STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	694020	A. BUILDING _____ B. WING _____	1/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDILODGE OF GAYLORD	508 RANDOM LANE GAYLORD, MI 49735

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F0000 SS=	INITIAL COMMENTS Medilodge of Gaylord was surveyed for a Recertification survey on 1/10/2024. Intakes: MI00139565 & MI00139931 Census: 77	F0000		
F0623 SS= E	Notice Requirements Before Transfer/Discharge §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under	F0623	ELEMENT #1 Written notification of the Transfer and Discharge Policy has been provided to residents/legal representatives for R10, R36, R41, and R65. Residents were assessed and experienced no negative effects. Resident R39 discharged from the facility. There was no Resident R11 in the sample list. ELEMENT #2 Any residents who are transferred to the hospital have the potential to be effected by this. Any transferred residents or their legal representatives will receive a written notification of their transfer with the reason, date, and location of transfer. ELEMENT #3 The DON/Designee will provide education to all staff on the Transfer and Discharge Policyfor any residents who transfer to an acute care setting. DON/NHA reviewed the Transfer and	2/19/2024

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

Electronically Signed | 02/02/2024

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	paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility		Discharge Policy and deemed it appropriate. The Business Office Manager/Designee will review daily Monday through Friday in Morning Meeting to ensure all Transfer Notifications have been completed. ELEMENT #4 The IDT will complete weekly audits to ensure written notification for 4 weeks or until substantial compliance is achieved. Business Office Manager will report the audit results to the QAPI Committee monthly until substantial compliance is achieved and maintained. The NHA is responsible for compliance.	

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	must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide written transfer notifications to the resident and/or resident's representatives including reason, effective dates, and the location to which the resident was being transferred for six Residents (R10, R11, R36, R39, R41, R65) of six residents reviewed for transfers out of the facility. This deficient practice resulted in the potential for residents and/or resident's representatives to be uninformed, as well as a potential for inappropriate discharge/transfers. Findings include: Resident #36 (R36) The medical record for R36 revealed a transfer to the hospital on 10/13/23 and again on 12/30/23. The medical record did not indicate a written notification of transfer was given to R36 or sent to her			

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	representative. Resident #39 (R39) The medical record for R39 revealed a transfer to the hospital on 10/29/23 and a return on 11/9/23. The medical record did not indicate a written notification of transfer was given to R39 or sent to her representative. Resident #41 (R41) During an interview on 1/8/24 at 3:53 PM, R41 stated she had been out to the hospital, but she was not sure when she had gone and did not have any records of the transfer. The medical record for R41 revealed two hospital transfers, first on 9/7/23 with a return on 9/9/23 and again on 9/25/23 with a return to the facility 9/29/23. The medical record did not indicate a written notification of transfer was given to R41 or sent to her representative for either of these transfers. **Resident #10 (R10)** **The medical record for R10 revealed a transfer to the hospital on 12/30/23. The medical record did not indicate a written notification of transfer was provided to R10 or provided to the resident representative.** **Resident #65 (R65)** **The medical record for R65 revealed**			

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	transfers to the hospital on 12/19/23 and 1/7/24. The medical record did not indicate a written notification of transfer was provided to R65 or provided to the resident representative for either date. Resident #21 (R21) The medical record for R21 revealed a transfer to the hospital on 9/25/23 with a return on 10/4/23. The medical record did not indicate a written notification of transfer was provided to R65 or sent to the resident representative. During an interview with the NHA on 1/10/24 at 9:05 a.m., the NHA said she did not have documentation of issuance of written notifications of transfer for facility-initiated resident transfers to the hospital. The NHA confirmed the facility did not have the required written notification information. On 1/10/24 at 10:05 a.m., the DON conveyed there were no written notifications of transfers provided when residents were transferred from the facility to the hospital. The DON stated "that's something we will be working on." The DON stated it was a system the facility had audited and was "a gap we are working on". The facility policy titled: "Transfer and Discharge" dated as reviewed 10/30/23 read in part: " ... j. Provide transfer notice as soon as possible to resident and representative."			
F0625 SS= E	Notice of Bed Hold Policy Before/Upon Trnsfr §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident	F0625	ELEMENT #1 Written notification of the Bed Hold Policy has been provided to residents/legal	2/19/2024

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	to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure six residents (R10, R11, R36, R39, R41, R65) of six residents reviewed for hospital discharges, were provided written notification of the bed hold policy upon transfer. This deficient practice resulted in the potential for the residents and/or their responsible parties to be uniformed of the bed hold policy and their rights following a transfer to the hospital. Findings include: Resident #36 (R36)		representatives for R10, R11, R36, R41, and R65. Residents were assessed and experienced no negative effects. Resident R39 was discharged from the facility. There was no Resident R11 in the sample list. ELEMENT #2 Any residents who are transferred to the hospital have the potential to be effected by this. Any transferred residents or their legal representative will receive a written notification of the Bed Hold Policy. ELEMENT #3 The DON/Designee will provide education to all staff on the Bed Hold Policy process for any residents who transfer to an acute care setting. DON/NHA reviewed the Bed Hold Policy and deemed it appropriate. The Business Office Manager/Designee will review daily Monday through Friday in Morning Meeting to ensure all Bed Hold Policies have been completed. ELEMENT #4 The IDT will complete weekly audits to ensure written notification for 4 weeks or until substantial compliance is achieved.	

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	The medical record for R36 revealed a transfer to the hospital on 10/13/23 and again on 12/30/23. The medical record did not indicate the bed hold policy was provided to R36 or her representative. Resident #39 (R39) The medical record for R39 revealed a transfer to the hospital on 10/29/23 and a return on 11/9/23. The medical record did not indicate the bed hold policy was provided to R39 or her representative. Resident #41 (R41) During an interview on 1/8/24 at 3:53 PM, R41 stated she had been out to the hospital. The medical record for R41 revealed two hospital transfers, first on 9/7/23 with a return on 9/9/23 and again on 9/25/23 with a return to the facility 9/29/23. The medical record did not indicate the bed hold policy was provided to R41 or her representative for either of these transfers. **Resident #10 (R10)** **The medical record for R10 revealed a transfer to the hospital on 12/30/23. The medical record did not indicate the facility bed hold policy was provided to R10 or provided to the resident representative.** **Resident #65 (R65)**		Business Office Manager will report the audit results to the QAPI Committee monthly until substantial compliance is achieved and maintained. The NHA is responsible for compliance.	

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	The medical record for R65 revealed transfers to the hospital on 12/19/23 and 1/7/24. The medical record did not indicate the facility bed hold policy was provided to R65 or provided to the resident representative for either date. Resident #21 (R21) The medical record for R21 revealed a transfer to the hospital on 9/25/23 with a return on 10/4/23. The medical record did not indicate the facility bed hold policy was provided to R65 or sent to the resident representative. During a discussion with the NHA on 1/10/24 at 9:05 a.m., the NHA stated she did not have documentation of issuance of the facility bed hold policy when residents were transferred from the facility. The NHA confirmed the facility did not have the bed hold notification information. During an interview on 1/10/24 at 12:09 PM, the Director of Nursing (DON) acknowledged the bed hold policy was not always included in the transfer process. The DON stated she would review the medical records for this documentation, but after review was unable to provide proof of bed hold documentation for these residents who had been transferred to the hospital. The facility policy titled: "Bed Hold Prior to Transfer" dated as reviewed 2/2/22 read in part: "Policy: It is the policy of this facility to provide written information to the resident and/or the resident representative regarding bed hold policies prior to transferring a resident to the hospital ... 1. The facility will have a process in place to ensure residents			

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	and/or their representatives are made aware of the facility's bed-hold and reserve bed payment policy well in advance of being transferred to the hospital ..."			
F0686 SS= D	Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: **Based on observation, interview, and record review, the facility failed to complete treatments as ordered by the physician, adhere to physician's orders for frequency of dressing changes, and maintain infection control practices to promote the healing of pressure injuries for one Resident (#65) of two residents reviewed for pressure injuries. This deficient practice had the potential to result in infections, worsening of existing pressure injuries, and the development of additional wounds. Findings include:** **Resident #65 (R65) was admitted to the facility on 11/8/2023 with diagnoses that included but were not limited to: urinary tract**	F0686	ELEMENT #1 Resident R65 was evaluated (pressure injuries are improving) and Plan of Care was reviewed and deemed appropriate. No negative outcomes related to this practice were identified. ELEMENT #2 All residents with a pressure ulcer have the potential to be effected. Residents with holes in the TAR were reviewed to ensure their wounds were properly cared for, appropriate treatments were in place, and documentation reflected why treatment was not completed. Any identified concerns were addressed immediately. ELEMENT #3 Pressure Injury Prevention and Management Policy was reviewed and deemed appropriate by DON/NHA. All licensed nurses were re-educated on the skin program and utilizing infection control practices during dressing changes. All licensed nurses were re-educated on treatment documentation.	2/19/2024

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	infection (UTI), muscle weakness, need for assistance with personal care, lack of coordination, convulsions, unspecified lack of expected normal physiological development in childhood, subarachnoid hemorrhage (bleeding in the brain), and cerebral palsy[. An admission Minimum Data Set (MDS) assessment dated 11/12/23 coded R65 as completely dependent on staff for Activities of Daily living (ADL) or coded "88" indicating the activity could not be attempted due to R65's medical condition and the safety of the resident. An ADL care plan documented, "Resident has an ADL self-care performance deficit related to Cerebral Palsy, confined to a chair all or most time, incontinent of bladder, incontinent of bowel, traumatic subarachnoid hemorrhage, subluxation of C1 -C2 vertebrae, tracheostomy, traumatic compression with herniation, convulsions, tube feeding." The MDS of 11/12/23 identified R65 with pressure injuries that included: one stage 2 (Partial-thickness loss of skin with exposed dermis, presenting as a shallow open ulcer) pressure injury, three stage 3 (Full-thickness loss of skin) pressure injuries, two stage 4 (Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer) pressure injuries, and 3 unstageable (full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because the wound bed is obscured) pressure injuries. On 1/10/24 at 11:19 a.m., Licensed Practical Nurse (LPN) "A" was observed completing treatments and dressing changes on the pressure injuries located on R65's right		ELEMENT #4 A pressure ulcer audit will be conducted 3 times a week for 4 weeks or until substantial compliance is achieved as determined by the QAPI Committee. DON will report the audit results to the QAPI committee monthly until substantial compliance is achieved and maintainted. The DON/Designee will be responsible for ensuring compliance is maintained.	

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	trochanter (hip bone) and right lateral malleolus (outer ankle). When preparing the supplies, LPN "A" placed the treatment and dressing supplies in a clear plastic bag then picked up a box of gloves and a canister of purple-topped sanitizing wipes. LPN "A" held the box of gloves and sanitizing wipes against her uniform to transport them into R65's room. LPN "A" placed the box of gloves and canister of sanitizing wipes on R65's un-sanitized bedside table and placed the bag of dressing supplies on top of R65's legs. LPN "A" announced R65's urinary catheter drainage bag was filled with urine and needed to be emptied before completing the treatments and dressing changes. LPN "A" emptied the content of the urinary drainage bag then removed the drainage bag from the side of the bed and placed it on top of the bag of treatment and dressing supplies that were on R65's legs. LPN "A" exposed R65's right side to reveal dressings on the right trochanter and right lateral malleolus that were dated 1/8/2024. LPN "A" said the dressings to the right trochanter and right lateral malleolus were ordered to be changed daily. LPN "A" then proceeded to complete the wound care. R65's physicians orders for wound care were reviewed. The treatment order for R65's right trochanter was "cleanse wound with wound cleanser and pat dry. Apply [name brand ointment] to non-blanchable skin (skin that does not turn white when pressed) and cover with a silicone dressing. Change daily and PRN (as needed)." The treatment order for R65's right lateral malleolus was "Cleanse area with wound cleanser and pat dry. Apply [name brand ointment] to area and cover with a silicone dressing every day shift."			

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	A review of R65's January 2024 Treatment Administration Record (TAR) revealed holes (not signed as completed) in the treatment record for R65's right trochanter and right medial malleolus. The treatments on the TAR had not been initialed as completed for 2 of the 10 days in January. There were holes on the TAR for 1/5/24 and 1/9/24. TAR notations did not indicate the reason the treatments were not completed on these dates. Progress notes for 1/5/24 and 1/9/24 were reviewed for R65. There was no documentation regarding the reason treatments were not completed on 1/5/24 and 1/9/24. A progress note dated 1/9/24 at 11:17 a.m. was entered into the medical record by R65's physician and documented the physician visited R65 due to a recent visit to the emergency room and UTI. The physician did not enter any documentation indicating he was aware the treatments for R65's right trochanter and right medial malleolus were not completed as ordered on 1/5/24 and 1/9/24. A care plan for R65's risk for impaired skin integrity contained an intervention that read "Preventative treatment(s) per orders." The facility policy "Clean Dressing Change" dated 12/28/23 read in part "It is the policy of this facility to provide wound care in a manner to decrease potential for infection and/or cross-contamination. Physician's orders will specify type of dressing and frequency of changes." The holes in the TAR and the observations made during the treatment and dressing changes by LPN "A" were conveyed to the Director of Nursing (DON) on 1/10/24 at 2:25			

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	p.m. The DON stated, "A lot went wrong with that. We'll be working on that." The DON acknowledged concerns with breaches of infection control with the treatment and dressing change procedure and confirmed the treatment and dressing on R65's right trochanter and right lateral malleolus were to be completed daily.			
F0690 SS= D	Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.	F0690	ELEMENT #1 Resident R65 catheter was placed back in appropriate placement below the bladder and LPN was educated on aseptic techniques when emptying urine bag and placement. Resident R65 was assessed and there were no negative outcomes. ELEMENT #2 Residents with urinary catheters have the potential to be effected. A full house audit of all residents with urinary catheters was completed to ensure all Care Plans and interventions are in place. Any identified concerns were addressed immediately. ELEMENT #3 DON/Designee will provide re-education to nurses and CNAs regarding the appropriate placement of indwelling catheters and aseptic emptying techniques. DON/NHA reviewed Catheter Care Procedure- Urinary Policy and deemed it	2/19/2024

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	This REQUIREMENT is not met as evidenced by: **Based on observation, interview, and record review, the facility failed to ensure a urinary drainage system was maintained in an aseptic manner for one Resident (#65) of 3 residents reviewed for catheters. This deficient practice resulted in the potential spread of infectious organisms, and the potential for R#65 to experience worsening of an existing urinary tract infection.** **Resident #65 (R65) was admitted to the facility on 11/8/2023 with diagnoses that included but were not limited to: urinary tract infection (UTI), muscle weakness, need for assistance with personal care, lack of coordination, convulsions, unspecified lack of expected normal physiological development in childhood, subarachnoid hemorrhage (bleeding in the brain), and cerebral palsy.** **An admission Minimum Data Set (MDS) assessment dated 11/12/2023 coded R65 as completely dependent on staff for Activities of Daily living (ADL) or coded "88" meaning the activity could not be attempted due to R65's medical condition and the safety of the resident. The MDS Section H coded R65 as having a urinary catheter.** **A physician's order dated 12/4/23 documented, "Keep Foley catheter in place r/t (related to) stage 4 (Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone) pressure injury to sacrum."** **On 1/10/24 at 11:19 a.m., Licensed Practical Nurse (LPN) "A" was observed completing**		appropriate. Review of new admissions and 24 hour reports to identify any new catheters in use to ensure Care Plans and interventions are in place and appropriate. ELEMENT #4 DON/Designee will condut audits of 5 residents 3 times per week for 4 weeks or until substantial compliance is achieved as determined by the QAPI Committee. DON will report the audit results to the QAPI Committee Meeting monthly until substantial compliance is achieved and maintained. The DON/Designee will be responsible for ensuring compliance is maintained.	

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	dressing changes to 2 areas of pressure injury on R65. Upon entering R65's room, LPN "A" placed a plastic bag containing dressing supplies on top of R65's legs. LPN "A" announced R65's urinary catheter drainage bag was filled with urine and needed to be emptied before completing the dressing changes. There was cloudy, amber-colored urine with sediment (particles or mucus made up of crystals, bacteria, or blood that are shed from the urinary tract) in the catheter drainage tubing. LPN "A" obtained a urinal and emptied the urine from the drainage bag by unclamping the drainage hose from the drainage bag and placing the drainage spigot directly against the inside rim of the urinal without sanitizing the drainage spigot. LPN "A" placed the urinal containing the drained urine directly on the floor next to the drainage bag to reconnect the drainage hose. There was no barrier on the floor when LPN "A" placed the urinal filled with urine on the floor. After emptying the urine from the drainage bag, LPN "A" removed the catheter drainage bag from the side of the bed and placed it on top of the bag of dressing supplies on R65's legs resulting in the drainage bag and drainage tubing being above the level of R65's bladder. The catheter drainage bag and tubing remained atop R65, above the level of the bladder, throughout the completion of dressing changes to the pressure injuries. A care plan for R65's indwelling catheter contained an intervention to "Maintain drainage bag below the bladder level." The intervention was documented as initiated on 11/15/23. A form "Pertinent Charting Initial - Infections/Signs Symptoms - V 2" dated			

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	1/10/24 documented R65 developed signs and symptoms of a UTI on 1/8/24 and a urinalysis was obtained. The urinalysis was positive for UTI and R65's physician prescribed an injectable antibiotic to be administered daily starting 1/9/2024. A review of the physician's orders reflected R65 was prescribed ceftriaxone with an order to inject 1 gram intramuscularly at bedtime for UTI for 6 Days. The facility policy "Catheter Care Procedure - Urinary" dated 12/28/2023 stated in part "Policy: it is the policy of this facility to provide catheter care to all residents that have an indwelling catheter in an effort to reduce bladder and kidney infections. . . (4) Catheters should be maintained to provide gravity drainage . . ." According to the Centers for Disease Control (CDC) recommendations for proper techniques for urinary catheter maintenance to prevent catheter-associated urinary tract infections (CAUTI) (CAUTI Guidelines | Guidelines Library | Infection Control | CDC) Recommendation #III.B.2. read in part: "Keep the collecting bag [drainage bag] below the level of the bladder at all times." Recommendation #III.B.3. stated in part: "prevent contact of the drainage spigot with the nonsterile collecting container." The observations made during the treatment and dressing changes, including the catheter care and maintenance observations, were conveyed to the Director of Nursing (DON) on 1/10/24 at 2:25 p.m. The DON stated, "A lot went wrong with that. We'll be working on that." The DON acknowledged breaches of infection control practices that could cause			

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	worsening of infections and agreed that catheter drainage bags were to be maintained below the level of the bladder.			
F0756 SS= D	Drug Regimen Review, Report Irregular, Act On §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as	F0756	ELEMENT #1 Pharmacy recommendations for R50 and R55 have been addressed with rationale included in the medical record. Residents were assessed and experienced no negative outcomes. ELEMENT #2 All residents have the potential to be effected by this. January pharmacy recommendations were reviewed by DON to ensure rationale was addressed and there was timely follow up. ELEMENT #3 The DON/Designee will provide education to Clinical IDT and providers regarding rationale and timely response to pharmacy recommendations. DON/NHA reviewed the Use of Psychotropic Drugs and Gradual Dose Reductions Policy and deemed it appropriate. Monthly pharmacy recommendations will be reviewed with prescriber and DON for timely follow up. DON to ensure rationale is completed by prescriber. ELEMENT #4	2/19/2024

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	evidenced by: Based on interview and record review the facility failed to ensure pharmacist irregularities reported in the monthly medication review were addressed timely in the medical record by the physician for two Residents (R50 & R55) of five residents reviewed for drug regimen reviews. This deficient practice resulted in the potential for unnecessary medications, drug interactions and undesirable medication side effects. Findings include: Resident R50 Review of pharmacy "Note to Attending Physician/Prescriber" revealed the following pharmacist recommendations: 8/13/2023 - "This Resident (R50) currently has an order for lorazepam (anti-anxiety medication) PRN (as needed). Please evaluate current diagnosis, behaviors and usage patterns and evaluate continued need. PRN psychotropic orders cannot exceed 14 days with the exception that the prescriber documents their rationale in the residents medical record and indicate the duration for the PRN order ... Please consider ...If PRN lorazepam is to be continued, please write a new PRN order and include the duration and rationale for continued use." The physician did not check the "Agree", "Disagree", or "Other" box on the form, and notated only "in chart" for the provision of rationale for the physician response. 12/4/2023 - "This resident (R50) currently has an order for lorazepam PRN (as needed). Please evaluate current diagnosis, behaviors and usage patterns and evaluate continued need. PRN psychotropic orders cannot exceed 14 days with the exception that the prescriber documents their rationale in the residents medical record and		The Clinical IDT will complete monthly audits of pharmacy recommendations and provider responses for 4 months or until substantial compliance is achieved. IDT Designee will report the audit results to the QAPI Committee monthly until substantial compliance is achieved and maintained. The DON is responsible for compliance.	

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	indicate the duration for the PRN order ... Please consider ...If PRN lorazepam is to be continued, please write a new PRN order and include the duration and rationale for continued use. Physician signed 12/5/23 and stated, 'Pt req. approximately every other day with dementia with agitation x 30 days, 5 mg mornings'." This PRN order was written for 30 days, not the 14 as specified in the recommendation from the pharmacist with no rationale for the duration of the PRN order present. 5/2/23 - "Resident (R50) has an order for cetirizine (allergy medication)10 mg daily, that can cause agitation and confusion. Consider tapering cetirizine to 5 mg daily. Monitor behaviors." Signed by physician on 5/4/23 - with no notation if he agreed, disagreed, or other. 7/5/23 - "This Resident (R50) is diagnosed with dementia and receiving the antipsychotic risperidone 1 mg (milligrams) in the morning and 3 mg at bedtime. Depakote (antidepressant medication) was recently started for mood lability. Consider tapering risperidone to 1 mg in the morning and 2 mg at bedtime. If risperidone is to be continued, please indicate the appropriate clinical situation to support the continued use of this medication. Behavioral symptoms present a danger to the resident or to others, AND one or both of the following..." Physician Signed 7/27/23 with no agreement, disagreement, or other box marked on the form and no rationale for continued use provided. Review of R50's Physician Orders revealed the following, in part: "Order Ativan (Lorazepam) Oral Tablet 0.5 mg (Lorazepam) Directions: Give 1 tablet by mouth every 6 hours as needed for anxiety/agitation related to Unspecified dementia, unspecified severity, with other behavioral disturbance for 6 months. Start Date 1/3/2024,			

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	End Date 7/3/24, Revision Date 1/3/24. No rationale of the extension beyond 14 days was found in the complete medical record. During an interview on 1/10/24 at 1:58 p.m., the Director of Nursing (DON) confirmed the facility had used her PRN medications quite often because of behaviors. When the DON was asked where the documented rationale was located within R50's Electronic Medical Record (EMR) the DON stated, "It (rationale for a 6 month PRN psychotropic medication) is probably not here." The DON reviewed R50's EMR and was unable to produce physician rationale for the 6 month PRN psychotropic medication. Resident R55 Review of R55's pharmacist "Note to Attending Physician/Prescriber" Medication Regimen Review Recommendations to change from a typical antipsychotic to a newer atypical antipsychotic beginning 2/2/23 with no change initiated until after the third recommendation from the pharmacist on 9/5/23, included the following, in part: 2/2/23: "Resident (R55) has an order for haloperidol (typical antipsychotic) with a diagnosis of paranoid Schizophrenia, GAD (Generalized Anxiety Disorder) and MDD (Major Depression Disorder). This medication has a higher side effect profile than the newer atypical antipsychotic medications. Consider a cross titration to an atypical antipsychotic, perhaps olanzapine." Physician Response: "Already given orders, signed 3/9/23. No agree, disagree or other signed. No rationale was provided. 3/2/23: "... Recommendation: Resident (R55) has an order for haloperidol (typical antipsychotic) with diagnosis of paranoid Schizophrenia, GAD,			

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	and MDD. This medication has a higher side effect profile than the newer atypical (not usual) antipsychotic medications. Consider a cross titration to an atypical antipsychotic, perhaps olanzapine." Routed to Physician - NO was written by physician. Written included: "Pt under care of psych, psych has control of those meds." Doctor signed with no date. 9/5/23: "Resident (R55) has an order for haloperidol (typical antipsychotic) with a diagnosis of paranoid Schizophrenia, GAD, and MDD. This medication has a higher side effect profile than the newer atypical antipsychotic medications. A recent AIMS score was 2. Consider a cross titration to an atypical antipsychotic, perhaps olanzapine 5 mg PO daily." Physician Response 9/8/23. "Decrease Haldol to 0.5 BID and start olanzapine 2.5 mg QD (daily). QD for 1 wk. Then d/c (discontinue) Haldol and increase olanzapine to 5 mg QD. and BCS/Psych consult. Report any ill effect and review with provider 2 wks (weeks). " During an interview on 1/10/24 at 1:42 p.m. the DON acknowledged she had taken over the DON position three months ago and stated, "The pharmacy recs (recommendations) were one of the first things I identified as an issue. I wasn't able to find the follow up (from the physician) so [the pharmacist] and I went through all of the recommendations ... I would say that in the past it was not addressed timely." The DON agreed the physician should have provided rationale for psychotropic medications prescribed for a duration of greater than 14 days. The DON said she could not speak to what happened related to resident Gradual Dose Reductions (GDRs), and the DON acknowledged the facility was still in the investigation stage of determining resident GDR status. The DON agreed that it would be appropriate to say the GDR documentation was unavailable for review. The DON stated, "I don't			

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	know where they were keeping that information prior to my employment here."			
F0758 SS= D	Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.	F0758	ELEMENT #1 Residents' R50 and R55 prn and scheduled psychotropic medications were evaluated to ensure 14 day stop date was completed for prn medications and GDR or Risk vs. Benefit was initiated. Residents were assessed and experienced no negative outcomes. Resident R27 discharged home from the facility. ELEMENT #2 Any resident who are prescribed prn or scheduled psychotropic medications have the potential to be effected. A full house audit of residents who are prescribed prn psychotropic medications was completed to ensure 14 day stop dates or documented rationale with stop date if prn was extended. A full house audit of residents who are prescribed scheduled psychotropic medications has been completed to evaluate GDR schedlue or Risk vs. Benefit by provider has been completed. ELEMENT #3 The DON/Designee will provide education to Clinical IDT and providers regarding 14 day stop dates for new prn psychotropic medications.	2/19/2024

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	This REQUIREMENT is not met as evidenced by: **Based on interview and record review, the facility failed to adhere to 14-day PRN psychotropic and antipsychotic prescription durations and ensure gradual dose reductions were attempted, unless contraindicated, for three Residents (R50, R55, and R27) of five residents reviewed for unnecessary medications. This deficient practice resulted in the potential for the administration of unnecessary medications and risk of medication adverse side effects. Findings include:** **Resident R50** **Review of pharmacy "Note to Attending Physician/Prescriber" revealed the following pharmacist recommendations:** **8/13/2023 - "This Resident (R50) currently has an order for lorazepam PRN (as needed). Please evaluate current diagnosis, behaviors and usage patterns and evaluate continued need. PRN psychotropic orders cannot exceed 14 days with the exception that the prescriber documents their rationale in the residents medical record and indicate the duration for the PRN order ... Please consider ...If PRN lorazepam is to be continued, please write a new PRN order and include the duration and rationale for continued use." The physician did not check the "Agree", "Disagree", or "Other" box on the form, and notated only "in chart" for the provision of rationale for the physician response.** **12/4/2023 - "This resident (R50) currently**		NHA/DON reviewed the Use of Psychotropic Drugs and Gradual Dose Reductions Policy and deemed it appropriate. New psychotropic medications will be reviewed Monday-Friday in monring clinical meetings to ensure stop dates, GDR or Risk/Benefits, and/or rationales are completed and reviewed. ELEMENT #4 The Clinical IDT will complete 5 random weekly audits to ensure 14 day stop dates are added for prn psychotropic medications, rationale with extended stop date if applicable, and GDR or Risk vs. Benefit of scheduled psychotropic medications are completed for 4 weeks or until substantial compliance is achieved. DON will report the audit results to the QAPI Committee monthly until substantial compliance is achieved and maintained. The DON is responsible for compliance.	

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	has an order for lorazepam PRN (as needed). Please evaluate current diagnosis, behaviors and usage patterns and evaluate continued need. PRN psychotropic orders cannot exceed 14 days with the exception that the prescriber documents their rationale in the residents medical record and indicate the duration for the PRN order ... Please consider ...If PRN lorazepam is to be continued, please write a new PRN order and include the duration and rationale for continued use. Physician signed 12/5/23 and stated, 'Pt req. (requests) approximately every other day with dementia with agitation x 30 days, 5 mg mornings'." This PRN order was written for 30 days, not the 14 as specified in the recommendation from the pharmacist with no indication for the duration of the PRN order present. Review of R50's Physician Orders revealed the following, in part: "Order Ativan (Lorazepam) Oral Tablet 0.5 mg (Lorazepam) Directions: Give 1 tablet by mouth every 6 hours as needed for anxiety/agitation related to Unspecified dementia, unspecified severity, with other behavioral disturbance for 6 months. Start Date 1/3/2024, End Date 7/3/24, Revision Date 1/3/24. No rationale of the extension beyond 14 days was found in the complete medical record. During an interview on 1/10/24 at 1:58 p.m., the Director of Nursing (DON) confirmed the facility had used R50's PRN medications quite often because of behaviors. When the DON was asked where the documented rationale for an extended duration (greater than 14 days) was located within R50's Electronic Medical Record (EMR) the DON stated, "It (rationale for a 6 month PRN			

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	psychotropic medication) is probably not here." The DON reviewed R50's EMR and was unable to produce physician rationale for the 6 month PRN psychotropic medication. Resident R55 Review of R55's pharmacist "Note to Attending Physician/Prescriber" Medication Regimen Review Recommendations to change from a typical antipsychotic to a newer atypical antipsychotic beginning 2/2/23 with no change initiated until after the third recommendation from the pharmacist on 9/5/23, included the following, in part: 2/2/23: "Resident (R55) has an order for haloperidol (typical antipsychotic) with a diagnosis of paranoid Schizophrenia, GAD (Generalized Anxiety Disorder) and MDD (Major Depression Disorder). This medication has a higher side effect profile than the newer atypical (unusual) antipsychotic medications. Consider a cross titration to an atypical antipsychotic, perhaps olanzapine." Physician Response: "Already given orders, signed 3/9/23. No agree, disagree or other signed. No rationale was provided. 3/2/23: "... Recommendation: Resident (R55) has an order for haloperidol (typical antipsychotic) with diagnosis of paranoid Schizophrenia, GAD, and MDD. This medication has a higher side effect profile than the newer atypical antipsychotic medications. Consider a cross titration to an atypical antipsychotic, perhaps olanzapine." Routed to Physician - NO was written by physician. Written included: "Pt under care of psych, psych has control of those meds." Doctor signed with no date.			

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	9/5/23: "Resident (R55) has an order for haloperidol (typical antipsychotic) with a diagnosis of paranoid Schizophrenia, GAD, and MDD. This medication has a higher side effect profile than the newer atypical antipsychotic medications. A recent AIMS score was 2. Consider a cross titration to an atypical antipsychotic, perhaps olanzapine 5 mg PO daily." Doctor addressed these three recommendations on 9/8/23. **During an interview on 1/10/24 at 1:42 p.m. the DON agreed the physician should have provided rationale for psychotropic medications prescribed for a duration of greater than 14 days. The DON said she could not speak to what happened related to resident Gradual Dose Reductions (GDRs), and the DON acknowledged they (facility) were still in the investigation stage of determining resident GDR status. The DON agreed that it would be appropriate to say the GDR documentation was unavailable for review. The DON stated, "I don't know where they were keeping that information prior to my employment here."** . Resident 27 (R27) Upon review of the medical record, R27 was admitted on 11/16/23 with diagnoses including hypertension, persistent mood affective disorder, major depressive disorder, acute kidney failure and generalized anxiety disorder. The MDS assessment for R27 dated 11/20/23 revealed a BIMS score of 15 of 15 indicating R27 was cognitively intact. The current physician orders included: - "Bupropion HCl Oral Tablet Extended Release			

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	24 Hour 300 MG (milligrams) Give 1 tablet by mouth in the morning" related to major depressive disorder, and anxiety disorder. Start Date 12/08/23. - "Bupropion HCl 15 MG Give one tablet by mouth three times a day related to generalized anxiety disorder." Start Date 12/28/23. - "Sertraline HCl Tablet 50 MG Give 3 tablet (sic) by mouth in the morning for depression related to generalized anxiety disorder" Start Date 12/02/23. - "Trazodone HCl Oral Tablet 50 MG Give 50 mg by mouth at bedtime related to generalized anxiety disorder. Start Date 12/1/23. - "Alprazolam Oral Tablet 0.25 MG Give 1 tablet by mouth every 8 hours as needed for anxiety. Give ½ tab prn (as needed) q (every) 8 hours." Start Date 12/6/23. The medical record was reviewed and no consent or education on the risk/benefits for the psychotropic medications were found. On 1/10/24, the DON presented the pharmacist monthly medication review of R27's medications. The review dated 11/20/23 recommended the physician discontinue the PRN Alprazolam with the rationale that PRN orders for antipsychotic drugs are limited to 14 days . The physician signed that he agreed with the recommendation and discontinued the PRN medication. On 12/6/23 an order was written for "Alprazolam oral tablet 0.25 MG Give 1 tablet every 8 hours as needed for anxiety. Give ½ tab prn (as needed) q (every) 8 hours." A review of the medication administration record revealed Alprazolam had continued past the 14 days and as of 1/10/23 had been administered six times in the month of			

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	January. During this time the DON was asked about consents for the antipsychotic medications for R27. During an interview on 1/10/24 at 3:30 PM, the DON said the facility had been auditing the consent process for psychotropic medications and R27 was on her audit and did not have a signed consent in place. She stated: "The process was being looked at." The facility policy titled "Medication-Psychotropic" and dated as "Reviewed/Revised: 10/30/23" read in part: "5. Residents and/or representatives shall be educated on the risks and benefits of psychotropic drug use, as well as alternative treatments/non-pharmacological intervention ... 8.b. PRN orders for antipsychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication." .			
F0849 SS= D	Hospice Services §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	F0849	ELEMENT #1 The Hospice Provider for Resident R35 provided the facility with updated Care Plans and notes for Resident R35 and placed in hospice binder. Resident was assessed and experienced no negative effects. ELEMENT #2 Any residents who receive hospice services have the potential to be affected. A full house audit of all hospice residents was complete to ensure updated Care Plans and progress notes are in place.	2/19/2024

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	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 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)		ELEMENT #3 The DON/Designee will provide education on Coordination of Hospice Services to all staff. NHA/DON reviewed the Coordination of Hospice Services Policy and deemed it appropriate. Re-education was provided to hospice staff on expectations of providing a Care Plan on admission, updated Care Plans with any revisions, and quarterly Care Plans. Weekly notes and updated Care Plans will be audited by Social Services Director/Designee. ELEMENT #4 The Clinical IDT will complete 5 random weekly audits to ensure weekly progress notes and updated Care Plans are included in hospice binder and resident electronic medical records for 4 weeks or until substantial compliance is achieved. SSD will report the audit results to the QAPI Committee monthly until substantial compliance is achieved and maintained. The DON is responsible for compliance.	

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	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 interdisciplinary team member must have a clinical background, function within their			

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	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 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			

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	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 interview and record review, the facility failed to ensure the Hospice Plan of Care was retained in the facility for one Resident (R35) of one resident reviewed for Hospice care. This deficient practice resulted in the potential for lack of continuity of care when the facility was not updated on the care and services planned and provided to R35. Findings include: During an interview on 1/10/24 at 10:45 a.m., R35's Hospice Plan of Care was requested from the Director of Nursing. The DON reviewed the Electronic Medical Record (EMR) and confirmed a Hospice Plan of Care was not scanned into the EMR. The DON stated that the [specific Hospice Agency] was not quite as organized as some of the other Hospice agencies and that is why they did not use them as regularly. The DON said the Hospice agency would be contacted to send the Plan of Care to the facility so that it could be placed into the Resident's Hospice Binder. When asked if she understood that it would be a concern not to have the printed Hospice Plan of Care available for review by facility staff, the DON stated, "Yes I understand. I am still going to contact them and ask them to send the documentation so we have it in the file." The DON said she understood the deficiency concern and concurred with the Surveyor that the Plan of Care should have been available in the facility for			

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	staff review to be aware of the services, visits, and other programming that Hospice would be providing. Review of R35's EMR Hospice focus care plan, initiated 12/29/2024, provided by the facility on 1/10/24 at approximately 11:30 a.m., was not signed or initialed by the Hospice agency signifying acknowledgement and acceptance of the facility Hospice care plan by the Hospice agency when the Hospice Plan of Care was not maintained in the facility. Review of the "Hospice" policy revised 10/26/2023, revealed the following, in part: "1. The facility maintains written agreements with hospice providers that specify the care and services to be provided and the process for hospice and nursing home communication of necessary information regarding the resident's care. 2. The facility and hospice provider will coordinate a plan of care and will implement interventions in accordance with the resident's needs, goals, and recognized standards of practice in consultation with the Resident's attending physician/practitioner and resident's representative, to the extent possible. 3. The plan of care will identify the care and services that each entity will provide in order to meet the needs of the resident and his/her expressed desire for hospice care... 4. The facility will communicate with hospice and identify, communicate, follow and document all interventions put into place by hospice and the facility. 5. The facility will monitor and evaluate the			

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	resident's response to the hospice care plans. 6. The facility will maintain communication with hospice as it relates to the resident's plan of care and services to ensure each entity is aware of their responsibilities..."			