STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345266	A. BUILDING _____ B. WING _____	03/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROANOKE LANDING NURSING AND REHABILITATION CENTER	1084 US 64 EAST PLYMOUTH, NC 27962

(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 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or	F 623		3/22/18

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

Electronically Signed | 03/22/2018

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F 623	Continued From page 1 (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice.	F 623		

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F 623	Continued From page 2 If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to provide the resident and resident representative a written notification for the reason for transfer to the hospital and did not send a copy of the notice to the ombudsman for 1 of 1 residents reviewed for hospitalization. (Resident #2) Findings included: Resident #2 was admitted to the facility on 5/18/15. His active diagnoses included hypertension, neurogenic bladder, diabetes mellitus, and hyperlipidemia. Review of Resident #2's most recent minimum data set assessment dated 11/21/17 revealed he was assessed as severely cognitively impaired. Review of Resident #2's chart revealed on 11/29/17 he was transferred to the hospital for	F 623	F 623 □ The process that led to this deficiency was the facility failed to provide the resident and/or resident representative a written notification for the reason for transfer to the hospital and did not send a copy of the notice to the Ombudsman for 1 of 1 residents reviewed. On 2/28/2018 100% audit of resident discharges x 30 days to include resident #2 was completed by the Administrator to ensure resident and/or resident representative received written notification indicating the reason for transfer/discharge from the facility and that a copy of the written notification was provided to the Office of the State Long-Term Care Ombudsman. All areas of concern were immediately addressed by the Administrator. On 2/28/18 written notifications for all	

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F 623	Continued From page 3 bleeding noted by the nurse from a recent surgical incision. No written notice of transfer was documented to have been provided to the resident or resident representative. During an interview on 2/28/18 at 1:50 PM the Social Worker stated she provided transfer notices to residents and resident representatives. She further stated she did not provide Resident #2 or his representative a written notification of the reason for his hospitalization on 11/29/17 and had not sent any such notification to the ombudsman. She further stated she had not been aware it was required to provide a transfer notice when a resident had an unplanned discharged to the hospital and would begin performing those notices. During an interview on 2/28/18 at 2:00 PM the Administrator stated she was not aware residents who had an unplanned discharged to the hospital should receive a written transfer and discharge notice as soon as practicable and a copy sent to the ombudsman. She further stated since it was in the regulations it was her expectation a discharge notification be given to Resident #2 and his representative as well as a copy sent to the ombudsman and it was not done.	F 623	resident transfers/discharges from the facility x 30 days to include resident #2 were mailed to the resident and/or Resident Representative and a copy forwarded to the Office of the State Long-Term Care Ombudsman by the Administrator. On 3/1/2018 an in-service on Notification of Ombudsman and Resident Representative for Discharges/Transfers was completed by the Facility Nurse Consultant with the Administrator, Director of Nursing (DON), Admissions Coordinator and Social Worker to include: 1. Facility must notify resident or resident representative of discharge/transfer at least 30 days before the resident is transferred or discharged 2. Facility must notify resident or resident representative of discharge/transfer as soon as possible when a. The safety of individuals in the facility would be endangered b. The health of individuals in the facility would be endangered c. The residents health improves sufficiently to allow a more immediate transfer or discharge d. An immediate transfer or discharge is required by the residents urgent medical needs e. A resident has not resided in the facility greater than 30 days 3. Written notification must include: a. The reason for transfer or discharge b. The effective date of transfer or discharge c. The location to which the resident is	

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F 623	Continued From page 4	F 623	transferred or discharged d. A statement of the residents appeal rights including the name, address and telephone number to submit appeal e. The name, address and telephone number to the Office of the State Long-Term Care Ombudsman f. Copy of written notification must be sent to the Office of the State Long-Term Care Ombudsman All newly hired Administrator, Director of Nursing (DON), Admissions Coordinator and Social Worker will be in-serviced by the Staff Facilitator during orientation on Notification of Ombudsman and Resident Representative for Discharges/Transfers to include: 1. Facility must notify resident or resident representative of discharge/transfer at least 30 days before the resident is transferred or discharged 2. Facility must notify resident or resident representative of discharge/transfer as soon as possible when a. The safety of individuals in the facility would be endangered b. The health of individuals in the facility would be endangered c. The residents health improves sufficiently to allow a more immediate transfer or discharge d. An immediate transfer or discharge is required by the residents urgent medical needs e. A resident has not resided in the facility greater than 30 days 3. Written notification must include: a. The reason for transfer or discharge	

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F 623	Continued From page 5	F 623	b. The effective date of transfer or discharge c. The location to which the resident is transferred or discharged d. A statement of the residents appeal rights including the name, address and telephone number to submit appeal e. The name, address and telephone number to the Office of the State Long-Term Care Ombudsman f. Copy of written notification must be sent to the Office of the State Long-Term Care Ombudsman Monitoring 25% audit of all resident discharges will be completed by the Social Worker weekly x 4 weeks, every 2 weeks x 4 weeks then monthly x 1 month utilizing the Nursing Home Notice of Transfer Audit Tool to ensure the resident and/or resident representative receives a written notification indicating the reason for transfer/discharge from the facility and that a copy of the written notification was provided to the Office of the State Long-Term Care Ombudsman. The DON will review the Nursing Home Notice of Transfer Audit Tool weekly x 4 weeks, then every 2 weeks x 4 weeks then monthly x 1 month to ensure all areas of concern were addressed. The Quality Improvement (QI) Nurse will forward the results of the Nursing Home Notice of Transfer Audit Tool to the Executive QI Committee monthly x 3 months. The Executive QI Committee will meet monthly x 3 months and review the Nursing Home Notice of Transfer Audit Tool to determine trends and / or issues	

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F 623	Continued From page 6	F 623	that may need further interventions put into place and to determine the need for further and / or frequency of monitoring. The Administrator and Director of Nursing will be responsible for the implementation of corrective actions to include all 100% audits, in services, and monitoring related to the plan of correction.	
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 interview, the facility failed to make a referral for re-evaluation after a change in mental health status for 1 of 2 residents (Resident #8) reviewed for Preadmission Screening and Resident Review.	F 644	F 644 The process that led to this deficiency was the facility failed to make a referral for re-evaluation after a change in mental health status for 1 of 2 residents reviewed for Preadmission Screening and Resident	3/22/18

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F 644	Continued From page 7 Findings included: Resident #8 was admitted to the facility on 1/26/12 with diagnoses which included major depressive disorder, single episode, epilepsy, and cerebrovascular accident (CVA). The quarterly Minimum Data Set-an assessment tool (MDS) dated 12/7/17 revealed Resident #8 was moderately cognitively impaired, displayed verbal behaviors towards others, and all activities of daily living (ADLs), except eating, required total assistance for completion. Active diagnoses included diabetes mellitus (DM), cerebrovascular accident (CVA), and depression. A record review revealed Resident #8 had a negative Level I Preadmission Screening and Resident Review (PASRR) completed prior to admission to the facility which indicated a negative PASRR screening. During an annual assessment dated 3/16/17, anxiety disorder was added to active diagnoses for Resident #8. On 11/16/17, Resident #8 had major depressive disorder (recurrent) added to her diagnoses in the electronic medical records system and indicated the diagnosis developed "during stay". Resident #8 was referred to behavioral health at that time by the facility physician. An interview was conducted with the medical records director on 2/28/18 at 1:45 PM. She stated when a psychiatric diagnosis was added she was notified, reviewed it and put it in the system. If a diagnosis was marked "during stay" it signified the diagnosis was made after admission to the facility. If a diagnosis changed a resident's	F 644	Review (PASRR) On 3/13/18 100% audit of newly added mental health diagnosis since admission to the facility x 12 months to include resident #8 was completed by the Director of Nursing to ensure any resident with a new mental health diagnosis was assessed for need to re-evaluate PASRR or Psych referral for mental health management initiated. All areas of concern related to PASRR re-evaluation were immediately addressed by the Medical Records Director. All areas of concern related to psych referrals were immediately addressed by the Resident Care Coordinator. On 3/2/18 resident #8 was referred for re-evaluation of PASRR. New PASRR level received on 3/5/18 at a Level 1. No change in PASRR status was noted. On 3/13/18 100% audit of all Behaviors Observed documentation x 30 days to include resident #8 was completed by the Administrator to ensure all behaviors were assessed and Psych referral for behavior management initiated as indicated. All areas of concern were immediately addressed by the Resident Care Coordinator. On 3/13/18 100% audit of all progress notes for behaviors or change in mental health status x 30 days to include resident #8 was completed by the Director of Nursing. All areas of concern were immediately addressed by the Resident Care Coordinator. On 3/13/18 an in-service on PASRRs was completed by the Administrator with the Medical Records, Minimum Data Set	

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F 644	Continued From page 8 mental health status a change in condition needed to be requested. She was unsure of a change of condition for (Resident #8). An interview was conducted with the Director of Nursing (DON) on 2/28/18 at 3:00 PM. She stated a Level II PASSR or a change of condition should have been requested for (Resident #8) in November when she had a change in mental health status. She stated, "Evidently, (the Medical Records Director) missed doing it or is not aware of the new regulations, but in November she (Resident #8) had a change in her mental health status."	F 644	Nurse (MDS), Director of Nursing and Resident Care Coordinator in regards to referral for re-evaluation following changes in mental health status to include: 1. The DON/Administrator will review all progress notes during clinical meeting to address any concerns related to resident behaviors or change in mental status to ensure appropriate referrals are initiated. 2. Resident Care Coordinator/Assistant Director of Nursing (ADON) will initiate psych referral for all residents with newly evident or possible serious mental disorders, intellectual disability or a related condition 3. Medical Records will forward to the MDS nurse all newly added diagnoses for mental health for review. 4. MDS nurse will assess all level II residents and all residents with newly evident or possible serious mental disorders, intellectual disability or a related condition for a level II resident upon a significant change in status assessment and request re-evaluation of PASRR. 5. The Medical Records Director will then submit updated medical information for any resident with newly evident or possible serious mental disorders, intellectual disability or a related condition for a level II resident upon a significant change in status assessment for re-evaluation of PASRR. 6. MDS nurse will update care plan for any PASRR level changes as indicated. All newly hired Medical Records, Minimum Data Set Nurse (MDS), Director of	

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F 644	Continued From page 9	F 644	Nursing, Assistant Director of Nursing and Resident Care Coordinator will be in-serviced during orientation on PASRRs in regards to referral for re-evaluation following changes in mental health status to include: 1. The DON/Administrator will review all progress notes during clinical meeting to address any concerns related to resident behaviors or change in mental status to ensure appropriate referrals are initiated. 2. Resident Care Coordinator/Assistant Director of Nursing (ADON) will initiate psych referral for all residents with newly evident or possible serious mental disorders, intellectual disability or a related condition 3. Medical Records will forward to the MDS nurse all newly added diagnoses for mental health for review. 4. MDS nurse will assess all level II residents and all residents with newly evident or possible serious mental disorders, intellectual disability or a related condition for a level II resident upon a significant change in status assessment and request re-evaluation of PASRR. 5. The Medical Records will then submit updated medical information for any resident with newly evident or possible serious mental disorders, intellectual disability or a related condition for a level II resident upon a significant change in status assessment for re-evaluation of PASRR. 6. MDS nurse will update care plan for any PASRR level changes as indicated.	

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F 644	Continued From page 10	F 644	Monitoring 25% audit of all newly added mental health diagnosis to include resident #8 will be completed by the Resident Care Coordinator/ADON weekly x 8 weeks, then monthly x 1 month utilizing the Mental Health Diagnosis Audit Tool to ensure any resident with a new mental health diagnosis was assessed for need to re-evaluate PASRR or Psych referral for mental health management initiated. The Director of Nursing will review the Mental Health Diagnosis Audit Tool weekly x 8 weeks, then monthly x 1 month to ensure all areas of concern were addressed. 25% audit of all Behaviors Observed documentation to include resident #8 will be completed by the Resident Care Coordinator/ADON weekly x 8 weeks, then monthly x 1 month utilizing the Behaviors Observed Audit Tool to ensure all behaviors were assessed and Psych referral for behavior management initiated as indicated. The Director of Nursing will review the Behaviors Observed Audit Tool weekly x 8 weeks, then monthly x 1 month to ensure all areas of concern were addressed. 100% audit of all progress notes for behaviors or change in mental health status to include resident #8 will be completed by the Resident Care Coordinator/ADON 5 times a week x 4 weeks, then weekly x 4 weeks, then monthly x 1 month utilizing the Progress Note Audit Tool to ensure all behaviors or change in mental health status were assessed and Psych referral for behavior	

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F 644	Continued From page 11	F 644	management initiated as indicated. The Director of Nursing will review the Progress Note Audit Tool weekly x 8 weeks, then monthly x 1 month to ensure all areas of concern were addressed. The Quality Improvement (QI) Nurse will forward the results of the Mental Health Diagnosis Audit Tool, Behaviors Observed Audit Tool and the Progress Note Audit Tool to the Executive QI Committee monthly x 3 months. The Executive QI Committee will meet monthly x 3 months and review the Mental Health Diagnosis Audit Tool, Behaviors Observed Audit Tool and the Progress Note Audit Tool to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring. The Administrator and Director of Nursing will be responsible for the implementation of corrective actions to include all 100% audits, in services, and monitoring related to the plan of correction.	
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte	F 692		3/22/18

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F 692	Continued From page 12 balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on record review, staff and physician interview, and observations, the facility failed to provide enteral feeding (tube feeding) as ordered for 1 of 5 residents (Resident #8) reviewed for nutrition. Findings included: Resident #8 was re-admitted to the facility 9/6/15. Active diagnoses included: diabetes mellitus (DM), cerebrovascular accident (CVA), hemiplegia (paralysis of one side of the body), seizure disorder, disorder of magnesium metabolism, and depression. A review of the quarterly Minimum Data Set-an assessment tool (MDS) dated 12/7/17 revealed Resident #8 was moderately cognitively impaired, was totally dependent on staff to complete all activities of daily living (ADLs) except eating, which required 1 person supervision. Resident #8 had an impairment on one side of an upper and lower limb, had a Percutaneous Endoscopic Gastrostomy- a feeding tube (PEG) and typically consumed 25 percent (%) or less of a mechanically altered diet.	F 692	F 692 The process that led to this deficiency was the facility failed to provide enteral feeding (tube feeding) as ordered for 1 of 5 residents. On 3/15/18 100% audit of physician□s orders x 30 days was completed to ensure all physician□s orders including diet orders/recommendations are being followed as prescribed. All areas of concern were immediately addressed by the Director of Nursing (DON). On 2/28/18 the diet order for resident # 8 was clarified to specify Isosource 1.5 calorie 250ml brick pack via enteral feeding tube bolus three times a day at 10 am, 2pm and 7pm if resident consumes < 50% of breakfast, lunch and dinner. On 2/28/18 an in-service was initiated by the Staff Facilitator on Observation and Reporting Acute Changes with all nursing assistants (NA) in regards to: 1. Vulnerability of Nursing Home Resident 2. Examples of resident changes to include decreased po intake/meal refusals 3. Reporting of a change in condition	

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	345266	A. BUILDING _____ B. WING _____	03/01/2018

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F 692	Continued From page 13 A review of a care plan dated 12/10/17 read, in part, "State of nourishment related to (r/t) g-tube (PEG) in place, resident receives scheduled H2O (water) flushes. One stated goal read the resident will not experience significant weight loss/gain thru next review. Interventions included diet as ordered; GT (PEG) feedings as ordered; and provide assistance with meals as indicated." A care plan dated 1/2/18 for Resident #8 read, in part, "problematic manner in which resident acts characterized by inappropriate behavior. Resistive to treatment/care related or due to cognitive impairment ... snacks on chips/cookies ...refuses food and wts.(weights). Interventions included honor resident choices, preferences and wishes regarding care and services; if resident refuses care leave resident and return 5-10 minutes." A change in condition form dated 2/27/18 at 3:50 PM read "Decreased PO (by mouth) intake since 2/26/18 in the AM (morning). MD (physician) notified 2/27/18 at 3:50 PM and ordered bolus feed (tube feed) with 250 ml (milliliters) of (Brand name tube feeding formula) with less than (<) 50 % meal consumption. Monitor." A physician order dated 2/27/18 read "Diet Order: Regular diet; (Brand name formula) 1.5 cal (calorie) one 250 mL (milliliter) brick pack via PEG tube after each meal if less than (<) 50% consumed. A clarification physician order dated 2/28/18 at 12:30 PM read, "(Brand name formula) 1.5 cal, one 250 mL brick pack via PEG tube bolus TID (3 times per day) at 1000 (10:00 AM), 1400 (2:00 PM), 1900 (7:00 PM) if < 50% of breakfast, lunch,	F 692	promptly to the unit nurse and/or RN Supervisor to include decrease po intake or meal refusals. No NAs will be allowed to work until in-service has been completed. In-service completed on 3/21/2018. All newly hired NAs will be in-serviced by the Staff Facilitator during orientation on Observation and Reporting Acute Changes to include: 1. Vulnerability of Nursing Home Resident 2. Examples of resident changes to include decreased po intake/meal refusals 3. Reporting of a change in condition promptly to the unit nurse and/or RN Supervisor to include decrease po intake or meal refusals. On 2/28/18 an in-service was initiated by the Staff Facilitator on Observation and Reporting Acute Changes with all licensed nurses, Minimum Data Set Nurse (MDS), Treatment Nurse, Assistant Director of Nursing (ADON), Resident Care Coordinator, and Quality Improvement Nurse (QI) in regards to: 1. Vulnerability of Nursing Home Resident 2. Examples of Atypical Presentation of Signs/Symptoms of acute changes to include decreased po intake/meal refusals 3. All changes in a resident condition should be taken seriously 4. Assessment of Acute Changes when any acute or subtle changes are reported 5. Interventions for Change in Residents Condition 6. Notification of Physician/RR for Changes in Resident□s Condition	

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F 692	Continued From page 14 and dinner consumed. An interview was conducted with NA #3 on 2/27/18 at 2:20 PM. She stated Resident #8 had eaten none of her breakfast and none of her lunch. She stated it was hard to keep Resident #8 awake after she received pain medication, and the resident was able to feed herself with her hands, but not with utensils. The NA also stated if a resident had not eaten the staff offered an alternative or asked the resident if they needed help eating. An interview was conducted with Nurse #4 on 2/27/18 at 2:30 PM. She stated, "I usually care for (Resident #8). The NA's should tell me anything that's different for any resident, like not eating. I haven't heard anything about (Resident #8) behaving differently or not eating today. She does like to sleep and she sleeps more with pain medications." An interview was conducted with the Director of Nursing (DON) on 2/27/18 at 2:50 PM. She stated if a resident refuses anything the NA was supposed to tell the nurse. The NA should tell the nurse after a resident refused to eat one meal. The nurse should assess the resident, including checking bowel and pain status, and treat appropriately by calling the doctor (MD), or finding out why the resident hasn't eaten. If she (Resident #8) hasn't eaten the nurse should have been told. My expectation is for all care plans and MD orders to be followed and there should be communication between the nurses and NA's for any changes or anything different for any resident." An interview was conducted on 2/27/18 at 4:00	F 692	No licensed nurses, Minimum Data Set Nurse (MDS), Treatment Nurse, Assistant Director of Nursing (ADON), Resident Care Coordinator, and Quality Improvement Nurse (QI) will be allowed to work until in-service has been completed. In-service was completed on 3/21/2018. All newly hired licensed nurses, Minimum Data Set Nurse (MDS), Treatment Nurse, Assistant Director of Nursing (ADON), Resident Care Coordinator, and Quality Improvement Nurse (QI) will be in-serviced by the Staff Facilitator during orientation on Observation and Reporting Acute Changes to include: 1. Vulnerability of Nursing Home Resident 2. Examples of Atypical Presentation of Signs/Symptoms of acute changes to include decreased po intake/meal refusals 3. All changes in a resident condition should be taken seriously 4. Assessment of Acute Changes when any acute or subtle changes are reported 5. Interventions for Change in Residents Condition 6. Notification of Physician/RR for Changes in Resident□s Condition On 2/28/18 an in-service was initiated by the Staff Facilitator on 24 Hour Nurse Shift Report with all licensed nurses, Minimum Data Set Nurse (MDS), Treatment Nurse, Assistant Director of Nursing (ADON), Resident Care Coordinator, and Quality Improvement Nurse (QI) in regards to communication of resident changes to include: 1. Documentation of: a. Acute change charting to include	

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F 692	Continued From page 15 PM with the Administrator. She stated it was her expectation that if a resident who usually feeds themselves doesn't eat or doesn't feed themselves, the staff should offer to feed them. She also stated she had spoken with Resident 8's physician and there was an order to supplement eating with tube feedings if Resident #8 had not consumed at least 50% of her meal. She stated the NA's were expected to inform the care nurse if a resident had not eaten. She also stated the family frequently brought outside fast food and the resident typically ate 100% of what was brought in. An interview was conducted on 2/27/18 at 4:40 PM with Resident 8's physician. He stated Resident #8 was 'a bit of a quandary' as he had only seen her 3 times. He also stated Resident #8 had a feeding tube and feeding parameters were always in place for any resident with a PEG tube to get a supplement of some kind if 50% or less of meals was consistently consumed. An observation was made on 2/28/18 at 8:35 AM. Resident #8 was sitting up in bed with a breakfast tray set up on the over bed table. No food had been consumed. An observation was made on 2/28/18 at 9:25 AM. Resident #8 was sitting up in bed with a breakfast tray set up on the over bed table. No food had been consumed. An interview was conducted on 2/28/18 at 10:30 AM with Nurse #5. She stated her assignment was the 300 Hall and the first 4 rooms on the 500 Hall. Resident #8 was in one of those 4 rooms. She stated the NA's were supposed to tell her what percentage of a meal a resident had eaten if	F 692	decreased po intake/meal refusals b. New orders (medications, therapy, diet) c. Medical appointments d. Admissions e. Antibiotic therapy monitoring f. Accidents/incidents (new safety interventions/neuro checks) g. Labs drawn, pending lab reports or new lab reports h. Discharges i. Abnormal vitals/vital sign monitoring 2. Nurses must review 24hr report during change of shift 3. All nurses are responsible for reviewing at least the past 72hrs of shift reports to ensure assigned nurse is aware of any changes in relation to resident care/new orders. No licensed nurses, Minimum Data Set Nurse (MDS), Treatment Nurse, Assistant Director of Nursing (ADON), Resident Care Coordinator, and Quality Improvement Nurse (QI) will be allowed to work until in-service has been completed. In-service was completed on 3/21/2018. All newly hired licensed nurses, Minimum Data Set Nurse (MDS), Treatment Nurse, Assistant Director of Nursing (ADON), Resident Care Coordinator, and Quality Improvement Nurse (QI) will be in-serviced by the Staff Facilitator during orientation 24 Hour Nurse Shift Report in regards to communication of resident changes to include: 1. Documentation of: a. Acute change charting to include decreased po intake/meal refusals b. New orders (medications, therapy,	

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F 692	Continued From page 16 it was less than their usual intake. She stated she was caring for (Resident #8) today and did not know how much breakfast she had eaten because, "Her NA didn't tell me yet." She also stated (Resident #8) was given breakfast about 8:30 AM today. She stated the resident was to receive a bolus feeding through her PEG if she consumed less than 50% of any meal. The bolus should be given as soon as possible after the meal was refused/or less than 50% was eaten. She had not given (Resident #8) a bolus feeding yet. An interview was conducted on 2/28/18 at 10:45 AM with NA #4. She stated (Resident #8) had eaten none (0%) of her breakfast. She also stated there was a shift report where she was told of any changes in resident status or care, or the nurse told her at the beginning of the shift. She stated if a resident's behavior or intake changed she was supposed to tell the assigned care nurse. She stated she told the 500 Hall nurse (Resident #8) had not eaten any breakfast, but had not told Resident #8's assigned care nurse. An interview was conducted with the DON on 2/28/18 at 11:05 AM. She stated if there was a change in therapy or resident status it was put in the book. The expectation for bolus feeds after meal refusal was immediately or within 1 hour of meal refusal, just like a medication, and it was the assigned NA who told the resident's care nurse about anything that had changed with the resident. She also stated the new MD order read Resident #8 was to receive a 250 mL bolus of tube feed formula any time she had not consumed at least 50% of a meal. She stated, "This bolus should be given immediately or within 1 hour of meal time so it doesn't interfere with the	F 692	diet) c. Medical appointments d. Admissions e. Antibiotic therapy monitoring f. Accidents/incidents (new safety interventions/neuro checks) g. Labs drawn, pending lab reports or new lab reports h. Discharges i. Abnormal vitals/vital sign monitoring 2. Nurses must review 24hr report during change of shift 3. All nurses are responsible for reviewing at least the past 72hrs of shift reports to ensure assigned nurse is aware of any changes in relation to resident care/new orders. On 2/28/18 an in-service was initiated by the Staff Facilitator with all licensed nurses, Minimum Data Set Nurse (MDS), Treatment Nurse, Assistant Director of Nursing (ADON), Resident Care Coordinator, and Quality Improvement Nurse (QI) on Following Physician□s Orders to include: 1. Processing new orders to include diet orders 2. 24hr chart checks 3. Checking pink slips to ensure medications received, order documented on MAR/TAR appropriately 4. Acceptable time frame for administering medications/feedings 5. Completing all diet orders as prescribed to include PEG feedings 6. Clarification of any order that does not specify clear dose, route, time or	

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F 692	Continued From page 17 next meal. We are already aware that the bolus feed was missed this morning for (Resident #8) and she's just getting it now at 11:00 AM. We're trying to work on something so if her bolus is given it won't interfere with the next meal. Like today, it's almost lunch time and she probably won't eat lunch since her bolus feed didn't start until 11 AM."	F 692	parameters for use. 7. Notification of DON for all order discrepancies No licensed nurses, Minimum Data Set Nurse (MDS), Treatment Nurse, Assistant Director of Nursing (ADON), Resident Care Coordinator, and Quality Improvement Nurse (QI) will be allowed to work until in-service has completed. In-service was completed on 3/21/2018. All newly hired licensed nurses, Minimum Data Set Nurse (MDS), Treatment Nurse, Assistant Director of Nursing (ADON), Resident Care Coordinator, and Quality Improvement Nurse (QI) will be in-serviced by the Staff Facilitator during orientation on Following Physician□s Orders to include: 1. Processing new orders to include diet orders 2. 24hr chart checks 3. Checking pink slips to ensure medications received, order documented on MAR/TAR appropriately 4. Acceptable time frame for administering medications/feedings 5. Completing all diet orders as prescribed to include PEG feedings 6. Clarification of any order that does not specify clear dose, route, time or parameters for use. 7. Notification of DON for all order discrepancies Monitoring 25% audit of all resident physician□s orders to include orders for resident #8 will be completed by the Resident Care	

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F 692	Continued From page 18	F 692	Coordinator/ADON weekly x 8 weeks, then monthly x 1 month utilizing the Physician□s Order Audit Tool to ensure all physician□s orders including diet orders are being followed as prescribed. The Director of Nursing will review the Physician□s Order Audit Tool weekly x 8 weeks, then monthly x 1 month to ensure all areas of concern were addressed. 25% audit of meal intake to include meal intake for resident #8 will be completed by the Resident Care Coordinator/ADON 5 times a week x 4 weeks, then weekly x 4 weeks then monthly x 1 month utilizing the Meal Intake Audit Tool to ensure any meal refusals are reported to nursing, resident assessment completed and MD/RR notification. The Quality Improvement (QI) Nurse will forward the results of the Physician□s Order Audit Tool and Meal Intake Audit Tool to the Executive QI Committee monthly x 3 months. The Executive QI Committee will meet monthly x 3 months and review the Physician□s Order Audit Tool and Meal Intake Audit Tool to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring. The Administrator and Director of Nursing will be responsible for the implementation of corrective actions to include all 100% audits, in services, and monitoring related to the plan of correction.	
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4)	F 700		3/22/18

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F 700	Continued From page 19 §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review the facility failed to assess for the use of side rails or attempt appropriate alternatives prior to installing bed rails for 1 of 1 residents reviewed for accidents (Resident #66). Findings included: Resident #66 was admitted to the facility on 2/20/17. His active diagnosis included hypertension, Alzheimer's disease, dementia, and muscle weakness. Review of Resident #66's bed rail evaluation dated 11/27/17 revealed the resident was	F 700	F 700 □ The process that led to this deficiency was the facility failed to assess for the use of side rails or attempt appropriate alternatives prior to installing bed rails for 1 of 1 residents reviewed. On 2/28/18 100% audit of all residents utilizing bedrails to include resident #66 was initiated by the Quality Improvement Nurse (QI) to ensure resident has been properly assessed for the use of bed rails and that appropriate alternatives had been attempted prior to installing bed rails. Audit was completed on 3/21/18. All areas of concern were immediately addressed	

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F 700	Continued From page 20 assessed to be oriented to person only and to have a safety awareness deficit with impaired short term memory. The resident was assessed to be totally dependent on staff for bed mobility. No alternative interventions were documented to have been attempted or assessed prior to installation of the bed rails. The assessment recommended half rails were to be used. Review of Resident #66's significant change Minimum Data Set assessment dated 1/30/18 revealed the resident was assessed as severely cognitively impaired. He required extensive assistance with bed mobility. Review of the medical record revealed there was no care plan in place for the use of bed rails. During observation on 2/27/18 at 2:33 PM the half rails on Resident #66's bed were observed to be up on the left and right side of the resident. The resident was sleeping in bed and a fall mat was placed next to the bed. During observation on 2/28/18 at 8:30 AM the half rails on Resident #66's bed were observed to be up on the left and right side of the resident. The resident was observed to be speaking incoherent sentences to an individual who was not there and was swinging his right arm, brushing the right bed rail with his forearm. There were no observed injuries to the resident's arms. During an interview on 2/28/18 at 9:52 AM Nurse Aide (NA) #1 stated Resident #66 was not alert and oriented and was very combative with staff. She further stated he would hallucinate when no one was in the room and swing his arms at his hallucinations. She stated Resident #66 did not	F 700	by the QI Nurse. On 2/28/18 resident #66 was re-evaluated for use of bed rails. Appropriate alternatives were initiated and bed rails were removed due to risk of entrapment. On 3/21/18 100% audit of all residents utilizing bedrails to include resident #66 was completed by the Director of Nursing (DON) to ensure resident is care planned for use of bed rails. All areas of concern were immediately addressed by the Minimum Data Set Nurse (MDS). On 3/21/18 an in-service on Bed Rails was completed by the Quality Improvement Nurse (QI) with all licensed nurses, MDS, Treatment Nurse, Staff Facilitator, Resident Care Coordinator, Maintenance Director and DON in regards to use of bed rails to include: 4. Assessing the resident for the risk of entrapment from bed rails prior to installation under the Bed Rail Evaluation in Point Click Care (PCC) a. Entrapment: an event in which a resident is caught, trapped or entangled in the space in or about the bed rail 5. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail (trapeze bar, low beds, frequent monitoring, activities) 6. Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent 7. Ensure the rail is installed per the manufactures recommendations and specifications 8. Ensure the bed rail is compatible with the mattress and bed frame and that the	

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F 700	Continued From page 21	F 700		

use the bed side rails to help staff with activities of daily living. She stated the resident had always had bed side rails to her knowledge. NA #1 stated his arms did hit the bed side rails at times when he swung his arms but Resident #66 had not sustained any injuries yet.

During an interview on 2/28/18 at 10:15 AM Nurse #1 stated Resident #66 was only oriented to himself and was very combative with staff. She further stated he would swing his arms or legs when he had hallucinations and also at staff. The nurse stated Resident #66 had side rails since she started work for the facility in September of 2017. She stated she was not aware of any alternatives to side rails usage being attempted or assessed by the facility.

During an interview on 2/28/18 at 11:15 AM the Staff Development Coordinator stated she helped with bed rail assessments in November when the new regulations were put in place. She said she completed Resident #66's bed rail evaluation. She stated the facility had not attempted or assessed for alternative interventions to bed side rails before placing the bed side rails on Resident #66's bed. The Staff Development Coordinator continued to state Resident #66 had the bed side rails in place during his entire stay in the facility from 2/20/17 to now. She further stated no assessment for alternative approaches was completed before the installation of the bed rails and she was not aware of this being required in the new regulations. She stated she assessed the rails to see if they fit properly and the continued use of the bed side rails was based on the fact he had always had bed side rails.

During an interview on 2/28/18 at 11:33 AM the

dimensions are appropriate for the residents size and weight
9. Inspect regularly the mattress and bed rail for the possibility of entrapment
10. Maintenance monitors bed rails regularly to ensure they are installed correctly and/or have no shifted or loosen over time.
11. Appropriate documentation in PCC with use of bed rails (see attached) under QI Restraint/Enabler Progress Note
12. Resident is care planned for use of bed rails

No licensed nurses, QI nurse, Minimum Data Set Nurse (MDS), Treatment Nurse, Staff Facilitator, Resident Care Coordinator, Maintenance Director and Director of Nursing (DON) will be allowed to work until in-service on Bed Rails has been completed. In-service was completed on 3/21/2018.
All newly hired licensed nurses, QI nurse, Minimum Data Set Nurse (MDS), Treatment Nurse, Staff Facilitator, Resident Care Coordinator, Maintenance Director and Director of Nursing (DON) will be trained by the Staff Facilitator on Bed Rails during orientation to include:
1. Assessing the resident for the risk of entrapment from bed rails prior to installation under the Bed Rail Evaluation in Point Click Care (PCC)
a. Entrapment: an event in which a resident is caught, trapped or entangled in the space in or about the bed rail
2. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail (trapeze bar, low beds,

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F 700	Continued From page 22 Director of Nursing (DON) stated residents should have alternatives attempted or assessed before bed rails were put in place on resident beds. She further stated it was her expectation alternatives to bed side rails be attempted or assessed in the bed rail assessments prior to installing bed rails on Resident #66's bed and it was not done. She also stated she was not the Director of Nursing at that time and was unable to speak to what guidance was given about the bed side rail assessments in November. She further stated no new training about the new regulations had been given to the staff.	F 700	frequent monitoring, activities) 3. Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent 4. Ensure the rail is installed per the manufactures recommendations and specifications 5. Ensure the bed rail is compatible with the mattress and bed frame and that the dimensions are appropriate for the residents size and weight 6. Inspect regularly the mattress and bed rail for the possibility of entrapment 7. Maintenance monitors bed rails regularly to ensure they are installed correctly and/or have no shifted or loosen over time. 8. Appropriate documentation in PCC with use of bed rails (see attached) under QI Restraint/Enabler Progress Note 9. Resident is care planned for use of bed rails Monitoring: 25% audit of all residents with use of bed rails to include resident #66 will be completed by the QI Nurse weekly x 8 weeks, then monthly x 1 month utilizing the Bed Rail Audit Tool to ensure: 1. The resident was assessed for the risk of entrapment 2. Bed Rail Assessment is completed accurately in PCC 3. The facility attempted use of appropriate alternatives prior to installing a side or bed rail (trapeze bar, low beds, frequent monitoring, activities) 4. The facility reviewed the risks and	

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F 700	Continued From page 23	F 700	benefits of bed rails with the resident or resident representative and obtain informed consent 5. The rail is installed per the manufactures recommendations and specifications and is compatible with the mattress and bed frame and that the dimensions are appropriate for resident size and weight 6. Appropriate documentation in PCC with use of bed rails under QI Restraint/Enabler Progress Note 7. Resident is care planned for use of bed rails The DON will review the Bed Rail Audit Tool weekly x 8 weeks, then monthly x 1 month to ensure all areas of concern were addressed. The Quality Improvement (QI) Nurse will forward the results of the Bed Rail Audit Tool to the Executive QI Committee monthly x 3 months. The Executive QI Committee will meet monthly x 3 months and review the Bed Rail Audit Tool to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring. The Administrator and Director of Nursing will be responsible for the implementation of corrective actions to include all 100% audits, in services, and monitoring related to the plan of correction.	
F 849 SS=D	Hospice Services CFR(s): 483.70(o)(1)-(4) §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may	F 849		3/22/18

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do either of the following:
(i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices.
(ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer.

§483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements:
(i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services.
(ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following:
(A) The services the hospice will provide.
(B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter.
(C) The services the LTC facility will continue to provide based on each resident's plan of care.
(D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day.
(E) A provision that the LTC facility immediately

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notifies the hospice about the following:
(1) A significant change in the resident's physical, mental, social, or emotional status.
(2) Clinical complications that suggest a need to alter the plan of care.
(3) A need to transfer the resident from the facility for any condition.
(4) The resident's death.
(F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided.
(G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs.
(H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions.
(I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by

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the LTC facility.
(J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation.
(K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff.

§483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident.
The designated interdisciplinary team member is responsible for the following:
(i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services.
(ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family.
(iii) Ensuring that the LTC facility communicates

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F 849	Continued From page 27 with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and record review the facility failed to maintain	F 849	F849 The process that led to this deficiency	

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F 849	Continued From page 28 communication and coordination of services provided by Hospice and facility personnel for 1 of 1 sampled residents (Resident #44). The findings included: Resident #44 was admitted to the facility on 05/12/16 with a cumulative diagnosis including: gastrointestinal hemorrhage, protein malnutrition, anxiety, melena, dementia, and malignant neoplasm of colon. Resident #44's 01/8/18 Minimum Data Set (MDS) indicated that resident had severe cognitive impairments. The resident needed total assistance with toilet use, bathing, and personal hygiene. A care plan, revised 01/8/18 identified Resident #44 had a progressive decline, and Hospice care was provided due to progressive decline. A Medication Administration Record (MAR) dated 02/1/18 for Resident #44's listed a Do Not Resuscitate (DNR) order with a begin date of 05/12/16. A physician note dated 01/15/18 for Resident #44 revealed the resident's long-term prognosis is fair to poor. She was stable for the moment, to watch for signs of skin breakdown, to watch for signs of decompensation, and to watch for aspiration. Physician interventions revealed no change in her regimen. Her pain was well controlled and she was in no distress. A one page document titled "Interdisciplinary Home Communication Record" dated 01/26/18 - 02/26/18 was reviewed from a notebook located	F 849	was the facility failed to maintain communication and coordination of services provided by Hospice and facility personnel. On 2/19/18 100% audit of all residents receiving Hospice Services including resident #44 was completed by the Administrator to ensure appropriate documentation in medical record to include: 1. Hospice Plan of Care 2. Hospice Election Form 3. Physician Certification/Recertification of Terminal Illness 4. Hospice Medication Information specific to each resident 5. Hospice Physicians Orders 6. Treatments 7. Progress Notes 8. Evaluations. There were 5 areas of concern noted. On 2/19/18 the Facility Administrator, Director of Nursing (DON), Minimum Data Set (MDS) Coordinator, Resident Care Coordinator, and Social Worker met with Hospice Agency Clinical Service Director, Hospice Liaison, Office Coordinator, Hospice Case Manager to discuss facilities expectations in regards to hospice communication and providing facility with appropriate documentation to include: 1. Hospice Plan of Care 2. Hospice Election Form 3. Physician Certification/Recertification of Terminal Illness 4. Hospice Medication Information specific to each resident 5. Hospice Physicians Orders	

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F 849	Continued From page 29 on Resident #44's bedside table. The one page document was the only Hospice medical documentation in Resident #44's complete electronic or physical chart. This form listed one nurse visit on 02/26/18, which included vital signs (blood pressure, heart rate, respirations and temperature), with a significant finding of "patient in chair at nursing station, no pain". An interview on 02/27/18 at 12:36 with the Hospice Director of Operations (HDO) and the facility Administrator revealed that it was their expectation that the facility's Hospice nurse should have communicated to the facility better by providing the facility all communication records, physician orders, medication listings and progress notes, and did not. An interview on 02/28/18 at 10:50 AM Nurse #3 (Hospice Nurse) revealed that it was her expectation that Resident #44's complete Hospice medical records be available to staff on a 24 hour, 7 days per week, per facility agreement, and were not. The Hospice nurse agreed that a complete communication structure should have been set-up (verbal and written form) between facility and Hospice staff, and be present at the facility, and was not. She said she kept most of the resident's orders and notes in her computer. It was her expectation, from now on, she would print off resident #44's visit notes, updated orders and care plans and place them behind the Hospice tab in the resident's main facility chart. She said she would also document after each visit, a visit summary in writing and place it in the resident's physical chart behind the hospice tab located in the patient's physical chart, which she had not done previously.	F 849	6. Treatments 7. Progress Notes 8. Evaluations. On 2/27/18 Hospice Agency provided facility the required documentation for all residents receiving Hospice services to include resident #44 for the past 30 days to include: 1. Hospice Plan of Care 2. Hospice Election Form 3. Physician Certification/Recertification of Terminal Illness 4. Hospice Medication Information specific to each resident 5. Hospice Physicians Orders 6. Treatments 7. Progress Notes 8. Evaluations. On 2/27/18 the MDS Coordinator was designated as Facility Hospice Liaison. On 2/27/18 the MDS Nurse was in-serviced by the Administrator on the expectations of the Facility Hospice Liaison to include: 1. Ensuring appropriate documentation is maintained on all residents receiving hospice services to include: a. Hospice Plan of Care b. Hospice Election Form c. Physician Certification/Recertification of Terminal Illness d. Hospice Medication Information specific to each resident e. Hospice Physicians Orders f. Treatments g. Progress Notes h. Evaluations. 2. Weekly updates between Facility Hospice Liaison and Hospice Clinical	

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F 849	Continued From page 30 An interview on 02/28/18 at 11:30 AM with the facility Administrator revealed that it was her expectation that the Hospice Nurse follow the Hospice Agreement provision dated 2016 to provide information from Hospice to the Facility to include: Hospice medical information, Hospice orders, and did not. The Administrator revealed that the facility and their contracted Hospice provider failed to communicate or share Resident #44's documentation with facility's nursing staff, which was not available to facility staff on a 24 hour basis per Hospice agreement. An interview on 02/28/18 at 11:45 AM with the Director of Nursing (DON) revealed that it was her expectation that Hospice should have communicated more fully to facility staff as well as provided hospice nurse visit documentation to the facility, and did not. She said Hospice failed, per their revised Hospice agreement dated 06/2016, to communicate and coordinate of services provided by facility personnel and Hospice personnel and the provision of Hospice services 24 hours per day. And failed to provide hospice Resident #44's information from Hospice to the facility, which included Hospice medication information, nursing notes and hospice physician orders. The DON said it was her expectation that there be a complete verbal and paper communication process between Hospice and her staff, and there was not. An interview on 03/1/18 at 11:10 AM with Nurse #2 revealed it was her expectation that the Hospice nurse provide to the facility on site, the hospice care plan with orders, plan of treatment and coordination notes report provided to the facility after each facility visit, and did not.	F 849	Liaison. 3. Notification of Administrator with any concerns related to documentation provided by Hospice agency in regards to: a. Hospice Plan of Care b. Hospice Election Form c. Physician Certification/Recertification of Terminal Illness d. Hospice Medication Information specific to each resident e. Hospice Physicians Orders f. Treatments g. Progress Notes h. Evaluations. Monitoring 25% audit of all residents receiving Hospice services to include resident #44 will be completed by the MDS nurse weekly times 8 weeks, then monthly times 1 month in regards to Hospice communication utilizing the Quality Improvement (QI) Hospice Chart Audit Tool to ensure all residents have appropriate documentation to include: 1. Hospice Plan of Care 2. Hospice Election Form 3. Physician Certification/Recertification of Terminal Illness 4. Hospice Medication Information specific to each resident 5. Hospice Physicians Orders 6. Treatments 7. Progress Notes 8. Evaluations. All areas of concern will be immediately addressed by the DON. DON will review all Quality Improvement (QI) Hospice Chart Audit Tool weekly x 8	

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F 849	Continued From page 31 The Hospice care services agreement dated 07/13/16 was reviewed on 03/1/18. The facility policy on Advance Directives dated 02/2007 was reviewed on 03/1/18. The facility advance directives manual dated 02/2007 was reviewed on 03/1/18.	F 849	weeks then monthly x one month to ensure all areas of concern were addressed. The Quality Improvement (QI) Nurse will forward the results of the Quality Improvement (QI) Hospice Chart Audit Tool to the Executive QI Committee monthly x 3 months. The Executive QI Committee will meet monthly x 3 months and review the Quality Improvement (QI) Hospice Chart Audit Tool to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring. The Administrator and Director of Nursing will be responsible for the implementation of corrective actions to include all 100% audits, in services, and monitoring related to the plan of correction.	