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F 000	INITIAL COMMENTS A complaint investigation survey was conducted from 06/04/25 through 06/05/25. Event ID# B04011. The following intakes were investigated: NC00227373, NC00230170, NC00230844, NC00230947, and NC00231198. 3 of the 12 complaint allegations resulted in deficiency. Past-noncompliance was identified at: CFR 483.12 at tag F600 at a scope and severity (G)	F 000		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review, and staff , Psychiatrist, Nurse Practitioner, and the Medical Director's interviews the facility failed to protect a residents right to be free from resident-to-resident abuse	F 600	Past noncompliance: no plan of correction required.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/23/2025

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when Resident #1 hit and scratched Resident #2 on her left arm resulting in multiple areas of bruising and abrasions. This occurred for 1 of 4 residents reviewed for abuse (Resident #1).

Findings included:

Resident #1 was admitted to the facility on 12/23/24 with diagnoses of bipolar disorder, and bilateral below the knee amputation.

Review of the care plan dated 12/28/24 revealed Resident #1 required assistance with activities of daily living. There was no care plan in place regarding Resident #1 having behavioral disturbances.

The Minimum Data Set (MDS) quarterly assessment dated 3/10/25 revealed Resident #1 was cognitively intact. She had no physical or verbal behavioral symptoms directed toward others at the time of assessment. She required extensive two-person assistance with activities of daily living (ADL) and total dependence with transfers.

Resident #2 was admitted to the facility on 10/20/22 with diagnoses of cerebral vascular accident.

A physician's order dated 9/12/23 for Resident #2 revealed Eliquis (blood thinner) 5 milligrams twice a day for atrial fibrillation.

Review of the care plan dated 3/18/25 revealed Resident #2 required assistance with activities of daily living. There was no care plan in place regarding Resident #2 having behavioral

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disturbances.

The Minimum Data Set (MDS) quarterly assessment dated 5/1/25 revealed Resident #2 was cognitively intact. She required extensive two-person assistance with activities of daily living. She had no physical or verbal behavioral symptoms directed toward others at the time of assessment.

The facility investigation report dated 5/23/25 revealed: On 5/23/25 a nurse aide (Nurse Aide #4) was passing by the residents room (Resident #1 and Resident #2) and heard a resident yell for help. Nurse Aide #4 immediately attempted to separate the residents but neither resident would let go of the privacy curtain. Nurse Aide #4 stayed at the doorway and called for Nurse #2. Both residents were immediately separated. Resident #1 was placed on 1 to 1 supervision for safety. The Police, Adut Protective Services, the Ombudsman, the Physician, the Responsible Party, and the State Agency were notified. The police arrived and spoke with both residents. The on-call Psychiatric provider was notified for an emergency psychiatric evaluation of Resident #1. A skin assessment of Resident #2 revealed a hematoma (a collection of blood underneath skin), bruising, and minimal bleeding noted to the top left hand with scratch marks and minimal bleeding to the left arm, and a small bruise to the right hand. A skin assessment of Resident #1 revealed no new skin breakdown; blood was noted under the middle three digits of Resident #1's right hand. Resident #2 was transferred to the hospital for further evaluation. Resident #1 was later transferred to the hospital for a psychiatric evaluation. On 5/24/25 Resident #2 returned from the hospital. Imaging obtained

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revealed a fracture of the fifth metacarpal (finger) and a splint was placed. Resident #2 had abrasions and a hematoma to the left hand, with no significant open wounds. An orthopedic follow-up appointment was scheduled for 5/30/25. Involuntary commitment paperwork was filed for Resident #1, and she was notified of immediate discharge while she was at the hospital. Resident #1 did not appeal and stated she wanted to be discharged home. Resident #1 did not return to the facility.

A change in condition report dated 5/23/25 at 5:43 PM documented by Nurse #2 revealed Resident #2 had an altercation with her roommate (Resident #1) in their room. The residents were arguing regarding the privacy curtain being pulled. Nurse #2 was unable to say how the injury occurred. Both of Resident #2's hands were noted to be bruised with scratches and minimal bleeding to the left hand. The Physician responded to send Resident #2 to the emergency department for evaluation.

A progress note dated 5/23/25 at 6:33 PM documented by Nurse #2 revealed the police were in the facility to talk with the residents due to resident-to-resident altercation. Resident #2 was alert and oriented to person, place, and time and was able to show the officers her injuries to both hands. Resident #2 was made aware that she would have a room change today and that she was being sent to the emergency department for evaluation due to hematoma and bruises to her hands. Resident #2 was in agreement with going to the hospital for evaluation and requested not to remain in the room with her roommate. Resident #2 will be moved to another room upon return from the hospital.

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A progress note dated 5/23/25 at 7:10 PM documented by Nurse #2 revealed Resident #2 was transferred to the emergency department.

A progress note dated 5/24/25 at 3:25 AM documented by Nurse #7 revealed Resident #2 returned to the facility at this time accompanied by two emergency medical technicians. Her vital signs were within normal limits. She had no complaints of pain or discomfort at the time.

The hospital discharge summary dated 5/24/25 revealed Resident #2 was evaluated today with concern of a large hematoma on the left side of her dorsal (top) hand. She stated that she was in an altercation with her nursing home roommate. Reportedly Resident #2 was trying to keep a room privacy curtain closed and her roommate did not want it closed and therefore smacked her hand. Resident #2 was on a blood thinner for Atrial fibrillation and has a large hematoma present on arrival. Resident #2 has some pain in the left hand. The final impression revealed: Displaced fracture of the neck of the fifth metacarpal (finger) bone, on her left hand, with referral to Orthopedic Surgery. A hematoma of the left hand and abrasion of right hand. A splint was applied to the left hand. Resident #2 was discharged back to the facility on 5/24/25 at 2:50 AM.

A physician's order dated 5/24/25 for Resident #2 revealed Hydrocodone-Acetaminophen oral tablet 5-325 milligrams. Give 1 tablet by mouth every 6 hours as needed for pain for 14 days.

Review of the Medication Administration Record (MAR) dated May 2025 revealed Resident #2 was

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administered Hydrocodone-Acetaminophen oral tablet 5-325 milligrams for pain level of 6 on a scale from 1-10 on 5/24/25 at 9:17 PM, 5/25/25 at 8:20 PM, and 5/26/25 at 10:22 PM. No further doses were administered.

Review of the orthopedic surgeons note from the follow up appointment dated 5/30/25 revealed Resident #2 had soft tissue trauma of the left hand, with no obvious fracture. She had opened wounds on her left hand that needed dressing changes and antibiotics. Orders were written for Keflex (antibiotic) 500 milligrams twice a day for 1 week. Daily dressing changes to the left hand for 1-2 weeks. Apply nonstick dressing and ace wrap. Daily occupational therapy to prevent stiffness. Keep splint on and remove only for showers.

An interview was conducted on 6/4/25 at 12:00 PM with Resident #2. She was observed lying in bed and was alert and oriented to person, place, and time. She stated the incident occurred on Friday evening 5/23/25. She stated her roommate Resident #1 had been out of the room for most of the day. Resident #1 returned to the room around 5:00 PM and the privacy curtain was pulled and Resident #1 whose side was near the window wanted the privacy curtain opened. Resident #2 stated she wanted the curtain pulled for privacy. Resident #1 then tried to open the curtain and Resident #2 used her reacher (tool used to pick up hard to reach items) to grab the curtain to keep it closed. She stated Resident #1 grabbed the reacher so at that point both of them had a hold of it. Resident #1 then proceeded to pull on the reacher while Resident #2 was still holding on to it. She stated Resident #1 proceeded to claw at her left arm and hand with her long fingernails.

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She stated the clawing and scratching caused a lot of bleeding and blood was all over her bed. Resident #1 started yelling out for a staff member. While they were waiting on a staff member Resident #1 continued to scratch and claw at her left arm and hand leaving deep scratches that ended up with swelling and bruising. She stated when staff finally came into the room they decided to send her to the hospital for evaluation. She went out to the hospital shortly afterward and returned to the facility around 2:30 AM the following morning. She stated she had only been roommates with Resident #1 for two days prior to the incident. Until that time she had not had any altercations or incidents with her. She stated when the incident occurred she did not feel scared or frightened she was just very mad that it had occurred. She stated when she returned from the hospital they moved her to another room and notified her that Resident #1 had been discharged from the facility. She stated she currently felt safe in the facility since Resident #1 was no longer there.

An attempt was made on 6/4/25 at 1:00 PM to contact Resident #1. The phone number on file was not a valid number.

Attempts were made on 6/4/25 at 1:15 PM and 2:35 PM and 6/5/25 at 9:00 AM to contact Nurse Aide #4 who entered the room to separate the residents on 5/23/25. There was no response.

A witness statement obtained by the facility from Nurse Aide #4 during the investigation on 5/23/25 revealed she was making rounds and heard the residents yelling for help in the room. Both residents were pulling and fighting over the privacy curtain and neither resident was willing to

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let go. The nurse came in to assist. The residents were separated and were checked for bruising or scars. Resident #2 had a large scratch and bruising.

During an interview on 6/4/25 at 2:10 PM Nurse #2 stated she was the assigned nurse on 5/23/25. She stated she was called to the residents room. When she arrived Nurse Aide #4 was taking Resident #1 out of the room and Resident #2 was still in bed with blood on her hand. She was told the residents were arguing over the privacy curtain being pulled. Both residents had a reacher but denied hitting each other. Resident #1 clawed Resident #2 with her fingernails. The residents were separated. The police were notified and came out and talked with both residents. Resident #1 did not deny scratching but denied hitting Resident #2. Resident #1 was moved to a room down the hall and placed on 1 to1 supervision. Resident #2 was sent to the hospital for evaluation of her injuries. She stated Resident #2 was confused at times, but she was very aware. Nurse #2 stated she left after the end of her shift around 7:00 PM that evening, and Resident #1 was sent out to the hospital later that night. She reported that Resident #1 was a bilateral amputee and in a wheelchair during the incident, and Resident #2 was lying in her bed during the incident.

During an interview on 6/4/25 at 3:00 PM the Director of Nursing (DON) stated she was walking up to the nurses station when Nurse Aide #4 was standing at the door of the residents room yelling for Nurse #2. Both the DON and Nurse #2 went down to the room. As she came down the hall Nurse Aide #4 was pushing Resident #1 out of the room in her wheelchair. She went into the

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room and asked Resident #2 who was lying in bed what happened. She noticed the hematoma and scratch marks on her left hand and a small bruise on her right hand. She stated Resident #2 was calm about everything and said she wanted the curtain pulled one way and Resident #1 wanted it another way. After she spoke with Resident #2 and did the skin evaluation she went and spoke with Resident #1. Resident #1 reported the same thing. Resident #1 wanted to see out of the door and did not want the curtain pulled and they got in a scuffle. She assessed Resident #1, and she had blood under her fingernails. At that time, she was moved to another room and placed on 1 to 1 supervision. Resident #2 was sent to the hospital, and they called for an emergency psychiatric visit, but the psychiatrist was unable to come until the next day. The police came out and spoke with both residents prior to Resident #2 going to the hospital and Resident #2 wanted to press charges. Resident #1 was recently moved into Resident #2's room the day before on 5/22/25. Neither resident had complained to staff prior to this incident and had no prior altercations with each other. She stated Resident #1 had an incident with another resident at one time when another resident with dementia hit Resident #1 and Resident #1 reacted by hitting her back but there were no injuries. Resident #2 had never had any altercations with other residents. She stated Resident #1 was later sent out to the hospital that same night for a psychiatric evaluation since the Psychiatrist could not do an emergency visit that evening. The hospital called later and informed staff they could not do a psychiatric evaluation due to not having a psychiatric provider on staff that night. Later at 4:30 AM the hospital called the facility and stated

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Resident #1 did not need a psychiatric evaluation and they were sending her back to the facility. The facility had to sign a petition for involuntary commitment so that Resident #1would not return to the facility before being evaluated by a Psychiatrist. She stated Resident #1 never returned to the facility but indicated she thought Resident #1 discharged home.

A progress note dated 5/27/25 documented by the Psychiatrist who provided services at the facility, revealed Resident #2 was evaluated for follow up after an altercation with her roommate. Resident #2 stated Resident #1 hit and scratched her hand while she attempted to keep the privacy curtain pulled. Resident #2 did have a fracture. Resident #2 stated she felt safe now that Resident #1 was discharged. She denied depressed mood or anxiety.

During a phone interview on 6/4/25 at 4:50 PM the Psychiatrist stated she was made aware of the incident on 5/23/25 between the residents but was not clear on all of the details. She stated she would be evaluating Resident #2 again on her next visit later this week. She stated Resident #1 had confusion at times but was alert and oriented to person, place, and time. She stated Resident #1 was not on an antipsychotic medication, but she did receive the antidepressant medication Trazadone nightly for insomnia. She stated she did not feel Resident #1 was a threat to other residents and had she returned to the facility she would have made medication changes. She indicated Resident #2 was evaluated by her following the incident. She was not on any psychotropic medications and there had been no incidents involving Resident #2 prior to this incident of which she was aware.

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During a phone interview on 6/4/25 at 5:15 PM the Medical Director stated he was made aware of the incident that occurred on 5/23/25 between the residents. He stated he was aware the Orthopedic surgeons report read no fracture although the hospital diagnosed Resident #2 with a fracture of the 5th digit. He stated he trusted the Orthopedic surgeon over the hospital impressions but indicted he was uncertain if an x-ray was done at the orthopedist office. He stated he would reevaluate Resident #2 on his next visit and refer her back to Orthopedics for follow up.

During an interview on 6/5/25 at 10:00 AM the Social Worker stated she spoke with Resident #2 on Saturday 5/24/25 the day after the incident. She stated Resident #2 reported to her that she was not fearful and not in danger since Resident #1 had been removed from the facility. She stated there were no prior incidents between the two residents. She stated she continued to check in with Resident #2 several times a week and she was doing well. She had no complaints with her new roommate. The Social Worker stated she went to the hospital on Saturday 5/24/25 to visit Resident #1. She stated Resident #1 listened to what she said but would not speak to her about the incident.

An observation of Resident #2's left hand and forearm was conducted 6/5/25 at 1:30 PM along with the Nurse Practitioner. Resident #2 stated she felt better today, and the wounds were healing. The left hand and forearm were noted to have scattered scabbed areas with bruising in various stages of healing. There was no drainage or swelling noted and no complaints of pain at the time. Resident #2 stated she was receiving an

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antibiotic and daily dressing changes since the orthopedic visit.

During an interview on 6/5/25 at 1:30 PM the Nurse Practitioner stated x-rays were not done at the orthopedic office on 5/30/25. She stated she was uncertain whether Resident #2 had a finger fracture or not. She stated on today's exam she was able to move her hand and fingers without pain or discomfort. She indicated they would refer her back to the orthopedic surgeon to determine for certain whether a fracture occurred or not.

The progress note dated 6/5/25 documented by the Nurse Practitioner revealed Resident #2 was evaluated for follow up. The hospital left hand x-ray questioned avulsed fragment at the medial aspect of the fifth metacarpal (finger). The Orthopedic consult on 5/30/25 stated no obvious fracture. Discussed case with the Medical Director who recommended referral back to the orthopedic surgeon for reevaluation of fracture versus no fracture to the left hand. Continue antibiotic for infection prevention.

An interview was conducted on 6/5/25 at 5:30 PM with the Administrator along with the Director of Nursing (DON). The DON stated following the resident-to-resident altercation a plan of correction was initiated on 5/23/25 which included skin assessments, interviews of residents and staff, education, and discussions in Quality Assurance (QA).

The Plan of Correction (POC) initiated on 5/23/25 with a compliance date of 5/28/25 included the following:

1. Address how corrective action will be

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accomplished for those residents found to have been affected by the deficient practice.

On 5/23/25 (Nurse Aide #4) was passing by the room and heard a resident yell for help. Nurse Aide #4 immediately attempted to separate the residents but neither resident would let go of the privacy curtain. Nurse Aide #4 stayed at the doorway and called for Nurse #2.

Both residents were immediately separated. Resident #1 was placed on 1 to 1 supervision for safety.

The Police, Adut Protective Services, the Ombudsman, the Physician, the Responsible Party, and the State Agency were notified.

The police arrived and spoke with both residents.

The on-call Psychiatric provider was notified for an emergency psychiatric evaluation of Resident #1.

A skin assessment of Resident #2 revealed a hematoma (a collection of blood underneath skin), bruising, and minimal bleeding noted to the top left hand with scratch marks and minimal bleeding to the left arm, and a small bruise to right hand.

A skin assessment of Resident #1 revealed no new skin breakdown; blood was noted under the middle three digits of her right hand.
Resident #2 was transferred to the hospital for further evaluation.

Resident #1 was later transferred to the hospital for a psychiatric evaluation.

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F 600	Continued From page 13 On 5/24/25 Resident #2 returned from the hospital. Imaging obtained revealed a fracture of the fifth metacarpal (finger) and a splint was placed. Resident #2 with abrasions and hematoma to the left hand, with no significant open wounds. An orthopedic follow-up appointment was scheduled for 5/30/25. Involuntary commitment paperwork was filed for Resident #1, and she was notified of immediate discharge while she was at the hospital. Resident #1 did not appeal and stated she wanted to be discharged home. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. On 5/23/25 skin assessments were conducted on non-alert and oriented residents by nursing staff. There were no new findings as a result of the skin assessments. On 5/24/25 the Director of Nursing conducted staff interviews to inquire if staff had knowledge of the incident. Staff identified no behaviors. On 5/23/25 education was initiated and provided to staff by the Administrator and the Director of Nursing on resident abuse, behaviors, management of symptoms, and ensuring resident safety by identifying, reporting, and managing behavioral symptoms. The Director of Nursing will ensure all new staff and agency staff will be educated on the abuse policy, and all staff education will be conducted prior to their next shift.	F 600		

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On 5/24/25 the Social Worker interviewed alert and oriented residents regarding abuse. There were no negative findings.

On 5/26/25 residents with roommates were interviewed by facility staff to ensure roommate compatibility. There were no concerns identified.

On 5/26/25 grievances from the last 90 days were audited by facility staff to ensure no additional concerns existed that rose to the level of suspected resident abuse. There were no negative findings.

3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.

On 5/23/25 the Administrator and Director of Nursing initiated and provided education to current staff on abuse, neglect, and recognizing signs and symptoms of abuse, and reporting abuse. Education forms were signed by trained staff for the verbal education that was provided. All new staff to include new agency staff will be educated by the DON on the facilities abuse prohibition policy in the new hire orientation program prior to working their first scheduled shift. All staff education will be conducted by the Administrator and DON prior to their next scheduled shift. Abuse education was initiated on 5/23/25, and provided on 5/24/25, 5/25/25, and 5/27/25.

4.Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.

The facility made the decision to incorporate the

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plan of correction and audits into their Quality Assurance and Performance Improvement (QAPI) committee on 5/26/25.

The Administrator will interview five residents with a brief interview of mental status of eight or greater per week for twelve weeks to inquire if they have felt abused or have witnessed or suspected abuse or neglect.

The Administrator will review all grievances on a daily basis for twelve weeks to ensure no concerns rise to the level of suspected abuse.

Facility staff will interview five residents with roommates twice a week for six weeks to ensure appropriate roommate compatibility and to ensure no concerns related to resident abuse exist between roommates.

Immediate action will be taken for any positive findings. Results of these audits and interviews will be brought before the Quality Assurance and Improvement Committee (QAPI) monthly with the QAPI committee responsible for ongoing compliance.

An Ad HOC QAPI meeting with the interdisciplinary team was held on 5/26/25 at 11:00 AM to discuss the resident-to-resident altercation that occurred on 5/23/25.

In the monthly QAPI meeting the Interdisciplinary team will review all resident-to-resident abuse allegations to ensure appropriate interventions are in place and the care plans were updated for eight weeks.

The Administrator will report the results of the

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F 600	Continued From page 16 monitoring to the QAPI committee to review audits and make recommendations to assure compliance is maintained. The QAPI committee will determine the need for further intervention and auditing beyond three months to assure compliance is sustained. A root cause analysis discussed in QAPI determined the cause was due to the residents involved in the altercation were not compatible roommates. The facility alleged a compliance dated of 5/28/25. Validation of the corrective action plan was completed on 6/5/25. This included staff interviews regarding the incident and in-service training that was received to ensure understanding and knowledge of the training provided. Inservice training records were verified and included staff signatures. The initial audits including the weekly audits were verified. The minutes from the QAPI meeting held on 5/26/25 were reviewed. There were no concerns identified. The compliance date of 5/28/25 was validated.	F 600		
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.	F 849		6/7/25

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(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 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

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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 the LTC facility.
(J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual,

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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 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

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F 849	Continued From page 20 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 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 hospice staff and facility staff interviews, the facility failed to coordinate a plan of care with the Hospice provider and ensure required Hospice documentation was in the medical record for 1 of 1 resident (Resident #5) reviewed for Hospice	F 849	Social Service/ Designee obtained hospice records for Resident #1 and placed a hard copy document at the nursing station 6/5/25. The Social Service Director reviewed all	

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F 849	Continued From page 21 care. The findings included: Resident #5 was admitted to the facility on 08/23/23 with medical diagnoses which included Alzheimer's disease and end stage dementia. Resident #5's care plan dated 11/06/24 included the Hospice start date of 04/19/24 due to end stage diagnosis of dementia, and to provide activities for daily living (ADL) support, companionship and other interventions as desired by the resident, to promote comfort. An Election of Hospice Benefit form dated 02/13/25 for Resident #5 was the most current Hospice form noted in the resident's electronic medical record. The 04/18/25 annual Minimum Data Set (MDS) assessment revealed Resident #5 had severe cognitive impairments and hospice care was coded. Review of Resident #54's electronic medical record on 06/04/25 at 11:00 AM revealed no: Hospice orders, signed election form, Hospice plan of care, Hospice physician orders, Hospice physician notes, Hospice medication list, or Hospice nursing notes. An interview was conducted with the Director of Nursing (DON) on 06/04/25 at 5:30 PM. She confirmed that Residents #5 elected the Hospice benefit on 04/19/24 and that the Hospice benefit services were ongoing. The DON stated that the facility care plan should contain information regarding Hospice's plan of care and	F 849	residents receiving hospice services to ensure documentation was in place by 6/5/25. Administrator provided Education to Social Services Director on 6/5/2025 regarding ensuring the need for continual communication between the facility and hospice services and documentation that needs to be in the medical record from the hospice provider. This was completed on 6/5/2025. Beginning 6/6/25 the Social Services Director will audit 5 residents receiving hospice services twice weekly for eight weeks, and then weekly for four weeks to ensure hospice communication and coordination of services and documentation is in the medical record. The Director of Nursing Services and/or designee will review the results of these audits in the Quality Assurance Performance Improvement Committee for one quarter to ensure substantial compliance has been achieved and sustained. Subsequent plans of correction will be implemented as necessary. The center held a Quality Assurance Performance Improvement meeting on 6/5/2025. The Director of Nursing Services and/or designee will review the results of these audits in the Quality Assurance Performance Improvement Committee for one quarter to ensure substantial compliance has been achieved and	

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F 849	Continued From page 22 interventions provided for Resident #5. She revealed it 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 Resident #5. 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 plan of care. She said after they received a resident's complete Hospice admission documentation, including a Hospice care plan, the nurse should collaborate with the Hospice nurse to develop a facility care plan. The care plan should be developed and entered into the resident's electronic medical record no more than a few days after receiving the Hospice documentation and plan of care, which Hospice and facility staff failed to do. The DON stated she also looked in the resident's electronic medical records and observed that there was no Hospice documentation downloaded into the chart since 02/13/25. She stated that there should have been, especially when Hospice patients generally only have 6 months to live so not having Hospice documentation for three and a half months is too long not to have an updated care plan or communication between Hospice and the facility staff. An interview was conducted with Hospice Nursing Aide (NA) #3 on 06/05/25 at 8:07 AM. She stated that she kept most of Resident #5's Hospice assessments and notes on her computer tablets. She indicated they should have been scanned to the facility by her Hospice agency. An interview was conducted with the Hospice NA #1 on 06/05/25 at 2:07 PM. She stated that she kept Resident #5's Hospice notes in her computer	F 849	sustained. Subsequent plans of correction will be implemented as necessary. Compliance Date: 6/7/25	

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tablets, which should be sent to the facility by her office at least monthly. Hospice NA #1 stated she was not aware that Resident #5's Hospice documentation and notes were not added to the facility's care plans by the facility's nurses. She said the Hospice office personnel should have provided their documentation timely so the facility could update their documentation and care plan, ensuring all staff were all on the same page regarding the resident's plan of care. She said she visited Resident #5 five days per week, gave baths and showers and knew Resident #5 very well.

An interview was conducted on 06/05/25 at 8:40 AM with Nurse #3. She said Hospice NA #1 or Hospice Nurse #1 would stop by the nursing station after every visit with one of their residents and have her sign their tablets. She said they never gave her a resident report and she did not ask for one, they just had her sign their tablets and left. Nurse #3 stated that the Hospice nurse should always give at least a verbal report to one of the facility nurses before they left the building. Nurse #3 said Hospice staff only charted in their tablets, never in the facility's electronic record.

An interview was conducted on 06/05/25 at 11:00 AM with Hospice Nurse #1. She said Hospice NA #1 was taking care of Resident #5 earlier that morning (6/5/25). The Hospice Nurse said she and the Hospice NA kept Resident #5's notes and communications on their computer tablets. She said before she or the Hospice NA left the facility, they would get one of the staff members to sign off on their tablets. She said she last visited Resident #5 on Monday (06/02/25) but could not remember who signed off on her tablet. Hospice Nurse #1 said Hospice documentation and

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communication documents were supposed to be faxed to the facility by their clinical manager monthly. When she reviewed Resident #5's facility electronic medical record she observed that there were no current Hospice orders, signed election form, Hospice plan of care, Hospice physician orders, Hospice physician notes, Hospice medication list, or Hospice nursing notes. She verified the last Hospice visit documentation in the facility's electronic medical record was dated 02/13/25. When the nurse observed that there was no collaborated Hospice/facility care plan in the facility's medical record and that there was no Hospice documentation sent to the facility since 02/13/25, she said she did not realize it had been over 3 and 1/2 months since any Hospice documentation had been sent to the facility.

An interview was conducted with the Administrator on 06/05/25 at 12:51 PM. She said it was her expectation that the nurses incorporate Hospice documentation and the Hospice care plan into their care plan, and for Hospice to provide the resident's Hospice records timely so their physician, MDS and nursing staff could review and update resident's plan of care.

An interview was conducted with the Administrator and Director of Nursing (DON) on 06/05/25 at 1:00 PM. The DON and Administrator revealed that there was not a process in place to monitor and update Hospice documentation and residents' plan of care between Hospice and the facility to ensure Hospice information was included in the facility's care plan for Resident #5. They indicated a plan would be put in place moving forward.