| CENTER | S FOR MEDICARE & | MEDICAID SERVICES | | | | | 0. 0938-0391 | |
|--|---|--|---|-----|---|-------------------------------|----------------------------|--|
| | DF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | , í | | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
| | | 345577 | B. WING | | | 04/ | 13/2023 | |
| NAME OF PROVIDER OR SUPPLIER SWIFT CREEK HEALTH CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 221 BRIGHTMORE DRIVE CARY, NC 27511 | | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY) | | (X5) COMPLETION DATE | |
| E 000 | Initial Comments | | E | 000 | | | | |
| | conducted on 04/10/2 facility was found in c requirement CFR 483 Preparedness. Event | .73, Emergency | | | | | | |
| F 000 | INITIAL COMMENTS | | F | 000 | | | | |
| | 04/10/2023 through 0 ED2L11. | ey was conducted from 4/13/2023. Event ID# | | | | | | |
| F 578 SS=D | | ntnue Trmnt;Formlte Adv Dir 8)(g)(12)(i)-(v) | F | 578 | | | 4/28/23 | |
| | discontinue treatment | nt to request, refuse, and/or , to participate in or refuse imental research, and to directive. | | | | | | |
| | construed as the right the provision of medic | in this paragraph should be of the resident to receive al treatment or medical lically unnecessary or | | | | | | |
| | requirements specifie subpart I (Advance D (i) These requirement | - | | | | | | |
| | residents concerning medical or surgical tre resident's option, forn | the right to accept or refuse eatment and, at the nulate an advance directive. | | | | | | |
| | facility's policies to im and applicable State | | | | | | | |
| | entities to furnish this | hitted to contract with other information but are still | | | TITLE | | (X6) DATE | |

Electronically Signed

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES.

04/28/2023

PRINTED: 05/11/2023 FORM APPROVED

| | - | D HUMAN SERVICES | | | | RINTED: 05/11/2023 FORM APPROVED |
|--------------------------|--|---|---------------------|--|--|---|
| STATEMENT (| DF DEFICIENCIES CORRECTION | MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | CONSTRUCTION | | MB NO. 0938-0391 3) DATE SURVEY COMPLETED |
| | | 345577 | B. WING | | | 04/13/2023 |
| NAME OF PI | ROVIDER OR SUPPLIER | | S | TREET ADDRESS, CITY, STATE, ZIP CO | DE | |
| | EEK HEALTH CENTER | | 2: | 21 BRIGHTMORE DRIVE | | |
| SWIFTCR | EER HEALTH CENTER | | c | ARY, NC 27511 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY | ON SHOULD BE | (X5) COMPLETION DATE |
| F 578 | time of admission and information or articula has executed an adva may give advance dim individual's resident re- with State law. (v) The facility is not re- provide this informatio or she is able to recei Follow-up procedures the information to the appropriate time. This REQUIREMENT by: Based on records rev staff interviews, the fa Directives(AD) in the sampled residents. (R and Resident # 125). Findings included: 1. Resident #10 was a 03/20/2023. Quarterly Minimum Da 03/21/2023 indicated was intact. Review of the comput Resident #10 revealed noted in the resident's | r ensuring that the ection are met. Ial is incapacitated at the d is unable to receive the whether or not he or she ance directive, the facility ective information to the epresentative in accordance elieved of its obligation to on to the individual once he ve such information. I must be in place to provide individual directly at the is not met as evidenced views, resident interview and accility failed to have Advance residents' records for 3 of 7 Resident #10, Resident #14 admitted to the facility on ata Set (MDS) dated Resident#10's cognition rerized clinical record for d no advanced directive is medical record. | F 578 | The statements made on th Correction are not an admis not constitute an agreement alleged deficiencies. To rem compliance with all Federal Regulations the facility has t take the actions set forth in t Correction. The Plan of Cor constitutes the facility s alle compliance such that all alle deficiencies cited have been corrected by the date or date F578 For the residents involved, c action has been accomplish Resident #10 was contacted Admission Coordinator and provide an Advanced Directi declined resources. Reside | is Plan of sion to and do with the ain in and State caken or will this Plan of rection egation of eged n or will be es indicated. corrective ed by: l by the refused to ve and nt #10 was | |
| | A review of the form " | Advance Directive" dated in Resident#10's clinical | | | nt #10 was the facility on | 1 |

Facility ID: 110717

If continuation sheet Page 2 of 9

| | OF DEFICIENCIES | MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTI | | STRUCTION | | D. 0938-03 | |
|--|---|---|---------------------|--|---|--------------|------------|--|
| | CORRECTION | IDENTIFICATION NUMBER: | · / | A. BUILDING | | | COMPLETED | |
| | | 345577 | B. WING | | | 04/13/2023 | | |
| NAME OF PROVIDER OR SUPPLIER SWIFT CREEK HEALTH CENTER | | | | STREE | TADDRESS, CITY, STATE, ZIP CODE | • | | |
| | | | | | IGHTMORE DRIVE , NC 27511 | | | |
| (X4) ID PREFIX TAG | | | ID PREFIX TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY) | LD BE COMPLE | | |
| F 578 | Continued From page | a 2 | F 5 | 78 | | | | |
| 1 010 | | e if the resident wanted to | 1.5 | - | sident #126 and Resident # 14 we | | | |
| | formulate an advance | | | | ntacted by the Admission Coordina | | | |
| | | | | | sist to provide information to formul | | | |
| | During the interview v | | | Advanced Directive. Resident #12 | | | | |
| | 04/11/2023 at 11:30 A | | Re | esponsible Party provided the Adva | nced | | | |
| | she did not recall sigr | | | rective information and it was uploa | | | | |
| | form during the admis | | int | o Resident #126⊡s medical record | | | | |
| | she was admitted at t | he facility for a short-term | | | sident #14⊡s Responsible Party w | | | |
| | stay. | | | | ntacted by the Admissions Coordin | | | |
| | | | | | d an Advanced Directive was provi | | | |
| | During the interview v | | | the facility and uploaded in Resider | nt | | | |
| | (DON) on 04/12/2023 that the Admission's (| | | 4⊡s medical record. All of the | 2 | | | |
| | advance directive for | | | rrections were completed by April 1 23. | З, | | | |
| | responsible party dur | | - | prrective action has been accomplis | hed | | | |
| | | her indicated she did not find | | | all residents with the potential to b | | | |
| | - | in Resident #10's medical | | | ected by the alleged deficient pract | | | |
| | record and there was | no documentation found | | by | | | | |
| | that stated the reside | | An | audit of the Advanced Directives in | n the | | | |
| | the expectation was t | | me | edical record of current residents wa | as | | | |
| | should have been sca | | | mpleted by the Administrator and | | | | |
| | computerized clinical | | | missions Coordinator | | | | |
| | | to formulate an advance | | | ert and oriented residents that did | not | | |
| | directive. | | | | ve an Advanced Directive were | otor | | |
| | During the interview | with Admission Coordinator | | | ntacted by the Admissions Coordin d those that had an Advanced Dire | | | |
| | - | PM, she stated after the | | | ovided it to the facility and the | cuve | | |
| | residents were admit | | | | cuments were uploaded in the med | lical | | |
| | | e directive, she would give a | | | cord. Information was provided by t | | | |
| | | ion packet that indicated | | | cility to those residents/responsible | | | |
| | how to formulate an a | advance directive. She | | pa | rties that needed information regar | • | | |
| | | nilies did not bring the | | | vance Directives. Follow-up contac | | | |
| | | rm back to the facility. The | | | I be made by Admission Coordinate | | | |
| | | or indicated moving forward | | | ose that were provided information | as | | |
| | | in the resident's record if the | | | rt of the admission process. | _ | | |
| | family refused to bring | g back the advance | | | esidents Responsible Parties wer | | | |
| | directives form. | | | | ntacted by the Admission Coordina those residents identified that did | | | |
| | | with the Administrator on | | | ve an Advanced Directive and coul | | | |

Facility ID: 110717

If continuation sheet Page 3 of 9

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 345577 B. WING 04/13/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 221 BRIGHTMORE DRIVE SWIFT CREEK HEALTH CENTER CARY, NC 27511 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 578 Continued From page 3 F 578 04/13/2023 at 10:30 AM, she stated the articulate due to cognition impairments advanced directives should have been in that they have executed an Advanced Resident #10's clinical record or a note indicating Directive. The Responsible Parties refusal. The Administrator further stated the AC provided Advanced Directive information would ensure the residents' advanced directives and it was uploaded in the medical record were placed in the medical records if a resident for those residents. Information was had formulated one. provided by the facility to those residents/responsible parties that needed 2. Resident #14 was admitted to the facility on information regarding Advance Directives. 03/20/2023. Follow-up contacts will be made by Admission Coordinator for those that were Quarterly Minimum Data Set (MDS) dated provided information. (Exhibit 1) 03/16/2023 indicated Resident #14's cognition was moderately impaired. Review of the computerized clinical record for Measures put in place or systematic Resident #14 revealed no advanced directive changes made to ensure the alleged noted in the resident's medical record. deficient practice does not occur: The Vice-President of Sales and A review of the form "Advance Directive" dated Marketing provided education to the 02/13/2023 reviewed in Resident#14's clinical Admission team regarding the record did not indicate if the resident wanted to requirement for provision to inform and formulate an advance directive or refused. provide written information to residents and responsible parties concerning the right to formulate an Advanced Directive During the interview with Director of Nursing or to refuse an Advanced Directive. The (DON) on 04/12/2023 at 01:04 PM, she stated information also included to follow up with that the Admission's Coordinator reviews the the resident and/or responsible party advance directive forms with the residents or regarding the Advanced Directive responsible party during the admission to the decisions to ensure the Advanced facility. The DON further indicated she did not find Directive or refusal of formulating an the advance directive in Resident #14's medical Advanced Directive is part of the record and there was no documentation found resident□s medical record. (Exhibit 2) that stated the resident refused. She added that The facility has implemented a Quality the expectation was that the advanced directive should have been scanned in Resident #14's Assurance Monitor: computerized clinical record or a note indicating The Administrator/designee will monitor to the resident's refusal to formulate an advance ensure residents /responsible parties directive. have been provided information to assist

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: 110717

PRINTED: 05/11/2023

| STATEMENT | OF DEFICIENCIES | MEDICAID SERVICES | (X2) MULTIF | PLE CONSTRUCTION | OMB NO. 0938-03 (X3) DATE SURVEY |
|--|---|--|---------------------|--|--|
| AND PLAN OF | CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING | COMPLETED | |
| | | 345577 | B. WING | | 04/13/2023 |
| NAME OF PROVIDER OR SUPPLIER SWIFT CREEK HEALTH CENTER | | | | STREET ADDRESS, CITY, STATE, ZIF | ° CODE |
| | | | | 221 BRIGHTMORE DRIVE CARY, NC 27511 | |
| (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 ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE | CTION SHOULD BE COMPLETIC D THE APPROPRIATE DATE |
| F 578 | Continued From page | e 4 | F 57 | - | |
| F 578 | Continued From page 4 During the interview with Admission Coordinator on 04/12/23 at 02:42 PM, she stated after the residents were admitted and they need to implement an advance directive, she would give a form from the admission packet that indicated how to formulate an advance directive. She added most of the time the family did not bring the advance directives form back to the facility. The Admission Coordintor indicated moving forward she would document in the resident's record if the family refused to bring back the advance directives form. During the interview with the Administrator on 04/13/2023 at 10:30 AM, she stated the advanced directives should have been in Resident #14's clinical record or a note indicating refusal. The Administrator further stated the AC would ensure the residents' advanced directives were placed in the medical records if a resident had formulated one. | | | in formulating an Advanc to ensure assistance with offered as indicated. In a refusal to provide an Adv will be part of the medica monitored as a part of the monitoring will be done w months to ensure compli- findings will be reported i QAPI meetings. Any area needing improvement wil with corrections and resu at QAPI meeting to QAA any adjustments to the p will be initiated based on review/outcomes. (Exhibit | a information was addition, any anced Directive I record and e QA Tool. The veekly for 3 ance and the n the monthly a identified I be addressed lits at the monthly committee, and lan of correction |
| | 10/05/2022. The quarterly Minimu | erly Minimum Data Set (MDS) dated 3 had Resident #126 coded as | | | |
| | The care plan dated (| 03/14/2023 had focus of Not Resuscitate (DNR). | | | |
| | on 04/11/2023 at 10: she had a DNR order | sident #126 was conducted 17 AM. The resident stated • but did not recall being nced directive when she was | | | |

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| | - | D HUMAN SERVICES MEDICAID SERVICES | | | | | FORM | D: 05/11/2023 MAPPROVED D. 0938-0391 |
|--------------------------|---|---|--|-----|---------------------------------------|--|----------------------|--|
| STATEMENT C | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | | (X3) DATE S COMPL | |
| | | 345577 | B. WING | | | _ | 04/ | 13/2023 |
| NAME OF PF | ROVIDER OR SUPPLIER | | • | S | TREET ADDRESS, CITY, ST | ATE, ZIP CODE | | |
| SWIFT CR | EEK HEALTH CENTER | | | | 21 BRIGHTMORE DRIVE CARY, NC 27511 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | x | (EACH CORREC CROSS-REFEREN | PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| F 578 | Continued From page admitted. | • 5 | F | 578 | | | | |
| | conducted on 04/11/2 Admission Coordinate advanced directive wa aware there was more An interview with the <i>J</i> conducted on 04/12/2 Administrator stated w admission, residents of (RP) for the resident w advanced directive. If asked to bring in the f resident's chart. She r their RP didn't always Entering into Binding <i>J</i> CFR(s): 483.70(n)(2)(§483.70(n) Binding Ar If a facility chooses to representative to enter binding arbitration, the of the requirements in §483.70(n)(1) The face resident or his or her r agreement for binding admission to, or as a receive care at, the fa- inform the resident or his or her right not to a condition of admission continue to receive care | or stated she was taught an as a DNR and was not e to an advanced directive. Administrator was 023 at 10:52 AM. The when there was a new or the Responsible Party were asked if they had an they did, then they were forms to be placed in the reported residents and/or bring in the forms. Arbitration Agreements i)(ii)(3)-(5) rbitration Agreements ask a resident or his or her er into an agreement for e facility must comply with all this section. Solity must not require any representative to sign an g arbitration as a condition of requirement to continue to cicility and must explicitly his or her representative of sign the agreement as a in to, or as a requirement to are at, the facility. | F | 347 | | | | 4/28/23 |
| | §483.70(n)(2) The fac (i) The agreement is e | ility must ensure that: explained to the resident and | | | | | | |

If continuation sheet Page 6 of 9

| DEPARTMENT OF HEALTH CENTERS FOR MEDICARE | | | | FC | DRM APPROVED NO. 0938-0391 |
|---|---|---------------------|---|---|-------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ´ | TIPLE CONSTRUCTION | (X3) D | ATE SURVEY |
| | 345577 | B. WING | | | 04/42/2022 |
| NAME OF PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP | | 04/13/2023 |
| | | | 221 BRIGHTMORE DRIVE | | |
| SWIFT CREEK HEALTH CENTI | R | | CARY, NC 27511 | | |
| PREFIX (EACH DEFICI | ' STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION) | ID PREFIZ TAG | | CTION SHOULD BE THE APPROPRIATE | (X5) COMPLETION DATE |
| that he or she und language the resid representative und (ii) The resident of acknowledges that agreement; §483.70(n)(3) The grant the resident right to rescind the days of signing it. §483.70(n) (4) The state that neither to representative is re for binding arbitration to, or as a required at, the facility. §483.70(n) (5) The any language that resident or anyone federal, state, or le limited to, federal federal or state he and representative Long-Term Care Co with §483.10(k). This REQUIREME by: Based on a review agreement and ac facility failed to pro- that granted the re- the right to rescino of signing it. This a admission packet | ntative in a form and manner erstands, including in a lent and his or her | F | 847 The statements made on Correction are not an adm not constitute an agreeme alleged deficiencies. To re compliance with all Feder Regulations the facility ha take the actions set forth Correction. The Plan of C | n this Plan of nission to and do ent with the emain in ral and State as taken or will in this Plan of | |

Facility ID: 110717

If continuation sheet Page 7 of 9

PRINTED: 05/11/2023

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 345577 B. WING 04/13/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 221 BRIGHTMORE DRIVE SWIFT CREEK HEALTH CENTER CARY, NC 27511 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 847 Continued From page 7 F 847 facility. constitutes the facility□s allegation of compliance such that all alleged The findings included: deficiencies cited have been or will be corrected by the date or dates indicated. A review of the facility arbitration agreement titled, "Resident and Facility Arbitration Agreement." F847 was conducted. The Arbitration agreement stated, For the residents involved, corrective "the resident understand that he/ she has the action has been accomplished by: right to revoke this arbitration Agreement by Current residents were identified to have written notice delivered and received by facility the existing Arbitration Agreement in withing fourteen (14) days of signing this place. Liberty Senior Living Corporate arbitration Agreement." The arbitration agreement team reviewed existing agreement and did not indicate that the resident or representative updated the arbitration agreement to meet had the right to rescind the agreement in 30 days. the regulatory requirement of granting the resident or their responsible party the right An interview with the Admission Coordinator (AC) to rescind the agreement within 30 days of was conducted on 04/12/2023 at 02:27 PM. The signing the arbitration agreement. The AC stated the residents or resident representative Admissions Coordinator reviewed the are required to sign the arbitration agreements on updated arbitration agreement with admission. The agreements were explained in current residents or residents the language they understood and when a representatives and uploaded the updated resident or residents' responsible party signs the agreement for those who chose to sign it into the resident s medical record. This agreement, it states they understood the agreement. The AC also stated she did not know was completed by April 13, 2023. the residents had 30 days to rescind the Corrective action has been accomplished agreement. on all residents with the potential to be affected by the alleged deficient practice An interview was conducted with the by: Administrator on 04/13/2023 at 1:01 PM, She The Arbitration Agreement was updated revealed that both she and the Admission by the Corporate Legal Counsel to grant Coordinator reviewed the arbitration agreement. the resident or representative the right to and it did not indicate the resident or rescind the agreement within 30 calendar representative had the right to rescind the days of signing the agreement. This has agreement in 30 days. The Administrator been updated for all current residents who indicated she was not aware of the regulatory chose to sign it and will be utilized for all requirements of the resident or representative new admissions. This was completed by and had the right to rescind the agreement in 30 April 13, 2023. (Exhibit 1) days. The Administrator indicated the Corporate

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: 110717

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PRINTED: 05/11/2023

| STATEMENT | DF DEFICIENCIES CORRECTION | MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | PLE CONSTRUCTION G | (X3) DAT | O. 0938-039 E SURVEY IPLETED | |
|--------------------------|--|---|----------------------------|--|---|------------------------------------|--|
| | | 345577 | B. WING | | 04 | 04/13/2023 | |
| NAME OF P | ROVIDER OR SUPPLIER | | STREET ADDRESS, CITY, STAT | | | | |
| SWIFT CF | REEK HEALTH CENTER | | | 221 BRIGHTMORE DRIVE CARY, NC 27511 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN (EACH CORRECTIVE / CROSS-REFERENCED 1 DEFICI | ACTION SHOULD BE TO THE APPROPRIATE | (X5) COMPLETIO DATE | |
| F 847 | will update the arbitra that it indicates the re | ation agreements to ensure esident or resident ne right to rescind the | F 84 | 47 Measures put in place of changes made to ensure deficient practice does no The Vice-President of S Marketing educated the regarding the changes in facility arbitration agreem resident or representative rescind the agreement we days. The updated Arbit replaced the existing ag added to the admission 2) The facility has implement Assurance Monitor: The administrator/design arbitration agreements the correct arbitration Agreet Monitoring to be done we months to ensure the up Agreement is utilized and for needing improvement addressed with correction presented monthly at Q/ QAA committee, and and be initiated based on rev (Exhibit 5) | e the alleged not occur: ales and Admissions Team in the updated ment to grant the ve the right to vithin 30 calendar tration Agreement reement and was packet. (Exhibit ented a Quality nee will monitor o ensure the ement is in place. veekly for 3 odated Arbitration id areas identified it will be ons and results API meeting to y adjustments will | | |

Facility ID: 110717

If continuation sheet Page 9 of 9