Electronically delivered
January 14, 2022

Administrator
Mount Olivet Careview Home
5517 Lyndale Avenue South
Minneapolis, MN 55419

RE: CCN: 245071
Cycle Start Date: January 4, 2022

Dear Administrator:

On January 4, 2022, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F"and/or an E tag), i.e., the plan of correction should be directed to:

Jamie Perell, Unit Supervisor
Metro B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: jamie.perell@state.mn.us
Office: (651) 245-8094

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of

the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by April 4, 2022 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by July 4, 2022 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245071	A. BUILDING _____ B. WING _____	C 01/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNT OLIVET CAREVIEW HOME	**5517 LYNDALE AVENUE SOUTH MINNEAPOLIS, MN 55419**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 1/3/22 to 1/4/22, an abbreviated survey was completed at your facility by surveyors from the Minnesota Department of Health (MDH) to conduct multiple complaint investigations. Mount Olivet Careview Home was found to not be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaint was found to be substantiated: H5071082C (MN79812); however, no deficiencies cited due to action taken prior to survey. H5071083C (MN79736); however, only unrelated non-compliance was cited at F641 and F758. H5071088C (MN66987); however, no deficiencies cited due to action taken prior to survey. H5071091C (MN61548); however, no deficiencies cited due to action taken prior to survey. The following complaints were found to be unsubstantiated: H5071041C (MN48836) H5071084C (MN76279) H5071085C (MN75639) H5071086C (MN74986) H5071087C (MN73902) H5071089C (MN63917) H5071090C (MN62440) H5071092C (MN54507) H5071093C (MN51574)	F 000		

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

Electronically Signed | 01/21/2022

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 H5071094C (MN51435) H5071095C (MN50675) H5071096C (MN49434) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
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 (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	F 758		1/28/22

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F 758	Continued From page 2 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: Based on interview and document review, the facility failed to evaluate a resident for the continued use of an as needed (PRN) antipsychotic medication for use beyond 14 days for 1 of 1 resident (R14) who received the medication. Findings include:	F 758	The statements in the Plan of Correction do not constitute admission of agreement by the Provider of the truth or the facts alleged or the conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of the Federal and State Laws.	

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F 758	Continued From page 3 R14's Face Sheet dated 1/5/21, indicated R3 had diagnoses of dementia with behavioral disturbance, delirium, and weakness. R14's Physicians Orders dated 12/2/21, indicated R14 was prescribed Seroquel (antipsychotic medication) 12.5 milligrams (mg) PRN for psychotic disorder. The order lacked an end date. Review of R14's December 2021 Medication Administration Record (MAR) indicated R14 received Seroquel 12.5 mg PRN seven times between 12/2/21, and 1/4/22. R14's Consultant Pharmacist Medication Review dated 12/18/21, indicated PRN antipsychotics are limited to a 14-day duration and the resident must be re-evaluated and a new order provided each time. The recommendation was to add a 14-day stop date to R14's PRN Seroquel order. If the treatment was to be continued, perform a clinical evaluation and provide a new order with a stop date. The medication review was rejected by the medical provided and noted R14 was, "still experiencing behavioral escalations and the plan will be continued with re-evaluation in 60 days." During an interview on 1/4/22, at 11:45 p.m. registered nurse (RN)-C stated R14 had Seroquel ordered PRN and was used as a last resort to help with behaviors. RN-C stated Seroquel was used for R14 for 30-days and was reviewed by the pharmacist during the monthly review process. During an interview on 1/4/22, at 1:50 p.m. the assistant director of nursing (ADON) stated the pharmacist provided a recommendation for R14's Seroquel and the provider rejected the	F 758	It is the policy of Mount Olivet Careview Home to evaluate all residents for continued use of an antipsychotic medication that is prescribed on a PRN-(as needed) basis beyond 14 days. Resident R14□s physician was notified on 01/07/22 to evaluate the continued prescribing of Seroquel 12.5 mg as needed and an updated order was received at that time to continue the PRN dose for a duration of 14-days. Continued re-evaluation of this PRN antipsychotic will reviewed following the guidance for each resident to be Free from Unnecessary Psychotropic Meds/PRN use. R14□s Care Plan was reviewed also for the use of an antipsychotic, and a chart review was completed related to the administration of the PRN Seroquel, and no adverse side effects were noted. All residents with a PRN psychotropic medication had their orders reviewed for compliance with the guidelines for continued use of a PRN psychotropic medication. In addition, communication was sent out to Physicians and Nurse Practitioners related to the guidance and expectations when prescribing a PRN antipsychotic medication on 01/18/22. All nurses and health unit coordinators will be educated to ensure that a 14-day stop date is taken with any PRN psychotropic medication.	

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F 758	Continued From page 4 recommendation as R14 was still having behaviors. The ADON further stated the provider had noted they would re-evaluate R14 in 60 days. The ADON was not aware R14's Seroquel PRN order needed a re-evaluation and new order after 14-days. The ADON confirmed R3's Seroquel order lacked an end date and was active since 12/2/21. During an interview on 1/4/22, at 2:28 p.m. the consultant pharmacist stated they provided a recommendation to add a stop date for R14's PRN Seroquel order or to re-evaluate R14. If the recommendation was rejected, a follow-up with the medical director was needed. The recommendation was to avoid unnecessary use of psychotropic medication for R14. Facility policy titled Minimum Effective Dose Committee dated 3/19, indicated the committee will discuss recommendations and the nurse manager/social worker is responsible for follow up with the attending provider.	F 758	Drug Regimen recommendations will be reviewed by the Director of Nursing monthly upon completion by the Consulting Pharmacist and the resident provider to ensure that the provider has followed the recommendation for re-evaluation of a PRN antipsychotic medication as well as providing a new order. To ensure on-going compliance the Director of Nursing will audit all PRN psychotropic medications every week x 4 weeks, and then monthly x 3 months. Results of the audits will be brought to the quarterly QAPI meeting and reviewed to ensure that no unnecessary medications are being utilized. The Director of Nursing is responsible for on-going compliance.	

Electronically delivered
January 14, 2022

Administrator
Mount Olivet Careview Home
5517 Lyndale Avenue South
Minneapolis, MN 55419

Re: State Nursing Home Licensing Orders
Event ID: 0GK411

Dear Administrator:

The above facility was surveyed on January 3, 2022 through January 4, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the

"Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Jamie Perell, Unit Supervisor
Metro B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: jamie.perell@state.mn.us
Office: (651) 245-8094

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health

Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00178	A. BUILDING: _____ B. WING _____	C 01/04/2022

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 1/3/22 to 1/4/22, a survey was conducted by surveyors from the Minnesota Department of Health (MDH) to determine compliance for Minnesota (MN) state licensure in conjunction with complaint investigation(s): H5071041C (MN48836), H5071082C (MN79812), H5071083C (MN79736), H5071084C (MN76279), H5071085C	2 000		

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2 000	Continued From page 1 (MN75639), H5071086C (MN74986), H5071087C (MN73902), H5071088C (MN66987), H5071089C (MN63917), H5071090C (MN62440), H5071091C (MN61548), H5071092C (MN54507), H5071093C (MN51574), H5071094C (MN51435), H5071095C (MN50675), H5071096C (MN49434). As a result, the following correction orders are issued. Please indicate your electronic plan of correction that you have reviewed these order, and identify the date when they will be corrected. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic	2 000		

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2 000	Continued From page 2 State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 550	MN Rule 4658.0400 Subp. 4 Comprehensive Resident Assessment; Review Subp. 4. Review of assessments. A nursing home must examine each resident at least quarterly and must revise the resident's comprehensive assessment to ensure the continued accuracy of the assessment. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure the Minimum Data Set (MDS) was accurately coded with demonstrated behaviors for 1 of 4 residents (R14) reviewed for abuse. Findings include: R14's Face Sheet dated 1/5/21, indicated R14 had diagnoses which included dementia with behavioral disturbance, delirium, and weakness. R14's quarterly MDS dated 11/9/21, indicated	2 550	Corrected	2/4/22

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNT OLIVET CAREVIEW HOME	5517 LYNDALE AVENUE SOUTH MINNEAPOLIS, MN 55419

(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) COMPLETE DATE
2 550	Continued From page 3 R14 had not exhibited any physical or verbal behaviors towards others during the seven day look back period ending on 11/9/21. R14's progress notes dated 11/3/21, at 7:05 p.m. indicated R14 was agitated and angry towards caregivers and residents. R14 kicked roommate out of the room and threatened to hit roommate with a wheelchair cushion. R14's progress notes dated 11/4/21, at 6:05 a.m. indicated R14 was "very agitated, restless and angry." Further, R14 was calling staff names, swearing, disruptive to his roommate, and was difficult to redirect. During an interview on 1/4/22 at 10:55 a.m. registered nurse (RN)-A stated when R14 was upset or angry the situation involved yelling that was directed either at staff or residents. RN-A further stated R14 had problems with their previous roommate and was argumentative with them. During an interview on 1/4/22, at 1:00 p.m. RN-B stated when completing a residents MDS assessment the orders, diagnoses, assessments, tasks, and progress notes were all reviewed. RN-B reviewed R14's progress notes within the seven day look back period and stated R3's behaviors had not been reflected in his quarterly MDS. RN-A further indicated this was a miss and acknowledged R14's MDS was not correct. During an interview on 1/4/22, at 1:50 p.m. assistant director of nursing (ADON) stated when submitting a MDS, the expectation was for the nurse to complete a documentation review that included progress notes. The ADON further stated a resident MDS had to be truthful and	2 550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00178	A. BUILDING: _____ B. WING _____	C 01/04/2022

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2 550	Continued From page 4 accurately reflect the resident. A facility policy titled MDS Policy and Procedure (undated), directed a review of assessments, provider notes, progress notes, interviews and data collections were needed to complete assigned sections of the MDS. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review and revise policies and procedures related to ensuring that each individual resident's comprehensive assessment is accurately completed. They could then develop and implement a system of auditing to ensure staff accurately complete assessments. This information could then be presented to the Quality Assurance (QA) committee for review and, if needed, revision. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 550		