STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345515	A. BUILDING _____ B. WING _____	C 08/04/2021

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E 000	Initial Comments An unannounced complaint and recertification survey was conducted 8/2/2021 to 8/4/2021. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #NX4J11.	E 000		
F 000	INITIAL COMMENTS An unannounced, onsite Complaint and Recerticiation Survey was conducted 8/2/2021 to 8/4/2021 5 of 31 allegations were substantiated. Event ID #NX4J11.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2)	F 580		8/20/21

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

Electronically Signed | 08/23/2021

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F 580	Continued From page 1 is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to notify a resident representative about a newly acquired pressure ulcer for 1 of 1 resident reviewed for notification of change (Resident #147). Findings included: Resident #147 was admitted to the facility on 5/3/2020 with diagnoses to include a fractured femur (long leg bone) and hypertension. The admission Minimum Data Set (MDS) assessment dated 5/7/2020 assessed Resident #147 to be	F 580	This plan of Correction constitutes a written allegation of substantial compliance with Federal and Medicaid requirements. Preparation and/or execution of this correction do not constitute admission or agreement by the provider of the truth of items alleged or conclusions set forth for the alleged deficiencies. The plan of correction is prepared and/or executed solely because it is required by law to remove the deficiency. It also demonstrates our good faith and desire to continue to improve the	

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F 580	Continued From page 2	F 580		

cognitively intact. The MDS documented Resident #147 had no pressure ulcers. Resident #147 was discharged from the facility on 6/12/2020.

Demographic information for Resident #147 had one family member listed as the resident representative.

The nursing admission note dated 5/3/2020 documented a surgical wound but did not note a pressure ulcer.

A wound care note dated 6/3/2020 written by the wound care nurse (WCN) documented a pressure ulcer, Stage 2 on Resident #147 ' s sacrum (lower back, upper buttocks). The wound note documented the area was 2.3 centimeters (cm) long by 0.6 cm wide by 0.1 cm deep. The note documented there was no exudate (wound drainage) and the wound tissue was epithelial (pink, healing tissue). The note did not document Resident #147 ' s representative was notified of the new pressure ulcer.

A wound care note dated 6/10/2020 written by the WCN documented the pressure ulcer measurements of 1.2 cm length by 0.3 width and 0.1 cm deep. There was no exudate, the tissue was epithelial, and the wound bed was attached to the base of the wound. The note documented the wound was improving.

A facility discharge summary dated 6/12/2020 was reviewed and the form documented "no" Resident #147 was not responsible for herself.

A family member was interviewed on 8/2/2021 at 10:52 AM. The family member reported the quality of care and services to our residents.

What corrective action will be accomplished for the resident found to have been affected by the deficient practice?

On 8/20/2021 the Nurse Navigator audited all charts of current residents (1) with an acquired pressure ulcer to ensure that nursing staff appropriately notified the resident if alert and oriented or the resident representative otherwise of the change in condition. The audit revealed that 1 of 1 resident□s with an acquired pressure ulcer was notified timely of an acquired pressure ulcer/change in condition.

Resident #147 no longer resides at the facility.

How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?

All Licensed Nurses were in-serviced by the Director of Health Services (DHS)/Designee on 8/20/2021 on notification of an acquired pressure ulcer. The education included notifying the resident him/herself if alert and oriented and able to comprehend the information or their resident representative otherwise.

What measures will be put in place or what systemic changes will be made to

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F 580	Continued From page 3 resident representative for Resident #147 was not notified Resident #147 developed a pressure ulcer while a resident at the facility. The family member reported Resident #147 was discharged home and when she arrived home the resident representative noticed the pressure ulcer on her sacrum. The family member reported the pressure area was about the size of a silver dollar and there was yellow drainage. The family member denied the wound had an odor. The WCN was interviewed on 8/4/2021 at 10:03 AM. The WCN reported during June 2020 she was working both wound care and the floor passing medications. The WCN reported she did not recall Resident #147. The WCN explained when a new wound or pressure ulcer was identified, the nurse called the physician to get orders for wound treatment and the resident representative to notify of the new wound or pressure ulcer. The WCN reported that she was unable to find a nursing note that documented Resident #147 ' s representative was notified of the new pressure ulcer. The WCN reported Resident #147 was alert and oriented and the wound notification may have been made to only Resident #147. The nurse practitioner (NP) was interviewed on 8/4/2021 at 11:34 AM. The NP reported the nursing staff notified her of the pressure ulcer for Resident #147 and she gave orders for wound care. The Director of Nursing was interviewed on 8/4/2021 at 2:34 PM. The DON reported if a resident was alert and oriented the nursing staff would notify the resident regarding a new wound or change in treatment and if nursing felt	F 580	ensure that the deficient practice will not reoccur? During the daily clinical meeting, the Interdisciplinary Team (IDT) will review nursing progress notes for documentation of notification to alert and oriented resident or resident representative of any new acquired pressure ulcer. How will the corrective action be monitored to assure that the deficient practice will not reoccur, i.e., what quality assurance program will be put in place for monitoring to assure continued compliance. The DHS/designee will monitor each new acquired pressure ulcer via the audit tool for the presence of alert and oriented or resident representative notification of such change in condition. The DHS is responsible for the plan of correction and will track and trend the results via the audit tool weekly times four weeks and then monthly times three months and report the findings to the Quality Assurance Performance Improvement Committee (QAPI) to determine the need for continued monitoring or alteration to the established plan to ensure compliance. Date of Compliance August 20, 2021.	

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F 580	Continued From page 4 Resident #147 was unable to understand the change, then the nursing staff would have called the resident representative. The Administrator was interviewed on 8/4/2021 at 2:44 PM. The Administrator reported if a resident was alert and oriented, the facility would not have called the resident representative to notify of a new pressure ulcer or wound. The Administrator reported she expected a resident ' s representative to be notified of a change if the resident was not alert and oriented and was unable to comprehend the change.	F 580		
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 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.	F 849		8/20/21

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F 849	Continued From page 5	F 849		

(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 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.

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F 849	Continued From page 6 (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 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	F 849		

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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 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

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F 849	Continued From page 8 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 record review and staff interviews, the facility failed to maintain a hospice Plan of Care and hospice visit notes for 1 of 1 resident reviewed for hospice services (Resident #27). Findings included: The hospice/nursing home agreement with a revision date of 8/2013 read, in part: " ...The hospice will provide the facility with any modification to the ... Plan of Care ...revisions to the Plan of Care shall be recorded in the patient chart ...and a copy provided to the facility within 72 hours of such revision;" and, " ...the facility designee will obtain the following information: the most recent hospice Plan of Care for each hospice patient ..." Resident #27 was admitted to the facility on 3/17/2016 with diagnoses to include stroke and heart failure.	F 849	What corrective action will be accomplished for the resident found to have been affected by the deficient practice? On 8/20/2021 the Nurse Navigator audited all charts of current residents (3) receiving hospice services for hospice plan of care and hospice visit notes. The audit revealed that 3 of 3 residents had an updated hospice plan of care and hospice notes during the most recent benefit period. Resident #27 resides in the facility under hospice services. Resident□s hospice plan of care was updated on 8/12/2021. Resident□s hospice visit notes were uploaded to the chart with the most recent note dated 8/12/2021, this includes hospice notes dated between the recert period of 3/13/2021 and 5/29/2021.	

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F 849	Continued From page 9 Resident #27 was admitted to hospice on 10/21/2020. A hospice Plan of Care dated 10/28/2020 was noted in her medical record. The hospice benefit period was noted to be 10/21/2020 to 1/18/2021. The quarterly Minimum Data Set (MDS) assessment dated 4/16/2021 coded Resident #27 to have received Hospice services. The most recent significant change MDS 7/2/2021 assessed Resident #27 to be severely cognitively impaired. Resident #27 was coded to have received Hospice services on the 7/2/2021 MDS. No hospice Plan of Care dated for the certification periods after 1/18/2021 were in the medical record for Resident #27. Resident #27 ' s medical record was reviewed. The medical record had a hospice visit note dated 3/13/2021. The next hospice visit note was dated 5/29/2021. No visit notes were in the medical record between 3/13/2021 and 5/29/2021. Nurse #1 was interviewed 8/4/2021 at 1:51 PM. Nurse #1 reported the hospice nurse reported to the nurse assigned to Resident #27 after the hospice nurse completed a visit. Nurse #1 reported the hospice visit notes were put into the medical record by the hospice nurse. Nurse #2 was interviewed 8/4/2021 at 2:11 PM. Nurse #2 reported hospice visits notes were uploaded directly into the medical record by the hospice nurse. Nurse #2 explained the hospice documentation system allowed the hospice nurse to directly send the visit notes and the Plan of Care to Resident #27 ' s medical chart. Nurse #2 reported she was not aware the last Plan of Care for hospice was dated 10/28/2021 and no	F 849	How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All Licensed Nurses for assigned hospice office were in-serviced by the Hospice Designee on 8/20/2021 on documentation of hospice progress notes to the chart at time of visit and updating the hospice plan of care as needed. Both the hospice visit notes and plan of care are to be updated during each benefit period. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not reoccur? During the daily clinical meeting, the Interdisciplinary Team (IDT) will review hospice residents for updated hospice visit notes and updated plan of care weekly. For any note not found in chart, the Director of Health Services (DHS) is to notify the hospice office immediately and obtain most recent note and upload to medical record. How will the corrective action be monitored to assure that the deficient practice will not reoccur, i.e., what quality assurance program will be put in place for monitoring to assure continued compliance. The DHS/designee will monitor each hospice resident medical record for hospice progress notes and updated plan	

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F 849	Continued From page 10 updated Plan of Care was in the medical chart for Resident #27. Nurse #2 reported she was not aware the nursing visit notes from 3/13-5/29/2021 were not in Resident #27 ' s medical record. Nurse #2 reported she would call hospice and have them send the visit notes and the Plan of Care. The Director of Nursing (DON) was interviewed 8/4/2021 at 2:36 PM. The DON reported she was not aware Resident #27 ' s hospice visit notes were not in the medical chart and she was not aware the last Plan of Care was dated 10/28/2020. The DON reported it was her expectation the visit notes were added to the medical record at the time of the visit. The Administrator was interviewed 8/4/2021 at 2:49 PM. The Administrator reported the hospice nurse and staff nurses communicate at the time of the visit. The Administrator reported she expected the hospice visit notes and care plans were uploaded into the medical record appropriately. The Administrator was interviewed 8/5/2021 at 11:30 AM. The Administrator wanted to clarify that hospice documentation system indicated the visit notes and the Plan of Care had been transmitted to the facility medical record for Resident #27. The Administrator stated she felt the lack of hospice documentation was due to a hospice documentation transfer issue.	F 849	of care via the audit tool. The DHS is responsible for the plan of correction and will track and trend the results via the audit tool weekly times four weeks and monthly times three months. The DHS will report the findings to the Quality Assurance Performance Improvement Committee (QAPI) to determine the need for continued monitoring or alteration to the established plan to ensure compliance. Date of Compliance August 20, 2021.	