nurse discussed Resident #3 had the bolsters added to her bed to prevent the resident from falling out of bed. She stated hospice was unaware an assessment or evaluation had to be completed and that hospice had not completed an assessment or evaluation. The hospice nurse discussed the facility had contacted hospice to provide the bolster cover which she stated hospice had done but said the facility had placed the bolster cover on Resident #3's bed. The hospice nurse commented Resident #3 had been able to get out of the bed on her own prior to the bolster cover but Resident #3 could no longer get out of the bed on her own with the bolster cover.

The Director of Nursing (DON) was interviewed on 11-9-22 at 11:16am. The DON explained the process for a resident to receive a bolster cover was for the management team to discuss in their morning meeting options available to help a resident from falling out of bed and once a decision had been reached, the Physician was notified, and the intervention was put into place. The DON explained the Physician was not part of the decision for the intervention but was contacted to receive an order. She discussed the decision for Resident #3 to have a bolster cover had been decided by the management team which the Physician was not included. The DON

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stated the facility had not performed an assessment or evaluation for the bolsters to be placed on Resident #3's bed but had retrieved an order from the Physician. She stated prior to the bolster cover, Resident #3 was able to get out of bed but would fall due to the inability to walk. She said now, with the bolsters Resident #3 was unable to roll out of bed and the resident could still get out of bed with the bolsters but she was unsure how Resident #3 was getting out of bed.

During an interview with the Administrator on 11-9-22 at 11:45am, the Administrator stated she did not see the bolster cover for Resident #3 as a restraint. She explained the resident could still get out of bed but said she did not know how the resident was getting out of bed. The Administrator stated Resident #3 was rolling out of the bed at night and the bolster cover was placed to prevent Resident #3 from rolling out of the bed.

The facility Medical Director was interviewed on 11-9-22 at 4:45pm. The Medical Director explained Resident #3 was under the care of hospice, so he was not the resident's Physician and he had overlooked the order written in February 2022 for the bolster cover. He explained he was not included in the decision to place the bolster cover on Resident #3's bed but would have expected therapy to perform an assessment and/or evaluation prior to the bolster cover being placed on Resident #3's bed.

The Administrator was interviewed a second time on 11-10-22 at 12:45pm. The Administrator stated the facility should follow the policy and procedure for restraints and ensure all documents are completed when a restraint was being used.

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F 658	Continued From page 9	F 658		
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 observations, interviews with facility staff and record review the facility failed to remove a wander elopement prevention device for a resident no longer at risk for wandering and/or elopement for 1 (Resident #32) of 1 resident reviewed for elopement device. The findings included: Resident #32 was admitted to the facility on 6/16/22. Her diagnoses included Alzheimer's disease. The quarterly Minimum Data Set assessment dated 9/22/22 documented Resident #32 required extensive assistance for bed mobility and was totally dependent for all other activities of daily living. She had no locomotion or walking during the review period. Wander/elopement alarm was not used. On the elopement risk assessment dated 9/23/22 all the questions were answered no and indicated Resident #32 was not at risk for elopement. The care plan dated 10/27/22 for Resident #32 indicated she had impaired physical mobility and was at risk for falls related to being unaware of safety needs, confusion, and dementia. There	F 658	Resident #32 wanderguard (elopement prevention device) was removed by nurse on 11/9/22. 100% audit of all residents elopement risk assessments completed on 11/9/22 by Director of Nursing to determine elopement risk and whether or not a wanderguard (elopement prevention device) was warranted if scored at risk on assessment. No other wanderguards were found on residents that did not score at risk on assessment. Inservice with all nursing staff beginning on 11/7/22 to be completed by 12/8/22 by Director of Nursing and/or her designee on policy/procedures for use of wanderguards (elopement prevention device) in community. If resident scores at risk on assessment, wanderguard should be placed and policies/procedures followed. If a resident does not score at risk or if their risk assessment changes over time and the wanderguard (elopement prevention device) is no longer needed, wanderguard should be removed immediately.	12/8/22

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F 658	Continued From page 10 was no care plan for an elopement prevention device. On 11/8/22 at 2:50 PM Nurse #1 was providing a liquid nutritional supplement to Resident #32 who was sitting in a reclining wheelchair. Her left ankle was exposed and revealed an elopement prevention device was present. During the observation Nurse #1 stated the elopement prevention device had been present since she began working at the facility at the end of September 2022. Nurse #1 said Resident #32 could not walk or propel a wheelchair and probably did not need an elopement prevention device. A review of the physician's orders revealed there was no order for an elopement prevention device since Resident #32 was admitted. A review of the Medication Administration Records and the Treatment Administration records for June, July, August, September October, and November 2022 revealed no monitoring for an elopement prevention device. On 11/9/22 at 10:10 AM an observation of Resident #32 with the Director of Nursing (DON) revealed the elopement prevention device was no longer present. The DON stated Resident #32 should not have an elopement prevention device. During the observation Nurse #1 entered the room and reported to the DON that Resident #32 had an elopement prevention device on yesterday (11/8/22) when surveyor questioned her about the device. Nurse #1 said she did not remove the device. On 11/9/22 at 10:18 AM the Administrator said an	F 658	Elopement risk assessments as completed (on admission or at next due date on schedule) will be audited by DON or designee weekly x 4 weeks and monthly x 2 months to determine whether a wanderguard (elopement prevention device) is warranted for risk of elopement. Residents will be audited by Director of Nursing or designee to ensure a wanderguard is present if at risk or absent (removed) if not at risk. Findings of Elopement Risk audits will be presented to the QAPI Committee by Administrator monthly for three months with any changes to plan made as needed.	

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F 658	Continued From page 11 elopement prevention device should have a physician order for placement. She added it should be monitored for placement and for proper functioning but there was no monitoring documentation on the Medication Administration Record or the Treatment Administration record. She said she felt certain the device was present when the resident was admitted from the memory care assisted living part of the facility. The Administrator added it should have been removed when she was no longer at risk of elopement. During an additional interview with the DON on 11/9/22 at 11:24 AM she said there was no physician order for the elopement prevention device and no orders for monitoring the device. The DON said when Resident #32 was first admitted to the skilled unit she was able to propel a wheelchair short distances. The DON said the nursing assistant should have noticed the elopement prevention device during her baths or the nurses who completed the skin assessments should have questioned why she had the device, but no one did anything about the elopement prevention device.	F 658		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff and resident interviews the facility failed to provide incontinence care for 1 of 4 Residents (Resident #9) reviewed for Activities of Daily Living (ADL)	F 677	Incontinence care as provided to Resident #9 on 11/7/22. Inservice with all nursing staff beginning	12/8/22

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	345242	A. BUILDING _____ B. WING _____	11/10/2022

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F 677	Continued From page 12 care. Findings included: Resident #9 was admitted to the facility on 8-31-22 with a diagnosis of malignant neoplasm of the pancreas. Resident #9's care plan dated 9-11-22 revealed a goal he would remain free from skin breakdown due to incontinence and brief use. The interventions included clean peri-area with each incontinence episode. The significant change Minimum Data Set (MDS) dated 9-14-22 revealed Resident #9 was cognitively intact with no behaviors and required extensive assistance with one person for bed mobility, transfers, dressing, personal hygiene and total assistance with one person for toileting and bathing. The MDS documented Resident #9 as always incontinent of urine. Resident #9 was interviewed and observed on 11-7-22 at 9:55am. Resident #9's under pad was noted to have a brown stain with a dark yellow ring around the brown stain. The resident explained he had spilled his nutritional drink earlier in the morning (11-7-22) and had urinated on himself. He stated he had informed the Nursing Assistant (NA) #1 when she brought him his breakfast tray but said the NA had told him he would have to wait until after breakfast to receive care. An interview occurred with NA #1 on 11-7-22 at 12:45pm. The NA explained she was informed by Resident #9 he had urinated and spilled his nutritional drink when she brought him his	F 677	on 11/7/22 to be completed by 12/8/22 by Director of Nursing and/or her designee on the importance of incontinent care in a timely manner to residents that require incontinence care. New hires will receive training during orientation as well as contract staff on first date of employment. Residents who require assistance with incontinent care will be randomly audited by Director of Nursing or designee weekly x 4 weeks and monthly x 2 months to ensure incontinent care is provided in a timely manner. Findings of Incontinence Care audits will be presented to the QAPI Committee by the DON monthly for three months with any changes to plan made as needed.	

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F 677	Continued From page 13	F 677		

breakfast tray around 9:15am. She stated she had informed Resident #9 she could not provide care to him right then because she was passing breakfast trays and said she told the resident she would clean him up after breakfast. The NA explained she had provided care to Resident #9 around 10:20am (11-7-22).

The Director of Nursing (DON) was interviewed on 11-8-22 at 12:46pm. The DON explained she would not expect the resident to wait an hour before receiving care especially if he had urinated. She explained she would have expected NA #1 to finish passing trays and then go back and provide the needed care. The DON stated she expected staff to provide incontinence care to the residents as soon as possible or ask for assistance.

An observation of incontinence care for Resident #9 occurred on 11-9-22 at 9:50am with NA #1. Resident #9's skin was noted to be intact with no redness present. The resident's gown and under pad was observed to be wet and the under pad had a dark yellow ring present however Resident #9's brief was observed to be dry on the inside.

During an interview with NA #1 on 11-9-22 at 10:10am, the NA confirmed Resident #9's under pad was wet with a dark yellow ring and the resident's gown was wet. She stated the resident's under pad and gown were wet every time she provided incontinent care, but his brief was usually dry. The NA explained she thought Resident #9 removed his penis from the brief and urinated in his bed. She said she checked for incontinence care every 2 hours and explained Resident #9 would usually put on his call light to let her know when he needed care.

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F 677	Continued From page 14 During an interview with the Administrator on 11-10-22 at 12:45pm, the Administrator stated she would expect the residents to receive incontinence care as soon as possible. She stated Resident #9 should have had incontinence care provided as soon as possible and not have waited an hour.	F 677		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.	F 690		12/8/22

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F 690	Continued From page 15 §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review the facility failed to prevent a urinary catheter bag from coming in contact with the floor for 1 (Resident #18) of 1 resident reviewed for urinary catheter. The findings included: Resident #18 was admitted to the facility on 3/30/21. Her current diagnoses included neurogenic bladder. The quarterly Minimum Data Set assessment dated 10/14/22 indicated Resident #18 was severely cognitively impaired. She required extensive to total dependence for activities of daily living except she was independent for eating. She had an indwelling urinary catheter. The care plan for Resident #18 updated 10/18/22 indicated Resident #18 had an indwelling catheter due to neurogenic bladder and obstructive uropathy. The interventions included to position the catheter bag and tubing below the level of the bladder and away from the entrance room door. On 11/8/22 at 9:45 AM the catheter bag for Resident #18 was observed from the doorway to be attached to the right lower edge of the foot of the bed. A privacy bag was	F 690	Resident #18□s bed was raised to a level to prevent the catheter bag from touching the floor. Inservice with all nursing staff beginning on 11/7/22 to be completed by 12/8/22 by Director of Nursing and/or her designee on the importance of not allowing a resident□s catheter bag to touch the floor. New hires will receive training during orientation as well as contract staff on first date of employment. Residents with catheter bags will be audited by Director of Nursing or designee weekly x 4 weeks and monthly x 2 months to ensure catheter bags are not touching the floor. Findings of Catheter audits will be presented to the QAPI Committee by the DON monthly for three months with any changes to plan made as needed.	

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F 690	Continued From page 16 covering the catheter bag, but the bottom of the catheter bag was touching the floor. On 11/8/22 at 9:48 AM Nurse #1 stated she observed the urinary catheter bag touching the floor when she conducted her medication pass with Resident #18 earlier that morning. She added she did not lower the bed during the medication pass. Nurse #1 said she was unsure if the bed should be raised a little higher so the catheter bag was not touching the floor. She then said Resident #18 did not move around in her bed and was not at risk for falling out of the bed. Nurse #1 then raised the bed, so the urinary catheter bag was no longer touching the floor. The Director of Nursing was interviewed on 11/8/22 at 3:40 PM. She stated the urinary catheter bag should not be on the floor even if the bed was in a low position. She added the facility would need to determine how to correct this, so it does not happen again.	F 690		
F 847 SS=D	Entering into Binding Arbitration Agreements CFR(s): 483.70(n)(2)(i)(ii)(3)-(5) §483.70(n) Binding Arbitration Agreements If a facility chooses to ask a resident or his or her representative to enter into an agreement for binding arbitration, the facility must comply with all of the requirements in this section. §483.70(n)(1) The facility must not require any resident or his or her representative to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility and must explicitly inform the resident or his or her representative of his or her right not to sign the agreement as a	F 847		12/8/22

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F 847	Continued From page 17 condition of admission to, or as a requirement to continue to receive care at, the facility. §483.70(n)(2) The facility must ensure that: (i) The agreement is explained to the resident and his or her representative in a form and manner that he or she understands, including in a language the resident and his or her representative understands; (ii) The resident or his or her representative acknowledges that he or she understands the agreement; §483.70(n)(3) The agreement must explicitly grant the resident or his or her representative the right to rescind the agreement within 30 calendar days of signing it. §483.70(n) (4) The agreement must explicitly state that neither the resident nor his or her representative is required to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility. §483.70(n) (5) The agreement may not contain any language that prohibits or discourages the resident or anyone else from communicating with federal, state, or local officials, including but not limited to, federal and state surveyors, other federal or state health department employees, and representative of the Office of the State Long-Term Care Ombudsman, in accordance with §483.10(k). This REQUIREMENT is not met as evidenced by: Based on record review and interviews with the Administrator and a resident representative the facility failed to grant the resident representative	F 847	The community□s Arbitration Agreement was revised to grant the resident representative the right to rescind the	

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F 847	Continued From page 18 the right to rescind the arbitration agreement within 30 days of signing it for 1 of 1 resident whose representative signed an arbitration agreement (Resident #31). The findings included: Resident #31 was admitted to the facility on 10/10/22. The arbitration agreement signed by the resident representative for Resident #31 on 10/10/22 read in part, "This agreement may be cancelled via a written notice sent to the Community administrator by certified mail, return receipt requested, within ten (10) business days of the date it is executed by the Resident." The admission Minimum Data Set assessment dated 10/14/22 indicated Resident #31 was severely cognitively impaired. On 11/08/22 at 1:45 PM the Administrator reported the facility offered an Arbitration Agreement to residents or their representative during the admission process. She stated only one of the facility residents (Resident #31) had entered into an arbitration agreement. She added there had been no arbitration disputes. On 11/8/22 at 2:18 PM the resident representative for Resident #31 stated he understood the arbitration agreement and he agreed to the terms of the agreement. On 11/8/22 at 2:48 PM the Administrator stated she was not aware of the need for the 30 day right to withdraw from the arbitration agreement.	F 847	arbitration agreement within 30 days of signing. Resident #31 has discharged from community. Inservice with social worker (admissions) and business office manager who handle admissions to community will be completed by Administrator by 12/8/22 covering updates to Arbitration Agreement including granting the resident representative the right to rescind the agreement within 30 days of signing. Arbitration Agreements signed will be audited by the Administrator or designee weekly x 4 weeks and monthly x 2 months to the revised Arbitration Agreement is being used. Findings of Arbitration Agreement audits will be presented to the QAPI Committee by Administrator monthly for three months with any changes to plan made as needed.	

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F 848	Continued From page 19	F 848		
F 848 SS=D	Binding Arbitration Agreements CFR(s): 483.70(n)(2)(iii)(iv)(6) §483.70(n)(2) The facility must ensure that: (iii) The agreement provides for the selection of a neutral arbitrator agreed upon by both parties; and (iv) The agreement provides for the selection of a venue that is convenient to both parties. §483.70(n)((6) When the facility and a resident resolve a dispute through arbitration, a copy of the signed agreement for binding arbitration and the arbitrator's final decision must be retained by the facility for 5 years after the resolution of that dispute on and be available for inspection upon request by CMS or its designee. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with the facility Administrator the facility failed to include the selection of a venue that was convenient to both parties in the Arbitration Agreement. This was for 1 of 1 (Resident #31) resident who entered into an Arbitration Agreement with the facility. The findings included: Resident #31 was admitted to the facility on 10/10/22. A review of the Arbitration Agreement signed by the responsible part for Resident #31 on 10/10/22 revealed there was no information to address the selection of a venue convenient to both parties. The admission Minimum Data Set assessment dated 10/14/22 indicated Resident #31 was	F 848	The community□s Arbitration Agreement was revised to include the selection of a venue that was convenient to both parties in the Arbitration Agreement. Resident #31 has discharged from community. Inservice with social worker (admissions) and business manager who handle admissions to community will be completed by Administrator by 12/8/22 covering updates to Arbitration Agreement including the selection of a venue that was convenient to both parties in the Arbitration Agreement. Arbitration Agreements signed will be audited by the Administrator or designee weekly x 4 weeks and monthly x 2 months	12/8/22

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F 848	Continued From page 20 severely cognitively impaired. On 11/08/22 at 1:45 PM the Administrator reported the facility offered an Arbitration Agreement to residents or their representative during the admission process. She stated only one of the facility residents (Resident #31) had entered into an arbitration agreement. She added there had been no arbitration disputes. On 11/8/22 at 2:48 PM the Administrator stated the Arbitration Agreement signed by the responsible party for Resident #31 did not contain any information about selecting a venue, so she was unsure if there was anything about the selection of the venue in the policy. On 11/9/22 at 4:17 PM the Administrator reported the facility's corporate office staff were working on a policy update for arbitration and she had informed the corporate office of the need to address the selection of a venue which was convenient to both parties.	F 848	to the revised Arbitration Agreement is being used. Findings of Arbitration Agreement audits will be presented to the QAPI Committee by Administrator monthly for three months with any changes to plan made as needed.	