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 01/26/2023

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MACGREGOR DOWNS HEALTH CENTER BY HARBORVIEW	2910 MACGREGOR DOWNS ROAD GREENVILLE, NC 27834

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 1/23/23 through 1/26/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #OYE411.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 1/23/23 through 1/26/23. Event ID# OYE411. The following intakes were investigated NC00191121, NC00197288, NC00188898, NC00193918, NC00194883, NC00195651, NC00195246, NC00196090, NC00197304 and NC00197347. 2 of the 25 complaint allegations were substantiated resulting in deficiencies.	F 000		
F 582 SS=F	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each	F 582		2/22/23

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

Electronically Signed | 02/16/2023

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F 582	Continued From page 1 resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide a Centers for Medicare and Medicaid Services (CMS) Skilled Nursing Facility Advanced Beneficiary Notice (SNF-ABN) prior to discharge from Medicare Part A skilled	F 582	1. Immediate action(s) taken for the resident(s) found to have been affected include: Resident #427 discharged from facility on 8/4/22. Resident #109 is still a current	

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F 582	Continued From page 2 services for 2 of 2 residents reviewed for beneficiary protection notification review who required the provision of the SNF-ABN form (Resident #427 and Resident #109). The findings included: 1. Resident #427 was admitted to the facility on 5/6/22. Review of CMS-R-131 (a form used to indicate Medicare Part B services are ending) revealed Resident #427's Medicare Part A skilled services ended on 7/13/22. He remained in the facility with benefit days remaining. Record review revealed that Resident #427 was not given the CMS-10555 Skilled Nursing Facility Advanced Beneficiary Notice (SNF-ABN). During an interview with Social Worker #2 on 1/24/23 at 3:20 PM she stated she was instructed by the former Administrator to use CMS-R-131. She reported the facility had been using the form for approximately a year. An interview was conducted with the Administrator on 1/24/23 at 9:56 AM who indicated Resident #427 should have received the CMS-10555 as required by Federal guidelines. The Administrator stated the facility social workers were responsible for providing the form. She reported the facility was not using the correct notification form. The Administrator reported the facility will begin using the correct form. 2. Resident #109 was admitted to the facility on	F 582	resident in the facility. Resident #109's current form was immediately corrected with correct form on 1/24/23 by Social Worker. Facility immediately replaced current form that was in use with correct CMS -10555 Advance Beneficiary Notice. Administrator immediately educated Social Services and MDS nurses on 1/24/23 on using CMS-10555 form going forward. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that residents with a qualifying hospital stay and Medicare Part A benefit days available have the potential to be affected. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: On 2/13/23 an initial audit was conducted on current residents who were admitted in the past six months, and corrective actions were completed immediately. On 1/24/22 the Administrator educated the following personnel on the facility's Advance Beneficiary Notices policy: Business Office Manager, Social Services Director, MDS Coordinator, Director of Nursing, Rehabilitation Program Manager. Copies of the relevant forms were placed in a binder in the offices of the Business Office Manager, MDS Coordinator and Social Services Director. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The MDS Coordinator will conduct a random audit of (5) residents 3x a week	

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F 582	Continued From page 3 6/22/22. Review of CMS-R-131 (a form used to indicate Medicare Part B services are ending) revealed Resident #109's Medicare Part A skilled services ended on 8/10/22. She remained in the facility with benefit days remaining. Record review revealed that Resident #109 was not given the CMS-10555 Skilled Nursing Facility Advanced Beneficiary Notice (SNF-ABN). During an interview with Social Worker #2 on 1/24/23 at 3:20 PM she stated she was instructed by the former Administrator to use CMS-R-131. She reported the facility had been using the form for approximately a year. An interview was conducted with the Administrator on 1/24/23 at 9:56 AM who indicated Resident #427 should have received the CMS-10555 as required by Federal guidelines. The Administrator stated the facility social workers were responsible for providing the form. She reported the facility was not using the correct notification form. The Administrator reported the facility will begin using the correct form.	F 582	for 2 weeks, weekly x 6 weeks to verify that notices were issued timely and appropriately. This plan of correction will be monitored at the monthly Quality Assurance meeting x 3 months Corrective action completion date: 2/22/23	
F 584 SS=B	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.	F 584		2/22/23

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F 584	Continued From page 4 The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and resident and staff interviews the facility failed to maintain resident's walls in good repair for 1 of 15 rooms (Room #49) on Hall 4 reviewed for environment.	F 584	1. Immediate action(s) taken for the resident(s) found to have been affected include: On 1/26/23 the Maintenance Director was	

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F 584	Continued From page 5 The findings included: On 1/23/23 at 11:26 AM an observation of Room #49 revealed 4 areas of unpainted dry wall repair approximately 5 feet from the floor along the wall beside Resident A's bed. These areas were 2 inches wide by 6 - 8 inches long. There were also 5-6 patches of unpainted dry wall repair of various sizes beside and behind the resident's bed. There were an additional 4 areas of unpainted dry wall repair on the wall just above the Resident B's bed. An interview was conducted in conjunction with the observation on 1/23/23 at 11:26 AM with the resident in Room #49 (bed A). During the interview the resident was alert and oriented to person, place, time and situation. The resident stated the walls had remained in the observed condition since she was assigned to the room 7 months ago. She said it was not very pretty to have to look at those places on the wall every day. She said she could not believe no one had come to paint over the patches so the room would seem more homelike. On 1/26/23 at 9:45 AM the Maintenance Director reported he had been working to patch the wall throughout the building then he was planning to paint the whole building but was waiting on administration to decide on the paint colors. On 1/26/23 at 2:48 PM the Administrator observed the unpainted dry wall patches in Room #49. She stated waiting 7 months to get the room painted was too long and the room should have been painted just after the repairs in that room were completed. She said she was not aware of a	F 584	immediately notified of unpainted areas in Room #49. The Maintenance assistant was immediately dispatched to resident's room to paint areas of issue. On 1/26/23 the Administrator in serviced Maintenance Director and Maintenance Assistant that any areas of damage or wear and tear must be addressed and a plan must be created to repair as soon as possible. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents with damage to facility room walls have the potential to be affected. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: An initial audit of the facility was completed on 2/13/23. The Maintenance Director will be responsible for weekly audit of entire facility to assess for damage or wear and tear that needs to be addressed. Audit will include dates to which the issue was identified and completed. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The Administrator will conduct a weekly x 6 weeks followed by monthly x 2 audit of Maintenance repair logs to ensure that all issues identified were addressed in a timely manner. This plan of correction will be monitored at the monthly Quality Assurance meeting x 3 months. Corrective action completion date: 2/22/23	

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F 584	Continued From page 6 plan for selecting paint colors or waiting to paint the whole building.	F 584		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. 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 note antipsychotic use on the Minimum Data Set (MDS) assessments for 1 of 32 MDS assessments reviewed (Resident #107). Findings included: Resident #107 was admitted to the facility on 5/17/22. The Medication Administration Record for December 2022 was reviewed and revealed Resident #107 received Seroquel (an antipsychotic medication) daily during the lookback period (consists of seven consecutive days ending on the assessment date) of the quarterly MDS assessment dated 12/12/22. Resident #107's quarterly MDS assessment dated 12/12/22 indicated he had received antipsychotic medications daily, but the Antipsychotic Medication Review section indicated antipsychotic medications had not been received. During an interview on 1/26/23 at 11:13 AM MDS Nurse #1 stated Resident #107 did receive	F 641	1. Immediate action(s) taken for the resident(s) found to have been affected include: Resident #107's antipsychotic assessment was immediately corrected on 1/26/23. MDS Director and MDS nurses were immediately in-serviced by Director of Nursing on 1/26/23 related to accurately documenting resident antipsychotic use in MDS assessments. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents on antipsychotic medication have the potential to be affected. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: On 1/26/23, Education was provided to all MDS nurses by the Director of Nursing to ensure all assessments are double checked for any errors before submission. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The Director of Nursing Services will audit any residents with new orders for	2/22/23

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F 641	Continued From page 7 antipsychotic medication during the lookback period of the and the Antipsychotic Medication Review section in the 12/12/22 MDS was incorrect. During an interview on 1/26/23 at 11:14 AM the Administrator stated MDS assessments should accurately reflect resident antipsychotic usage.	F 641	antipsychotics 2x a week for 2 weeks and then 1x a week for 2 weeks. All audits will be monitored by the Quality Assurance Team monthly x 3 months. Corrective action completion date: 2/22/23	
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to refer a resident with a new diagnosis of mental illness for a Preadmission Screening and Resident Review (PASARR) evaluation for 1 of 2 residents reviewed for PASARR (Resident #75).	F 644	Preparation and/or execution of this plan does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its	2/22/23

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F 644	Continued From page 8 Findings included: Resident #75 was originally admitted to the facility on 10/10/18 with diagnoses that included hypertension. Resident #75 had been readmitted to the facility on 6/14/22 with diagnoses including bipolar disorder and was prescribed an antipsychotic (to help stabilize symptoms) medication. Resident #75's admission Minimum Data Set (MDS) assessment dated 6/21/22 revealed she was not currently considered by the state Level II PASARR process to have a serious mental illness. Her diagnoses included bipolar disorder. A review of Resident #75's care plan revealed a plan initiated on 6/28/22 for psychotropic [medication] use related to depression and bipolar disorder. The interventions included to administer psychotropic medications as ordered by the physician, monitor for adverse effects of antipsychotic use, and monitor for target behaviors and notify physician if behaviors worsen or increase in frequency. During an interview on 1/25/23 at 10:30 AM Social Worker #2 stated she was responsible for referring residents with new psychiatric diagnosis to PASARR for an evaluation. She indicated she was advised of new psychiatric diagnoses during the clinical morning meetings and if she missed a meeting, she would not be aware of the new diagnoses. She explained she had not been aware of Resident #75's diagnosis and did not initiate a PASARR referral.	F 644	employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. 1. Immediate action(s) taken for the resident(s) found to have been affected include: Social Services Director immediately initiated a Preadmission Screening and Resident Review (PASARR) for Resident #75. On 1/25/23 the Administrator educated Social Services Director that all residents receiving a new diagnosis of mental illness must have a Preadmission Screening and Resident Review (PASARR) review completed. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents that have been started on new antipsychotic medication or have a new mental illness diagnosis could potentially be affected. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: On 1/25/23 the Administrator educated Social Services Director that all residents receiving a new diagnosis of mental illness must have a Preadmission Screening and Resident Review (PASARR) review completed. All residents with new psych meds or psych diagnosis are discussed in clinical start up, this communication is passed to social worker who will review resident's Preadmission	

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F 644	Continued From page 9 During an interview on 1/26/22 at 1:00 PM the Administrator indicated if a new psychiatric diagnosis required a new referral for PASARR evaluation, then the Social Worker #2 should have followed the correct referral process.	F 644	Screening and Resident Review (PASARR) level. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The Quality Assurance Nurse will audit all residents with new psych diagnosis or psych medication to ensure Preadmission Screening and Resident Review (PASAR) review is initiated as appropriate. This will be audited 5 days a week x 2 weeks and then 2x week x 2 weeks and then weekly x 2 weeks. All audits will be monitored by the Quality Assurance Team monthly x 3 months. Corrective action completion date: 2/22/23	
F 711 SS=D	Physician Visits - Review Care/Notes/Order CFR(s): 483.30(b)(1)-(3) §483.30(b) Physician Visits The physician must- §483.30(b)(1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; §483.30(b)(2) Write, sign, and date progress notes at each visit; and §483.30(b)(3) Sign and date all orders with the exception of influenza and pneumococcal vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on record review and medical provider	F 711	Preparation and/or execution of this plan	2/22/23

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F 711	Continued From page 10	F 711		

interview the Nurse Practitioner failed to accurately review and document the resident's medications for two consecutive visits for 1 of 1 resident (Resident #84) reviewed for anticoagulant medication.

The findings included:

Resident #84 was admitted to the facility on 10/12/22, His diagnoses included atrial fibrillation and multiple falls.

The quarterly Minimum Data Set assessment dated 12/9/22 documented Resident #84 was severely cognitively impaired.

The physician order dated 10/12/22 for Apixaban (anticoagulant medication) read "Give 5 mg (milligrams) by mouth two times per day for continuation of treatment for DVT (deep vein thrombosis)/PR for 30 days.

A review of the October 2022 and November 2022 Medication Administration Records (MAR) revealed Resident #84 received the Apixaban 5 mg two times per day from 10/12/22 through 11/10/22. He received one dose on 11/12/22. This medication was held for the next 2 doses, the evening dose on 11/11/22 and the morning does on 11/12/22. The MAR indicated he did not receive any additional doses of Apixaban during November.

The December 2022 MAR revealed no Apixaban was administered.

The provider note dated 10/26/22 written by Nurse Practitioner (NP) #1 under the subtitle Medication List listed "Apixaban Tablet 5 MG,

does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance.

1. Immediate action(s) taken for the resident(s) found to have been affected include:
The Nurse Practitioner made any necessary corrections to Resident# 84's medical chart on 1/26/23. The Director of Nursing educated the Nurse practitioner on 1/26/23 as it related to incorrect documentation in resident #84's medical chart. The Director of Nursing also educated the Nurse Practitioner that all documentation must be thoroughly reviewed and checked for accuracy prior to submitting physician visit progress note in residents' medical records. The Medical Director was notified on 1/26/23.
2. Identification of other residents having the potential to be affected was accomplished by:
The facility has determined that any resident on anticoagulants could potentially be affected.
3. Actions taken/systems put into place to reduce the risk of future occurrence include:
The Director of Nursing educated all Nurse Practitioners assigned to facility on ensuring accurate documentation in

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MACGREGOR DOWNS HEALTH CENTER BY HARBORVIEW	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 711	Continued From page 11 Give 5mg by mouth two times a day for continuation of treatment for DVT/PR for 30 days ...Active 10/13/22 to 11/12/22." Under the subtitle of Plan was documented "A. fib (atrial fibrillation) Stable. The patient's cardiac status and atrial fibrillation have been extensively assessed. The patient is adequately anticoagulated and rate is controlled on the present medical regimen. We will continue to monitor closely and adjust regimen as appropriate. Patient is on [trade name for Apixaban] 5 mg twice daily." The provider note dated 11/15/22 written by NP #1 under the subtitle Medication List listed "Apixaban Tablet 5 MG, Give 5mg by mouth two times a day for continuation of treatment for DVT/PR for 30 days ...Active 10/13/22 to 11/12/22." Under the subtitle of Plan was documented "A. Fib. Stable. The patient's cardiac status and atrial fibrillation have been extensively assessed. The patient is adequately anticoagulated and rate is controlled on the present medical regimen. We will continue to monitor closely and adjust regimen as appropriate. Patient currently on [trade name for Apixaban] 5 mg twice daily." The provider note dated 12/15/22 written by NP #1 under the subtitle Medication List listed "Apixaban Tablet 5 MG, Give 5mg by mouth two times a day for continuation of treatment for DVT/PR for 30 days ...Active 10/13/22 to 11/12/22." Under the subtitle of Plan documented "A. Fib. Stable. The patient's cardiac status and atrial fibrillation have been extensively assessed. The patient is adequately anticoagulated and rate is controlled on the present medical regimen. We will continue to monitor closely and adjust regimen as appropriate. Patient currently on	F 711	relation to resident charting on 1/26/23. All residents on anticoagulant therapy will be audited to ensure all orders match the most recent physician progress note. The Medical Director was notified of all education on 1/26/23. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The Quality Assurance nurse will randomly audit 3 resident charts weekly x 2 weeks and then 1 monthly x 3 months to ensure that resident order summary matches most previous progress notes from physician. All audits will be monitored by the Quality Assurance Team monthly x 3 months. Corrective action completion date: 2/22/23	

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F 711	Continued From page 12 [trade name for Apixaban] 5 mg twice daily." On 1/25/23 at 9:05 AM NP #1 stated his notes in November 2022 and December 2022 documented Resident #84 was on Apixaban and he was unsure when he was taken off the medication. He said he would review the record to see. NP #1 then said it was stopped based on his admission order which indicated it was to be stopped on 11/12/22 because it was only ordered to be given for 30 days. NP #1 stated he documented it wrong, and he did not take it out of his note when it was stopped.	F 711		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.	F 756		2/22/23

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F 756	Continued From page 13 (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review and Pharmacist and staff interviews the pharmacist failed to identify and report the lack of monitoring for a resident on antipsychotic medication for 1 of 5 residents reviewed for unnecessary medications (Resident #117). Findings included: Resident #117's discharge summary from the hospital dated 11/22/22 revealed Resident #117 was ordered Seroquel (antipsychotic)100 milligrams by mouth at bedtime for mild neurocognitive disorder due to multiple etiologies and major depressive disorder. Resident #117 was admitted to the facility on 11/22/22. Her active diagnoses included mild neurocognitive disorder (dementia) due to multiple etiologies and major depressive disorder. Resident #117's physician orders revealed on	F 756	Preparation and/or execution of this plan does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. 1. Immediate action(s) taken for the resident(s) found to have been affected include: On 1/25/23 an AIMS assessment was immediately completed on Resident # 117. On 1/25/23 the Director of Nursing audited all residents on antipsychotic medication were reviewed to ensure AIMS assessments were completed and correct. The Director of Nursing educated	

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F 756	Continued From page 14 11/22/22 she was ordered Seroquel 150 milligrams by mouth at bedtime. Resident #117's Minimum Data Set assessment dated 11/29/22 revealed she was assessed as receiving an antipsychotic 7 days of the 7-day look back period. Resident #117's care plan dated 12/3/22 revealed she was care planned to be at risk for drug related complications associated with use of psychotropic medications related to antipsychotic medications. The interventions included to monitor for side effects and report to physician any medication-sedation, drowsiness, dry mouth, constipation, blurred vision, extrapyramidal side effects, weight gain, edema, postural hypotension, sweating loss of appetite, urinary retention, monitor for target behaviors/symptoms and document, and report behavior changes to physician. On 12/27/22 Resident #117's Seroquel was increased to Seroquel 100 milligrams by mouth two times a day. Review of Resident #117's medical record revealed there was no documented AIMS (Abnormal Involuntary Movement Scale: a rating scale to measure involuntary movements that sometimes develop as a side effect of long-term treatment with antipsychotic medications) screening from 11/22/22 through 1/24/22. Review of Resident #117's monthly medication regimen reviews dated 12/15/22 and 1/19/23 revealed the pharmacist did not recommend an AIMS test be completed for Resident #117 and documented the monthly regimen review was	F 756	Admissions Nurse and ADON on 1/25/23 on proper completion of AIMS assessment and when to complete them. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents on antipsychotic medications could potentially be affected. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: On 2/9/23, the Director of Nursing educated the Admissions Nurse, Assistant Director of Nursing, MDS Director and MDS nurses and floor nurses that all residents on antipsychotic medication are to be reviewed to ensure AIMS assessments are completed and correct. The order listing report will be reviewed in clinical start up daily. If any antipsychotic order changes occur, the interdisciplinary team will ensure that an AIMS assessment is completed. Pharmacy Consultant was educated on facility process on 2/14/23. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The pharmacy consultant will audit all residents on antipsychotic medications to ensure AIMS assessments are completed for 2x week for 4 weeks, monthly x3 audit to ensure AIMS is completed. All audits will be monitored by the Quality Assurance Team monthly x 3 months. Corrective action completion date: 2/22/23	

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F 756	Continued From page 15 completed with no recommendations. During an interview on 1/25/23 at 8:39 AM the Director of Nursing stated Resident #117 was admitted on 11/22/22 and was on an antipsychotic from the hospital. She further stated the monthly pharmacy medication regimen review should identify that an AIMS had not been completed and she could not speak to why it was not identified on the monthly medication review by the Pharmacist. She concluded an AIMS screening should be completed for residents on antipsychotics upon admission and then every six months. During an interview on 1/25/22 at 1:51 PM Pharmacist #1 stated if the facility did not have a recommendation from him for an AIMS on Resident #117 then he probably did not recommend an AIMS. He did not know why Resident #117's lack of an AIMS was missed on his monthly medication regiment review. He concluded an AIMS should be completed every 6 months on residents receiving an antipsychotic to monitor for side effects of the medication and he did review the clinical justification of the Seroquel.	F 756		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and	F 758		2/22/23

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F 758	Continued From page 16 (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by:	F 758		

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F 758	Continued From page 17 Based on record review and staff interviews the facility failed to complete an AIMS (Abnormal Involuntary Movement Scale: a rating scale to measure involuntary movements that sometimes develop as a side effect of long-term treatment with antipsychotic medications) for a resident prescribed an antipsychotic medication for 1 of 5 residents reviewed for unnecessary medications (Resident #117). Findings included: Resident #117's discharge summary from the hospital dated 11/22/22 revealed Resident #117 was ordered Seroquel 100 milligrams by mouth at bedtime. Resident #117 was admitted to the facility on 11/22/22. Her active diagnoses included mild neurocognitive disorder due to multiple etiologies, major depressive disorder and mood disorder with delusions. Resident #117's Admission/Readmission Nursing Evaluations Packet dated 11/22/22 revealed in section XII: AIMS Rating, the Admissions Nurse documented Resident #117 was not receiving any antipsychotic medications. The Admissions Nurse did not complete an AIMS screening on Resident #117. During an interview on 1/25/22 at 9:42 AM Admissions Nurse #1 stated she did not know Seroquel was an antipsychotic medication which was why she documented the resident was not receiving an antipsychotic and did not complete an AIMS. Resident #117's Minimum Data Set assessment	F 758	Preparation and/or execution of this plan does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. 1. Immediate action(s) taken for the resident(s) found to have been affected include: On 1/25/23, an AIMS assessment was immediately completed on Resident # 117. On 1/25/23 the Director of Nursing audited all residents on antipsychotic medication were reviewed to ensure AIMS assessments were completed and correct. The Director of Nursing educated Admissions Nurse and ADON on 1/25/23 on proper completion of AIMS assessment and when to complete them. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents on antipsychotic medications have the potential to be affected. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: On 2/9/23, the Director of Nursing educated the Admissions Nurse, Assistant Director of Nursing, MDS Director and MDS nurses and floor nurses that all residents on antipsychotic medication are	

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F 758	Continued From page 18 dated 11/29/22 revealed she was assessed as receiving an antipsychotic 7 days of the 7-day look back period. Resident #117's care plan dated 12/3/22 revealed she was care planned to be at risk for drug related complications associated with use of psychotropic medications related to antipsychotic medications. The interventions included to monitor for side effects and report to physician any medication-sedation, drowsiness, dry mouth, constipation, blurred vision, extrapyramidal side effects, weight gain, edema, postural hypotension, sweating loss of appetite, urinary retention, monitor for target behaviors/symptoms and document, and report behavior changes to physician. Resident #117's orders revealed on 11/22/22 she was ordered Seroquel 150 milligrams by mouth at bedtime. This order was discontinued on 12/27/22 and a new order was written for Seroquel 100 milligrams by mouth two times a day. Review of Resident #117's medical record revealed there was no documented AIMS screening from 11/22/22 through 1/24/22. During an interview on 1/25/23 at 8:39 AM the Director of Nursing stated Resident #117 was admitted on 11/22/22 and was on an antipsychotic from the hospital. She stated the Admission Nurse would complete the Admission/Readmission Nursing Evaluations Packet for new admissions and if the resident was prescribed an antipsychotic, they would document this on that evaluation packet which would then trigger their system to initiate AIMS	F 758	to be reviewed to ensure AIMS assessments are completed and correct. The order listing report will be reviewed in clinical start up daily. If any antipsychotic order changes occur, the interdisciplinary team will ensure that an AIMS assessment is completed. Pharmacy Consultant was educated on facility process on 2/14/23. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The Director of Nursing will audit all residents on antipsychotic medications to ensure AIMS assessments are completed for 2x week for 4 weeks, monthly x3 audit to ensure AIMS is completed. All audits will be monitored by the Quality Assurance Team monthly x 3 months. Corrective action completion date: 2/22/23	

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F 758	Continued From page 19 screening on the resident every six months. She stated when Admissions Nurse #1 completed the form, she documented in error that Resident #117 was not on an antipsychotic resulting in the AIMS screening not being trigged for Resident #117. She further stated the monthly pharmacy medication regimen review would also identify that an AIMS had not been completed and she could not speak to why it was not identified on the monthly medication review. She concluded an AIMS screening should be completed for residents on antipsychotics upon admission and then every six months. During an interview on 1/25/22 at 1:51 PM Pharmacist #1 stated an AIMS should be completed every 6 months on residents receiving an antipsychotic to monitor for side effects of the medication.	F 758		
F 805 SS=D	Food in Form to Meet Individual Needs CFR(s): 483.60(d)(3) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(3) Food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to provide food in the correct consistency per the physician's orders for 1 of 4 residents reviewed for food. (Resident #33) The findings included: Resident #33 was admitted to the facility on	F 805	Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's	2/22/23

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F 805	Continued From page 20 10/27/22. Her diagnosis included dysphagia. The 5-day Minimum Data Set dated 12/09/22 indicated Resident #33 was cognitively intact. She required supervision for eating. She had range of motion limitations on both the upper and lower extremity on one side. The care plan revised on 12/19/22 indicated Resident #33 was at risk for alteration in nutritional status related to mechanically altered diet. The interventions included: "Continue to monitor food and fluids for appropriate texture and consistency. Diet as ordered. Set up meal tray, assist as needed." The care plan also indicated Resident #33 had a swallowing problem related to dysphagia with interventions which included: "All staff to be informed of resident's special dietary and safety needs. Observe for shortness of breath, choking, labored respirations, lung congestion. Observe/document report PRN (as needed) any s/sx (signs/symptoms) of dysphagia." A review of the physician's orders dated 1/3/23 revealed a diet order "Regular diet, pureed texture, regular/thin consistency." On 1/23/23 at 12:55 PM Social Worker (SW) #1 was observed sitting next to Resident #33's bed with the meal tray on the over the bed table. During the observation SW #1 stated she was feeding Resident #33, but the resident was not eating very much. The meal tray ticket was present on the tray and indicated Resident #33's diet was pureed and pureed apple crisp was included. The observation revealed the dessert in a blue insulated bowl was apple slices with bread like topping. SW #1 said the apple crisp	F 805	credible allegation of compliance. 1. Immediate action(s) taken for the resident(s) found to have been affected include: The incorrect food item was immediately removed from resident #33's room on 1/23/23. On 1/23/23 the Director of Nursing educated staff working with resident #33 on this day on confirming resident tray tickets with corresponding resident meal tray before entering resident room. On 1/23/23, dietary staff in resident #33's pantry were educated on confirming resident tray tickets with corresponding resident meal tray before releasing meal trays for staff to pass to residents. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents on specialized diets have the potential to be affected. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: On 2/9/23, the Director of Nursing educated all nursing, therapy and dietary staff on confirming resident tray tickets with corresponding resident meal tray before entering resident room or releasing tray to be served to resident. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The dietary manager will audit (5) specialized diet resident trays per week x 4 weeks and then (5) specialized diet	

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F 805	Continued From page 21 was not pureed so she did not attempt to feed it to Resident #33. She did not replace the apple crisp with the pureed one because Resident #33 told the SW she was not going to eat anything else. On 1/26/23 at 9:00 AM Speech Therapist #1 said she completed a swallowing evaluation for Resident #33 to determine what texture the resident was safe consuming. She said Resident #33 had oral dysphagia where she would chew food and then expel it from her mouth. She added the apple crisp should have been pureed unless a speech therapist was feeding her. She added the resident did not require any special feeding technique as long as she received pureed textures. On 1/26/23 at 10:41 AM the Director of Nursing reported SW #1 told her Resident #33's tray had food on it that was not pureed. The Director on Nursing stated if the resident received the wrong consistency food it would put her at risk for aspiration. On 1/26/23 at 11:22 AM the Dietary Manager stated the apple crisp was prepared and sent to each pantry for placement into the serving bowls by the dietary assistants. The bowls of apple crisp were placed on the residents' trays according to the meal tray ticket. She said the nursing assistants were also trained to read the meal ticket. She added all the items on the tray have a lid on them. Attempts to interview Resident #33 were unsuccessful. On 1/26/23 at 12:37 PM Resident #33's physician	F 805	resident trays per month x 2 months to ensure that tray tickets are confirmed with corresponding resident meal tray before entering resident room or releasing tray to be served to resident. This plan of correction will be monitored at the monthly Quality Assurance meeting x 3 months. Corrective action completion date: 2/22/23	

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(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 805	Continued From page 22 stated although the apple crisp had cooked apples the consistency should have been pureed.	F 805		
F 847 SS=E	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 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	F 847		2/22/23

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F 847	Continued From page 23 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, staff, resident, and resident representative interviews the facility failed to explain the arbitration agreement to cognitive residents and/or their representative prior to having them sign the agreement. This occurred for 2 of 3 residents (Resident #230, and Resident #5) reviewed for arbitration. Findings included: The facility's "Alternative Dispute Resolution Agreement" dated 5-17-22 stated signature on behalf of the facility hear by attest that before the resident and/or residents representative signed the document the facility offered the resident and/or resident representative the opportunity to read the document in full or to have the document read to them. The agreement also stated the resident and/or the resident representative understood what they were signing. a. Resident #230 was admitted to the facility on 12-23-22	F 847	Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. 1. Immediate action(s) taken for the resident(s) found to have been affected include: Residents #5 and #230 were discharged from the facility prior to the release of 2567. The Administrator educated both Admissions Directors on 1/24/23 that all residents that are cognitively intact and able to comprehend and sign arbitration agreements must be given the opportunity to. Administrator also in serviced that arbitration agreement must be explained	

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F 847	Continued From page 24 The 5-day Minimum Data Set (MDS) revealed Resident #230 was cognitively intact. A review of the arbitration agreement for Resident #230 revealed a resident representative signed the form and the form was not dated. A telephone interview occurred with Resident #230 on 1-24-23 at 10:39am. The resident stated he was not aware of an arbitration agreement and the form had not been explained to him. He also stated if the facility had allowed him to be present and explained the form to him, he would have declined to have the arbitration form signed. Resident #230's representative was interviewed by telephone on 1-24-23 at 10:53am. The representative stated she had signed the arbitration agreement but did not know what she was signing. She explained Resident #230 could have signed for himself but stated once they arrived at the facility, she was escorted into an office and told to sign the forms. The representative said no one explained to her what she was signing other than they were admission forms. b. Resident #5 was admitted to the facility on 12-20-22. The admission Minimum Data Set (MDS) dated 12-27-22 revealed Resident #5 was cognitively intact. Review of Resident #5's arbitration agreement revealed a representative had signed for the resident and the agreement was not dated.	F 847	fully to either resident or responsible party. If resident states they would like responsible party to review and sign for them, Admission Director would then be able to allow Responsible Party to sign arbitration agreement. On 1/24/23 the Vice President of Clinical Services was notified that the form needs to be modified to include the date. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all new residents admitting to the facility who are cognitively intact could potentially be affected. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: The company legal department was notified of needed changes to the Arbitration Agreement on 1/24/23 and the Arbitration Agreement was revised on 1/25/23. The revised Arbitration agreement was given to Admissions Coordinators to use going forward. On 2/13/23 all resident arbitration agreements for the past 30 days will be audited to ensure that any current residents that remains in the facility at this time and have a signed arbitration agreement and that if resident is cognitively intact, was given the opportunity to sign arbitration agreements themselves. If the resident wishes responsible party to sign instead, then resident representative signature will be accepted. 4. How the corrective action(s) will be monitored to ensure the practice will not	

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F 847	Continued From page 25 During an interview with Resident #5 on 1-25-23 at 12:13pm, the resident stated she could not remember what was discussed during her admission process. She stated she was not present when her representative signed the admission paperwork. A telephone interview with Resident #5's representative occurred on 1-25-23 at 12:57pm. The representative stated she was the one who signed the arbitration agreement but stated she did not know what she was signing. She explained when she arrived in the facility with Resident #5, she was escorted into an office, handed a stack of papers, and was told the papers were admission papers that she needed to sign for the resident. The representative stated no one explained any of the papers to her, she just signed them. During an interview with the Admissions Manager on 1-24-23 at 9:26am, the Admissions Manager explained she decided on who signs the arbitration agreement by looking at the resident's hospital discharge summary to see who the resident's emergency contact person was. She said if the emergency contact person was not the resident's representative, she would ask the emergency contact person who was the representative for the resident. The Admissions Manager explained most people signing the paperwork for the resident were not the resident's legal representative. She stated the facility does not request legal papers from representatives unless the representative wants medical records or to remove money from the resident's account. The Admissions Manager discussed most of the time the resident was present when the arbitration agreement was being discussed but	F 847	recur: The administrator will audit 5 arbitration agreements weekly x 4weeks, then monthly x 1 month to ensure that all arbitration agreements are signed/dated and if resident is cognitively able, that the resident is offered the opportunity to sign themselves. This plan of correction will be monitored at the monthly Quality Assurance meeting x 3 months. Corrective action completion date: 2/22/23	

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F 847	Continued From page 26 said the resident would often request their representative to sign for them. She said she could not remember if Resident #230 and Resident #5 were present. She also stated the arbitration agreement does not include an area for when the resident was present but requested the representative to sign and she stated she does not document that the resident was present or understood the agreement. The Admissions Manager discussed the date the agreement was signed was the admission date most of the time but not always. She stated she would not know when the signing of the agreement took place since there was no date present. The Administrator was interviewed on 1-24-23 at 9:40am. The Administrator stated the arbitration agreement was discussed during their morning meeting on Fridays to ensure the agreement was completed. She discussed reviewing random agreements to ensure they were completed but had not noticed they were not dated and was unaware the residents were not being included but stated she thought the agreement was being explained to the resident representatives.	F 847		
F 848 SS=E	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	F 848		2/22/23

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F 848	Continued From page 27 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 staff interviews the facility failed to include the selection of a venue that was convenient to both parties in the Arbitration Agreement. This occurred for 3 of 3 residents (Resident #229, Resident #230, and Resident #5) who entered into an Arbitration Agreement with the facility. Findings included: a. Resident #229 was admitted to the facility on 1-12-23. The 5-day Minimum Data Set (MDS) dated 1-15-23 revealed Resident #229 was cognitively intact. Review of the Arbitration Agreement signed by Resident #229's representative on 1-12-23 revealed there was no information to address the selection of a venue convenient to both parties. b. Resident #230 was admitted to the facility on 12-23-22 The admission Minimum Data Set (MDS) revealed Resident #230 was cognitively intact. Review of the Arbitration Agreement signed by Resident #230's representative, which was not dated revealed no information to address the selection of a venue convenient to both parties.	F 848	Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. 1. Immediate action(s) taken for the resident(s) found to have been affected include: Residents #5, #229 and #230 were discharged from the facility prior to the release of 2567. The Vice President of Clinical Services was notified on 1/24/23, that the arbitration agreement form needed to be modified to include an area to enter a date of agreement and the selection of a venue that was convenient for both parties in the Arbitration Agreement. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all new residents admitted to the facility have the potential to be affected. 3. Actions taken/systems put into place to reduce the risk of future occurrence include:	

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F 848	Continued From page 28 c. Resident #5 was admitted to the facility on 12-20-22. The admission Minimum Data Set (MDS) dated 12-27-22 revealed Resident #5 was cognitively intact. Review of the Arbitration Agreement signed by Resident #5's representative, which was not dated revealed there was no information to address the selection of a venue convenient to both parties. During an interview with the Admissions Manager on 1-24-23 at 9:26am, the Admissions Manager stated she was responsible for explaining the Arbitration Agreement to new admissions. She said she was not aware the Agreement did not provide information regarding venue selection. The Administrator was interviewed on 1-24-23 at 9:40am. The Administrator stated she was not aware the Arbitration Agreement did not have information regarding venue selection. She explained when the facility changed ownership, the new corporation had provided the facility with a new Arbitration Agreement form and stated she would inform the corporation that the Agreement needed information regarding venue selection.	F 848	The company legal department was notified of needed changes to the Arbitration Agreement on 1/24/23 and the Arbitration Agreement was revised on 1/25/23. The revised Arbitration agreement was given to Admissions Coordinators to use going forward. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The Administrator will audit (5) arbitration agreements weekly x 4 weeks, then monthly x 1 month to ensure the correct Arbitration Agreement is being utilized. This plan of correction will be monitored at the monthly Quality Assurance meeting x 3 months. Corrective action completion date: 2/22/23	
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;	F 867		2/22/23

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F 867	Continued From page 29 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor interventions that the committee had previously put into place following the recertification and complaint investigation survey of 5-14-21 and a complaint investigation of 3-22-21. The deficiencies were in the areas of Free from Unnecessary Psychotropic Medications/as needed use (F758) and Accuracy of Assessments (F641). The continued failure during two federal surveys of record showed a pattern of the facility's inability to sustain an effective Quality Assurance Program. Findings included: This tag is cross referenced to: F758 Based on record review and staff interviews the facility failed to complete an AIMS (Abnormal Involuntary Movement Scale: a rating scale to measure involuntary movements that sometimes develop as a side effect of long-term treatment with antipsychotic medications) for a resident prescribed an antipsychotic medication for 1 of 5 residents reviewed for unnecessary medications (Resident #117). During the recertification and complaint investigation survey of 5-14-21, the facility was cited for not completing an antipsychotic medication gradual dose reduction as recommended by the pharmacist and ordered by the physician.	F 867	Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. 1. Immediate action(s) taken for the resident(s) found to have been affected include: On 2/6/23 an ADHOC Quality Assurance Performance Improvement was held by the Administrator with Regional Nurse Consultant, Director of Nursing, Staff Development Coordinator, Minimum Data Set Director, Social Services Director and Assistant, Activities Director, Therapy Director, Dietary Director, Maintenance Director and Environmental Director regarding the repeat tags to ensure the Quality Assurance Performance Improvement Committee has maintained and monitored the interventions put into place. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents on antipsychotic medications have the potential to be affected. 3. Actions taken/systems put into place to reduce the risk of future occurrence include:	

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F 867	Continued From page 30 F641 Based on record review and staff interviews the facility failed to accurately note antipsychotic use on the Minimum Data Set (MDS) assessments for 1 of 32 MDS assessments reviewed (Resident #107). During a complaint investigation survey of 3-22-21 the facility was cited for not accurately coding an admission Minimum Data Set for functional limitations in range of motion. The Administrator was interviewed on 1-26-23 at 2:10pm. The Administrator discussed the facility had more than one performance improvement plan a year and tried to correct any on-going issues that were identified.	F 867	On 2/6/23 an ADHOC Quality Assurance Performance Improvement was held by the Administrator with Regional Nurse Consultant, Director of Nursing, Staff Development Coordinator, Minimum Data Set Director, Social Services Director and Assistant, Activities Director, Therapy Director, Dietary Director, Maintenance Director and Environmental Director regarding the appropriate functioning of the Quality Assurance Performance Improvement Committee and the purpose of the committee to identify trends and root causes for correction on repeated deficiencies related to completion of AIMS assessments and accurate documentation on MDS assessments for antipsychotic use. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The Quality Assurance Performance Improvement Committee will review root cause and trends to identify concerns. The Quality Assurance Performance Improvement Committee will address root cause with corrective actions and further training or other interventions. The Administrator is responsible for ensuring the implementation of an acceptable plan of correction. The Administrator will monitor the process of completing AIMS assessments and accuracy of assessments in relation to residents on antipsychotic medications x 12 weeks for compliance and will report monthly in Quality Assurance Performance Improvement for 3 months. Any deficient practice will be corrected immediately	

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F 867	Continued From page 31	F 867	from findings by the Administrator. Administrator increased QAPI meetings from quarterly to monthly to ensure monitoring and corrective actions completed. This plan of correction will be monitored at the monthly Quality Assurance meeting x 3 months. Corrective action completion date: 2/22/23	
F 948 SS=D	Training for Feeding Assistants CFR(s): 483.95(h) §483.95(h) Required training of feeding assistants. A facility must not use any individual working in the facility as a paid feeding assistant unless that individual has successfully completed a State-approved training program for feeding assistants, as specified in §483.160. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to ensure paid feeding assistants completed a state approved training program prior to feeding a resident at meals for 1 of 1 (Social Worker #1) paid feeding assistant observed feeding a resident. The findings included: On 1/23/23 at 12:55 PM Social Worker (SW) #1 was observed sitting next to Resident #33's bed with the meal tray on the over the bed table. During the observation SW #1 stated she was feeding Resident #33, but the resident was not eating very much. The meal tray ticket was present on the tray and indicated Resident #33's diet was pureed.	F 948	Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. 1. Immediate action(s) taken for the resident(s) found to have been affected include: The Social Worker #1 was immediately educated on 1/25/23 that staff are not permitted to assist residents with feeding	2/22/23

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F 948	Continued From page 32 During a lunch meal observation on 1/25/23 at 12:45 PM SW #1 was sitting next to Resident #33's bed. She said she attempted to feed Resident #33 but the resident wanted to hear music so she was attempting to find the correct song on her telephone. SW #1 said she attempted to feed Resident #33 her meat but she spit it back out. She said she had attempted other foods too but the Resident would not eat them. The observation of the food items on the tray revealed SW #1 had attempted to feed some of the pureed food items from the meal tray. On 1/26/23 at 8:16 AM the Administrator said the facility did not employ paid feeding assistants. On 1/26/23 at10:24 AM SW #1 said she was feeding Resident #33. She said she wanted to help the nursing assistants because the nursing assistants were busy helping other residents. She said she had not received any formal training about feeding residents. On 1/26/23 at 10:41 AM the Director of Nursing stated she was not aware the SW could not feed residents unless trained to do so. She said the facility had never employed paid feeding assistants. On 1/26/23 at the Administrator said she was not aware the SW was feeding residents, but she knew staff had to be trained to be paid feeding assistants because one of the other facilities where she previously was the Administrator had a feeding assistant program.	F 948	unless they are a Nurse, Certified Nursing Assistant, Occupational Therapist, or a staff member that has completed a state approve training program for feeding assistants. Administrator immediately in serviced all administrative staff on 1/25/23 of the previous as well. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents that require assistance with feeding could potentially be affected. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: All staff were educated on 2/9/23 that staff are not permitted to assist residents with feeding unless they are a Nurse, Certified Nursing Assistant, Occupational Therapist, or a staff member that has completed a state approve training program for feeding assistants. Administrator immediately in serviced all administrative staff of the previous as well. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The Director of Nursing, Assistant Director of Nursing and Staff Development Coordinator will randomly audit all 6 dining room on all 3 meals and completed (3) audits per week for 4 weeks and (3) audits per month for 1 month to ensure any staff that assist residents with feeding are approved to do so. This plan of correction will be monitored at	

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F 948	Continued From page 33	F 948	the monthly Quality Assurance meeting x 3 months. Corrective action completion date: 2/22/23	