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	345160	A. BUILDING _____ B. WING _____	C 04/17/2025

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DAVIS HEALTH CARE CENTER	1011 PORTERS NECK ROAD WILMINGTON, NC 28411

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E 000	Initial Comments A recertification survey and complaint investigation was conducted on 04/14/25 through 04/17/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # 1GR911.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted on 04/1420/25 through 04/17/2025. Event ID # 1GR911. The following intakes were investigated: NC00224964, NC00227190, and NC00225446. 7 of the 7 complaint allegations did not result in a deficiency.	F 000		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life	F 565		5/7/25

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

Electronically Signed | 05/07/2025

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F 565	Continued From page 1 in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, and staff and resident interviews, the facility failed to provide a resolution and communicate the efforts to address grievances reported during Resident Council meetings for 10 of 12 months reviewed (June 2024, July 2024, August 2024, September 2024, October 2024, November 2024, December 2024, January 2025 February 2025, March 2025). Findings included. The Resident Council meeting minutes were reviewed for the period of April 2024 through March 2025. The meeting minutes did not include resolutions to the concerns expressed by the residents for the following months: 6/26/24: The Resident Council minutes noted concerns regarding not getting evening showers that were scheduled. Staff wearing headphones during their shift and having snacks available.	F 565	F565 Resident/Family Group Response The facility failed to provide resolution and communicate the efforts to address grievances reported during Resident Council meetings for 10 of the 12 months reviewed. 1. Resident Council was held on 4/17/2025 and attended by Administrator to hear resident updates 2. Administrator or designee will attend future Resident Council meetings to ensure resident concerns are provided with resolution by following grievance procedure. 3. Resident will receive paper copy of resolved grievance to ensure resolution of concern. 4. Administrator or designee with review Resident Council minutes monthly for 3 months then, quarterly for 1 quarter and will be discussed at QA.	

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F 565	Continued From page 2	F 565		

7/10/24: The Resident Council minutes did not include a discussion regarding resolution of old business including the concerns that were reported. Concerns were reported again regarding receiving scheduled showers and staff being on their phones and having ear buds in during resident care.

8/10/24: The Resident Council minutes did not include a discussion regarding resolution of old business including the concerns that were reported during the July meeting. No new concerns were reported.

9/4/24: The Resident Council minutes did not include a discussion regarding resolution of old business including concerns reported during July 2024 meeting. New concerns were reported regarding short staffing and answering call lights.

10/16/24: The Resident Council minutes did not include a discussion regarding resolution of old business. Concerns were reported regarding timeliness of medications, answering call lights, and getting breakfast served late.

11/13/24: The Resident Council minutes did not include a discussion regarding resolution of old business. Concerns were reported regarding timeliness of medications, answering call lights, and Nurse Aides being disrespectful, and staff using headphones and cell phones during shift.

12/11/24: The Resident Council minutes did not include a discussion regarding resolution of old business. Concerns were reported regarding shower schedules not being adhered to, and getting breakfast served to late and earlier than 10:00 AM.

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F 565	Continued From page 3	F 565		

1/29/25: The Resident Council minutes did not include a discussion regarding resolution of old business. No new concerns were reported in the meeting minutes.

2/12/25: The Resident Council minutes did not include a discussion regarding resolution of old business from previous months meetings. Concerns were voiced regarding shower schedules not being followed.

3/5/25: The Resident Council minutes did not include a discussion regarding resolution of old business. No repeat concerns were reported during the meeting.

During the Resident Council meeting interviews on 4/16/25 at 10:05 AM residents in attendance stated that they had ongoing concerns that had been voiced for months during the Resident Council meetings. Residents stated their concerns were not being addressed and there was no discussion held at the beginning of each monthly meeting to address any resolutions regarding concerns voiced from the previous month. Residents reported breakfast continued to be served late on one of the units. Shower schedules continued to not be adhered to. Call lights were not being responded to within a reasonable time, and staff continued to use headphones or ear buds during care.

During an interview with the Activity Director on 4/16/25 at 11:00 AM she stated she was recently hired two weeks ago and was now the full-time Activities Director. She stated she did not know how the meetings were being conducted prior to her taking on this role. She stated she would be

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F 565	Continued From page 4 including a discussion regarding resolution of any concerns at the beginning of each meeting moving forward. She indicated she had been instructed to notify the appropriate department of any concerns voiced during the monthly Resident Council meetings and would ensure that the concerns were being addressed. During an interview on 04/16/25 at 2:42 PM the Administrator stated she became the Administrator in January 2025. She stated she did not know how the previous Administrator and Activities Director handled the concerns voiced during the Resident Council meetings. She stated she had no documentation that could show the grievances reported during the monthly meetings had been addressed. She stated the process now included that the department managers typically attend the monthly Resident Council meetings, and the concerns voiced were sent to each department to address. She stated moving forward she would ensure that Resident Council minutes were being addressed each month. She indicated staff education would be held on Resident Rights and resolving and following up on grievances reported during the monthly Resident Council meetings.	F 565		
F 640 SS=B	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates.	F 640		5/7/25

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F 640	Continued From page 5 (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and	F 640		

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F 640	Continued From page 6 approved by CMS. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to transmit Annual Minimum Data Set (MDS) assessments (Resident #14, Resident #58, and Resident #27) and a Discharge MDS assessment (Resident #80) to the Centers for Medicare and Medicaid Services (CMS) system 14 days after completion of the assessment for 4 of 23 residents reviewed for MDS assessments. Findings included: a.Resident #14 was admitted on 2/8/24. Resident #14's Annual MDS assessment with an assessment reference date (ARD) of 1/31/25 was listed as "production batch." The Annual MDS assessment had not been transmitted to CMS within the required timeframe. b. Resident #58 was admitted on 8/10/22. Resident #58's Annual MDS assessment dated 3/6/25 status indicated "finalized." The Annual MDS assessment had not been transmitted to CMS within the required timeframe. c. Resident 27 was admitted on 10/5/23. Resident #27's Annual MDS assessment dated 3/7/25 status was listed as "production batch." The Annual MDS assessment had not been transmitted to CMS within the required timeframe. d. Resident #80 was admitted on 10/28/24. Review of Resident #80's MDS assessments indicated a discharge return not anticipated MDS	F 640	F640 Encoding/Transmitting Resident Assessments The facility failed to transmit Annual MDS assessments had not been transmitted to CMS within the required timeframe. 1. MDS Coordinator or designee will train back up secondary submitter to ensure timely MDS submissions. 2. MDS transmissions will occur 3 times per week effective 5/5/2025. 3. MDS Coordinator or designee will review transmissions monthly for 3 months for timely submissions of MDS assessments. 4. Additional labor hired for MDS team. Additional document(s) have been developed and appears sustainable under the supervision of DON. 5. Auditing will continue for 90 day period to be discussed at QA for breaches and outliers.	

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F 640	Continued From page 7 assessment dated 11/5/24 had a status listed as "finalized." This discharge MDS assessment had not been transmitted to CMS within the required timeframe. An interview was conducted with the Director of Nursing (DON) on 4/15/25 at 1:15 PM. The DON stated she was new to the position, the MDS nurses were all new and she oversaw the MDS calendar of assessments. The DON stated she was responsible for the management and coordination of the assessments. The DON stated there were 3 new nurses that had not worked in MDS previously and they were being trained but were not functioning yet in the role of MDS. The DON stated the term "finalized" indicated that the MDS assessment was completed but not transmitted and the term "production batch" indicated the MDS assessment was not sent. The DON indicated that the assessments were to be transmitted within the regulatory time frame which was 14 calendar days after the completion date. The DON stated the assessments were not transmitted within the required time frame due to changes in personnel in the MDS department.	F 640		
F 809 SS=F	Frequency of Meals/Snacks at Bedtime CFR(s): 483.60(f)(1)-(3) §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and	F 809		5/7/25

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F 809	Continued From page 8 breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, and staff, Ombudsman, Director of Dining Services, Certified Dietary Manager, Club Cook, Compliance Coordinator, and Registered Dietitian (RD) interviews, and record review, the facility failed to have no greater than a 14-hour lapse between the provision of a substantial evening meal and breakfast the following day for residents served their meals on 5 of 8 meal carts (Club area Cart-1&2; Pavilion area Cart; Haven area Cart, and River Bend area Cart) utilized for meal service. This practice had the potential to affect all the residents (91 of 91) in the facility for meal delivery. The findings included: An interview with the Ombudsman on 04/11/25 at 9:43 AM indicated that there were problems with the meal service times. The Ombudsman stated lunch and dinner meals were served early and breakfast was late. A schedule of the Dining Service Times was provided by the facility on 04/15/25. A review of this schedule indicated the meal cart delivery times allowed as much as 15 - 16 hours to lapse	F 809	F809 Frequency of Meals The facility failed to have no greater than 14 hour time lapse between provision of a substantial evening meal and breakfast the following day for residents served. 1. Resident meal times were moved effective 4/18/2025 to 8 AM, 12 PM and 6 PM. 2. Substantial snack will be available to residents daily in the evening. 3. CDM or designee will audit meal times 3 times a week for 4 weeks, then 1 time per week for 4 weeks, then monthly for 3 months to ensure meal time meet regulatory compliance. 4. Meals rescheduled not to exceed 14 hour window for fasting. Unidine to monitor successful executive of meals at appropriate times. 5. Observations and discussions will be reviewed at QA for 90 days.	

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F 809	Continued From page 9	F 809		

between the last meal of the day and first meal of the following day.

An observation was conducted at the Rehabilitation Hall on 04/17/25 at 8:47 AM and indicated the breakfast trays were being served.

An interview with Nursing Assistant (NA#1) on 04/17/25 at 8:47 AM revealed that they started serving breakfast between 8:15 AM and 8:45 AM.

An observation in the Club Dining Room on 04/17/25 at 8:49 AM revealed the residents were being served breakfast.

An interview with the Hospitality Aide (HA#1) 04/17/25 at 8:49 AM revealed they started serving the breakfast meal at 8:30 AM.

An interview and observation with Resident #14 on 04/17/25 at 8:50 AM revealed the resident sitting in the Club dining room eating breakfast. Resident #14 stated breakfast was good, but anything would taste good when you were really hungry. The resident stated that it was a long time between dinner and breakfast, and she was hungry in the morning at breakfast.

An observation on 04/17/25 at 8:55 AM revealed residents on the Riverbend Hall were being served breakfast trays.

An observation in the Club Dining Room on 04/17/25 at 8:59 AM revealed meal trays were being plated to be served.

On 04/17/24 at 9:30 AM, Director of Dining Services provided a copy of the facility's current Dining Service Times. A review of the facility's

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F 809	Continued From page 10	F 809		

current Dining Service Times (not dated) were scheduled as follows: Breakfast 8:00 AM, Lunch 12:00 PM, and Dinner 5:00 PM.
-The Club area Cart #1 delivered at 4:30 PM for dinner and 9:30 AM for Breakfast, indicative of a 17-hour and time span between the two meals.
-The Club area Cart #2 was delivered at 4:30 PM for dinner and 9:30 AM for Breakfast, indicative of a 17-hour time span between the two meals.
-The Pavilion area Cart was delivered at 4:30 PM for dinner and 8:30 AM for Breakfast, indicating a 16-hour time span between the two meals.
-The Haven Hall meal cart was delivered at 4:30 PM for dinner and 8:30 AM for Breakfast, indicative of a 16-hour time span between the two meals.
-The River Bend Hall meal cart was delivered at 4:30 PM for dinner and 8:30 AM for Breakfast, indicative of a 16-hour time span between the two meals.

An interview with the Compliance Coordinator on 04/17/25 at 9:35 AM revealed the interdisciplinary team had discussed mealtimes in recent Quality Assurance (QA) meetings but had not come up with a conclusion as to how to ensure that meals are served timely and within the appropriate time frames. The Compliance Coordinator stated that there needs to be a process in place to ensure that meals are served within the appropriate time frames.

An interview conducted on 04/17/25 at 9:40 AM with the Director of Dining Services and the Certified Dietary Manager revealed that residents' breakfast and dinner meals were currently served 15 hours or greater between the dinner meal and breakfast meal service times, which should be less than 14 hours.

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F 809	Continued From page 11	F 809		

An interview conducted on 04/17/25 at 12:40 PM with the facility's Registered Dietitian (RD). During the interview, the RD was shown the facility's Dining Service Times schedule provided and asked what her thoughts were with regards to the time lapse between the evening meal and breakfast the following day. The RD stated, "15 hours or more, is not okay." The RD acknowledged that the facility would need to offer a nourishing snack to everyone if greater than 14 hours elapsed between Dinner and Breakfast the next day. She reported that to her knowledge, the facility did not meet these requirements.

An interview was conducted on 04/17/25 at 12:50 PM with Club Cook #1. She said breakfast in the Club Dining Room was served usually between 9 AM - 9:30 AM. She said the facility staff does not pass out evening snacks to residents. She said facility staff used to go around with carts of substantial snack carts in the evenings, but no more. The Cook said dinner to breakfast meals from 5:00 PM to 9:00AM (16 hours) was way too long between meals, without a substantial evening snack. She said if they had the snack carts back, they would be able to go around and offer residents an evening substantial snack like a peanut butter or ham sandwich, like they used to, which according to her would be a "great idea". Upon review, the Cook stated she was not sure why the dinner carts were delivered from the main kitchen around 4:30 PM or why breakfast was ready around 9:00 AM, which was over 15 hours between dinner and breakfast meals. The Cook also said she was not sure why the facility stopped using the snack carts or stopped offering residents a significant evening snack, like sandwiches, and now if the residents ask, they

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F 809	Continued From page 12 offer them a package of crackers or maybe a small plastic fruit cup.	F 809		
F 849 SS=D	Hospice Services CFR(s): 483.70(n)(1)-(4) §483.70(n) Hospice services. §483.70(n)(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(n)(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	F 849		5/7/25

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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.
(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.

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F 849	Continued From page 14 (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(n)(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	F 849		

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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 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(n)(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

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F 849	Continued From page 16 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 coordinate a plan of care with the Hospice provider for 2 of 2 residents (Resident #54 and #21) reviewed for Hospice care. The findings included: a. Resident #54 was admitted to the facility on 08/23/23 with medical diagnoses which included in part: Hospice, senile degeneration of the brain, influenza, malnutrition, abnormal weight loss, and dementia. An Election of Hospice Benefit form was signed by Resident #54's Responsible Party (RP) on 02/07/25. Review of the 02/20/25 significant change Minimum Data Set (MDS) assessment revealed Resident #54 had severe cognitive impairments, and Hospice care was indicated. Review of the care plan dated 04/10/25 included activities for daily living (ADL) self-deficit related to dementia, chronic pain related to the history of fractures, and a nutritional deficit problem. No facility care plan problems indicated that Resident #54 received Hospice services. A review of Resident #54's electronic care plan record did not reveal a current hospice plan of care, only Hospice progress notes.	F 849	F849 Hospice Services The facility failed to coordinate a plan of care with the hospice provider for 2 of 2 residents reviewed for hospice care. 1. Hospice care plans will be reviewed weekly with DON or designee during IDT meetings effective 4/22/2025. 2. Hospice provider will be included in IDT meeting to collaborate with clinical team. 3. DON or designee will audit residents receiving hospice services for placement of care plan 1 time per week for 4 weeks, then 2 times per month for 3 months to ensure regulatory compliance. 4. Audit will be discussed in QA.	

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b. Resident #21 was admitted to the facility on 03/14/25 with medical diagnoses which included in part: encephalopathy (brain dysfunction or damage), polymyalgia (widespread muscle pain and stiffness), anorexia, depression, pleural effusion, dementia, pain, hypertension, and heart disease.

Review of the 04/03/25 Minimum Data Set (MDS) assessment revealed Resident #21 had severe cognitive impairments, and Hospice care was indicated.

An Election of Hospice benefit was signed by the resident and resident's power of attorney (POA) on 04/04/25.

Review of the care plan dated 04/10/25 included activities for daily living (ADL) self-deficit related to dementia, acute and chronic pain related to the history of fractures, and a nutritional deficit problem due to diagnosis of dementia and weight loss. No facility care plan problems indicated that Resident #21 received Hospice services.

An interview was conducted with the MDS Nurse Instructor/Director of Nursing (DON) on 04/15/25 at 1:15 PM. She confirmed that Residents #54 elected Hospice benefit on 02/07/25, and Resident #21 elected Hospice benefit on 04/04/25, and that the Hospice benefit services were ongoing. The MDS Nurse/DON stated that the facility care plan should contain information regarding Hospice services and interventions provided for the two residents but did not. The DON could not locate any documentation to show that the facility's care plan had been collaborated with the Hospice staff for either Resident #54 or Resident #21. She further indicated that she was

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training two new MDS Nurses, and that the two new MDS Nurses must have overlooked updating the facility's care plans for Resident #54 and Resident #21to include a Hospice section. The DON said she was ultimately responsible for not following up with Hospice as she should have, and for the facility of not having a clear process in place to obtain and coordinate a Hospice care plan. She said after the MDS Nurse received resident's complete Hospice admission documentation, including a Hospice care plan, the nurse would collaborate with the Hospice Nurse, to develop a facility Hospice care plan. The care plan should be developed and entered into the resident's electronic medical record within 3 to 5 days after receiving the Hospice documentation and care plan, which the MDS Nurse failed to do.

An interview was conducted with the Clinical Compliance Administrator on 04/17/25 at 10:20 AM. She said it was her expectation that the MDS Nurses to incorporate Hospice documentation and care plan into their care plan, which they did not do.

An interview was conducted with the Hospice Nurse on 04/17/25 at 10:30 AM. She stated that she kept most of Resident #54 and Resident #21's Hosice orders, assessments, and notes in her computer, which were scanned to the facility timely. The Hospice Nurse stated she was not aware that Resident #54 and Resident #21's Hospice care plans were not added to the facility's care plans by the facility's MDS nurses. She said the MDS nurses should have updated the facility's care plan to include her Hospice care plan, so that all facility and Hospice staff were all on the same page regarding residents' plan of

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F 849	Continued From page 19 care. An interview was conducted with the Administrator and Director of Nursing (DON) on 04/17/25 at 10:00 AM. The DON and Administrator revealed that there should have been Hospice information included in the facility's care plan for Resident #54 or #21 and there was not. An interview was conducted with the Administrator on 04/17/25 at 10:05 AM. She indicated it was her expectation that the Hospice section be available in the facility's care plan for all residents receiving Hospice services. She further explained that her expectation was for Hospice care plan to have been developed and available in the facility's care plan for Resident #54 and Resident #21, which there wasn't.	F 849		