STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255126	A. BUILDING _____ B. WING _____	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILKINSON COUNTY SENIOR CARE	116 SOUTH LAFAYETTE STREET CENTREVILLE, MS 39631

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F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care	F 656		5/2/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/17/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 656	Continued From page 1 plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, staff and Resident Representative (RR) interview, record review, and facility policy review, the facility failed to ensure the comprehensive care plan was implemented for Activities of Daily Living (ADL) for one (1) of 16 sampled residents. (Resident #30) Findings include: Review of the facility's policy titled, "Care Plan-Comprehensive, "dated 10/2016 revealed, " Policy Statement: .An individualized (person centered) comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident ... 1. Our facility's Care Planning/Interdisciplinary Team, in coordination with the resident, his/her family or resident representative, develops and maintains a comprehensive care plan for each resident that identifies the highest level of functioning the resident may be expected to attain... 3. Each resident's comprehensive care plan is designed to ... d. Reflect the resident's expressed wishes regarding care and treatment goals..." A record review of the comprehensive Care Plan with a date initiated of 12/10/2019, revealed "FOCUS: The resident has an ADL Self-Care	F 656	A. The Minimum Data Set (MDS) Nurse reviewed resident #30 plan of care to include observation and trimming of resident #30 toenails. On 3/30/2024 Resident #30 toenails were trimmed by the podiatrist. B. All residents requiring assistance for Activities of Daily Living have the potential to be affected. C. The Director of Nursing (DON) on 3/29/2024 in-serviced the Minimum Data Set Nurse on reviewing and updating the plan of care to include observing and providing proper care as needed. The nursing staff was in-serviced on 3/29/2024 by the Director of Nursing on providing proper foot/nail care and following each individual resident's care of plan task to provide level of assistance needed by each resident. D. Beginning 3/29/2024 Activities of Daily Living care plans for all residents were reviewed by Minimum Data Set Nurse for accuracy. Beginning 4/1/2024 Director of Nursing will monitor nail/foot care is being completed according to the care plan	

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F 656	Continued From page 2 Performance Deficit...Interventions ... The resident requires total assistance with personal hygiene ..." During an interview with the RR for Resident #30, on 3/25/24 at 10:46 AM, she revealed the facility has failed to keep her brother's toenails cut. During an observation on 3/25/24 11:02 AM, of Resident #30's toenails revealed the resident's toenails were thick, yellow, and extended post of the end of his toes. During an interview on 3/27/24 at 10:24 AM, Licensed Practical Nurse (LPN) #5 confirmed Resident #30's toenails were "long and past due time for cutting." During an interview with Registered Nurse (RN) #1 on 3/28/24 at 12:32 PM, when discussing the Care Plan, RN #1 revealed the care plan is designed to provide information to staff on how care for residents. She confirmed that ADL care includes nail care. During an interview on 3/28/24 at 1:57 PM, the Director of Nursing (DON), confirmed the purpose of the care plan is to ensure residents' needs are met. She pointed out that ADL care included cutting of the toenails. She stated that if the care plan is not followed, it could result in additional needs of the resident.	F 656	through rounds four (4) times per week for four (4) weeks then monthly for three (3) months. Director of Nursing will report findings to the Quality Assurance Performance Committee beginning 5/1/2024 for review, revision or resolution of the plan for three (3) months.	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary	F 677		5/2/24

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F 677	Continued From page 3 services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, staff and Resident Representative (RR) interviews, record review, and facility policy review, the facility failed to ensure a dependent resident received Activities of Daily Living (ADL) care, as evidenced by long thick toenails for one (1) of 16 sampled residents. (Resident #30) Findings include: Review of the facility's policy titles, "ADL Care Policy," dated 8/23 revealed, " POLICY It is the policy of this facility to provide appropriate treatment and services in relation to ADL care to residents to ensure all ADL needs are met on a daily basis, while attaining or maintaining the residence of highest, practicable, physical, mental, and social well-being ... 2. The resident, to the extent possible, and /or the family/resident representative will be included in setting goals of care related to ADL's ... " On 3/25/24 at 10:46 AM, during an interview with the RR for Resident #30, she revealed she has concerned about the resident's toenails. She said the facility has failed to keep them cut. On 3/25/24 at 11:02 AM, in an observation and interview of Resident #30's toenails revealed his toenails were yellow, thick, and extended over the toes. When asked if he would like his toenails to be cut regularly, Resident #30 nodded yes. On 3/26/24 at 3:36 PM, an observation of Resident #30, revealed his toenails are still uncut	F 677	A. On 3/30/2024 resident #30's ADL needs were met as evidence by the podiatrist in facility visit trimming resident #30's toenails. The comprehensive Care Plan was implemented for ADL care to include podiatry visits every three (3) months and as needed (PRN) and being followed to reveal podiatrist visits every three (3) months and PRN. Resident's Representative was notified of resident #30's toenails being trimmed with documentation in resident #30's chart on 4/1/2024. B. All residents have the potential to be affected by this deficient practice. C. 4/1/2024 an in-service was conducted by the Director of Nursing with the nursing staff on completing a weekly body audit of each resident to include fingernail/toenail care. Fingernail/toenail care provided will be documented in the resident's body audit. The resident's physician and representative will be notified of any refusal of care and documented in the resident's chart. D. The nurse will review fingernail/toenail care for all residents while performing the resident's weekly body audit. The Director of Nursing or Assistant	

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F 677	Continued From page 4 and the appearance remains unchanged from the observation on 3/25/24.. On 3/27/24 at 10:24 AM, in an interview and observation, regarding the toenails of Resident #30, Licensed Practical Nurse (LPN) #5 indicated from what she knows, it is the role of the Registered Nurse (RN) to cut the toenails of the residents. During the observation, LPN #5 confirmed that the resident's toenails are "long and past due time for cutting." On 3/27/24 at 10:40 AM, in an interview with LPN #3 the Medical Records Nurse, she points out that both RNs and LPNs are responsible for cutting toenails, depending on the diagnoses of the resident. However, in the case of Resident #30, since he is not a diabetic, any nurse can cut his toenails. She stated that she usually notes on her spreadsheet if a resident refuses care when the Podiatrist comes. She points to the spreadsheet on her computer screen and indicated Resident # 30 has not refused nail care. She revealed the Podiatrist comes every three months but does not see every resident on each visit. She pointed out that the podiatrist last saw Resident #30 on 1/24/24 and she does not have any records of him ever refusing care. She added the podiatrist is scheduled to come Saturday (3-30-24), and Resident # 30 is on the list to be seen. On 3/27/24 at 11:03 AM, in an interview and observation of Resident # 30 toenails with the Director of Nurses (DON), she stated she cannot disagree that his toenails need to be cut but she does admit that staff has told her he refused to get his toenails cut.	F 677	Director of Nursing, beginning 4/1/2024 will conduct an audit of at least five (5) residents per week for three (3) months. The Director of Nursing will report findings to the Quality Assurance Performance Committee beginning 5/1/2024 for review, revision or resolution of the plan for three (3) months.	

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F 677	Continued From page 5	F 677		

A record review of a printed nurse's note provided by the DON, dated 3/27/24, and signed by LPN #6 indicated Resident #30 refused nail care today.

On 3/28/24 at 11:12 AM, in a second interview with the RR, she revealed she comes to see her brother every Tuesday and Saturday. She mentioned that on multiple of visits she had asked the staff to cut his toenails and they would respond by indicating it would be taken care of. However, each time she came, she noticed they were still not cut. She stated that when she had asked the staff if she could cut them. She stated she was told it is the facility's responsibility to cut his toenails, so she was not allowed to do so. The RR added that it had never been brought to her attention that her brother was refusing nail care.

On 3/28/24 at 12:32 PM, in an interview with RN#1, she revealed there have been times that the facility would send residents out to the podiatrist for toenail care when the need was identified. She added that this is done when the podiatrist scheduled in-house visit is still a few weeks away.

On 3/28/24 at 1:57 PM, in an interview with the DON, she described Resident #30's toenails as thick and 1/4 of an inch the past the end of his toe. She indicated it is the nurse's responsibility to cut residents toenails between podiatrist visits. She confirmed the facility does send residents out to the podiatrist if it is needed. She described this need as when staff is unable to cut the toenails.

A record review of the "Admission Record" for Resident #30 revealed the facility admitted the resident on 11/19/2019. His diagnoses included

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F 677	Continued From page 6 Hemiplegia and Hemiparesis following Cerebral Infarction and Thoracic, Thoracolumbar and Lumbosacral Interverbal Disc Disorder. A record review of the Quarterly Minimum Data Set (MDS), with Assessment Reference Date (ARD) of 3/5/24, revealed that Resident #30 had a Brief Interview for Mental Status (BIMS) score of 00, which indicated that the resident had severe cognitive impairment. Further review of the MDS revealed the resident id dependent for personal hygiene, A record review of the "Order Summary Report," with active orders as of 3/28/24 revealed a physician order dated 4/5/23 ... "May have Podiatry ...Consult PRN (as needed)."	F 677		
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight.	F 700		5/2/24

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F 700	Continued From page 7 §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on interviews, record review, and facility policy review, the facility failed to inform a resident or Resident Representative (RR) of the risks and benefits of the use of bed rails prior to bed rail installation for one (1) of 16 sampled residents. (Resident #14) Findings include: Review of the facility policy titled, "Physical Restraints," dated 2/20/2012, revealed, " ...Restraints shall only be used for the safety and well-being of the residents...1. Restraints will only be used with... the informed consent from the resident, physician and/or responsible party... 5. Practices that are not permitted include: a. Using bedrails to keep a resident from voluntarily getting out of bed as opposed to enhancing mobility while in bed ...." On 3/25/24 at 10:30 AM, an observation revealed ¼ bedrails on the bed of Resident #14. The resident was not in bed and the bedrails were down. On 03/27/24 at 10:30 AM, during an interview and record review of the medical record with Licensed Practical Nurse (LPN) #1 confirmed Resident #14 did not have an order for the use of bed rails in the physician's orders. Bed rails were not listed on the Kardex (nursing worksheet that includes a summary of resident information and daily care) nor was there a signed informed consent for the	F 700	A. Current residents were mailed a consent form (Side Rail Notification and Acknowledgement Decision Form)and educational form (Side Rail Education Form) on 4/2/2024. B. All residents have the potential to be affected by this deficient practice. C. An in-service was performed 4/2/2024 by the Administrator and Director of Nursing (DON) with the Assisted Director of Nursing, Social Service Director, Medical Records Supervisor, and Minimum Data Set (MDS) Coordinator regarding education of families of the benefits and risks of side rail use, the requirement of consent or declination of bed rail use, and ensuring side rail assessments are performed timely for all residents. D. Beginning 4/2/2024, the Administrator will track all responding representatives to ensure that a written acceptance or declination has been obtained for each resident based on the 4/2/2024 census. The Side Rail Notification and Acknowledgement Decision Form and Side Rail Education Form will be placed in the admissions package as of 4/2/2024 for all new admits. Beginning monthly on 5/1/2024 for 3 months, the administrator	

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F 700	Continued From page 8 use of bed rails that included the risk and benefits of bed rail use. On 3/27/24 at 11:00 AM, in an interview with the RR for Resident #14, she revealed she was a part of the admission of her mother into the facility. The RR stated she cannot recall all the documents she signed but does remember the discussion of informed consent for the use of safety devices, if needed. She added that she has no remembrance of signing any documents related to bed rails for her mother, but does know they are on her bed, as she has seen them on visits. On 03/27/24 at 11:45 PM, in an interview with Registered Nurse (RN) #1/MDS Nurse confirmed the medical record for Resident #14 did not have an informed consent that indicated the benefits and risks of the use of bed rails. On 03/27/24 at 12:00 PM, in an interview with the Director of Nurses (DON), she confirmed Resident #14 does not have the appropriate consent for the use of bed rails, nor was the bed rails included in the resident's Kardex. Review of the "Admission Record" revealed the facility admitted Resident #14 on 08/10/23, with diagnoses that included Unspecified Dementia, Bradycardia, and Syncope and Collapse. Record review of the quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 2/14/24, revealed Resident #14 had a Brief Interview for Mental Status (BIMS) score of 05, which indicated severe cognitive impairment.	F 700	will present a summary of any outstanding current resident representatives who have not returned these forms to the 5/1/2024 Quality Assurance and Performance Committee using the Side Rail Consent Acknowledgement Tracking Form. Follow-up phone calls will begin on 5/1/2024 to outstanding resident family members to return consent forms using the same tracking form.	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary	F 812		5/2/24

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F 812	Continued From page 9 CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record reviews, and facility policy review, the facility failed to ensure that tray line food temperatures were checked and documented prior to serving each meal for 15 days of 24 days of recorded temperatures reviewed for the month of March 2024. Findings include: Review of the facility's policy titled, "Monitoring Temperature of Cooked Foods," with a revision date of 10/17, revealed ... "POLICY: The temperature of TCS (Time/Temperature Control) cooked foods will be monitored to ensure that the foods are not in the danger zone (above	F 812	A. On 3/25/2024 food temperatures were checked prior to serving of meals. All temperatures were in safe temperature range and documented. B. All residents that receive a meal tray from dietary department have the potential to be affected. C. On 3/25/2024 the Administrator educated the Dietary Manager (DM) on the importance and the safety of the residents for checking the temperatures of the meals prior to being served. On 3/25/2024 the Dietary Manager began an	

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F 812	Continued From page 10 41degrees F {Fahrenheit} and below135 degrees F) for more than 6 hours ....PROCEDURE: 2 ... b. When food is placed in the hot holding equipment. The temperature of the food should be 135 degrees F or higher ..." On 03/25/24 at 9:40 AM, an initial tour of the kitchen with the Dietary Manager (DM) revealed several of the pages in the tray line temperature log binder, were incomplete or blank. The DM stated she expects staff to check tray line food temperatures and document the temperatures in the binder. She stated she recently did an inservice on checking temperatures and staff knows the requirements. On 03/27/24 at 10:55 AM, in an interview with Cook #1 she stated she always checks tray line temperatures before serving food. She stated she may have forgotten to write them in the book. She confirmed they are supposed to be documented when they are done. Review of the of the temperature log sheets revealed on 3/10/24 dinner temperatures logs were blank, 3/11/24 the entire page was blank, 3/12/24 lunch was blank, 3/13/24, 3/14/24 and 3/15/24 breakfast and lunch were blank, and 3/16/24- 3/24/24 all meals were blank. On 3/28/24 at 3:00 PM, in an interview with the Administrator, she stated she had inserviced the DM on the importance of documenting the tray line temperatures. She revealed that for resident safety, she expects the temperatures to be checked and recorded.	F 812	in-service and in-service was completed on 3/26/2024 to all dietary staff on the policy Monitoring Temperatures of Cooked Foods. D. Beginning 3/26/2024,the Dietary Manager will audit meal service that include food temperature checks and ensure temperature for each meal is being documented in the food temperature log. These audits will be done daily five (5) days per week for four (4) weeks then monthly for three (3) months. Audit logs will be maintained in the dietary department and findings will be submitted to the Quality Assurance Committee beginning 5/1/2024 for review and recommendations for three (3) months.	
F 849 SS=D	Hospice Services CFR(s): 483.70(o)(1)-(4)	F 849		5/2/24

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WILKINSON COUNTY SENIOR CARE	116 SOUTH LAFAYETTE STREET CENTREVILLE, MS 39631

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§483.70(o) Hospice services.
§483.70(o)(1) A long-term care (LTC) facility may do either of the following:
(i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices.
(ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer.

§483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements:
(i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services.
(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

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

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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 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

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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 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.

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F 849	Continued From page 15 This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to ensure the facility's designated Hospice Coordinator coordinated the care provided by the Hospice service and the facility for one (1) of two (2) Hospice residents reviewed. (Resident #27) Findings include: A review of facility's policy titled, "Hospice Program," dated 7/13/17, revealed, "It is the policy of the facility to contract hospice services for residents who wish to participate in such programs ...Procedure:.. 8. As the facility designee, the Director of Nursing, is responsible for working with hospice representatives to coordinate care to the resident provided by the facility staff and hospice staff. The Director of Nursing is responsible for the following: a. Collaborating with hospice and coordinating the facility staff participation in the hospice care planning process. b. Communicating with hospice staff participating in the care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the resident and family ..." On 03/25/24 at 1:26 PM, in an observation of Resident # 27, was observed in his room with his eyes closed. The resident was nonverbal and did not respond to his name. On 03/27/24 02:15 AM, in an interview with Social Service (SS), she revealed when a resident is admitted to Hospice, she coordinates the initial Hospice communication with the family. She stated she contacts the Hospice service that the	F 849	A. On 3/28/2024, the Hospice Coordinator/Director of Nursing was educated by the Administrator to ensure that coordinated care is provided by the hospice services and then communicated to the proper facility staff. The Hospice Coordinator (HC)/Director of Nursing (DON) communicated with the Hospice supervisory staff servicing Wilkinson County Senior Care residents that documentation should be placed in the resident's hospice chart. The Hospice Coordinator/Director of Nursing communicated to the Hospice supervisory staff to ensure hospice staff communicates with the Director of Nursing, Assistant Director of nursing, floor staff responsible for resident receiving Hospice services to ensure continuity of care for residents. B. All residents receiving Hospice Services have the potential to be affected. C. On 3/28/2024 the Hospice Coordinator/Director of Nursing conducted an in-service with the Social Service Director Supervisor on including the hospice nurse to participate in residents plan of care by inviting the hospice nurse by letter to the resident's plan of care meeting. A copy of the invite will be placed on the resident's chart. Weekly audits were initiated on 4/1/2024 by the Hospice Coordinator/Director of	

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F 849	Continued From page 16 family chooses and sets up the initial meeting. However, she stated she does not coordinate with Hospice after the resident is admitted to their services. On 03/27/24 at 2:25 PM, in an interview and observation with Licensed Practical Nurse (LPN) #3/Medical Records, she stated she keeps track of the Hospice records only. She stated the current Hospice records should be in the Hospice chart for the staff to use. LPN #3 sorted through stacks of Hospice records and pulled out notes dated 2/20/24. She continued to look through the stacks and found 3/1/24 through 3/18/24 Hospice notes. On 03/27/24 at 2:32 PM, in an interview with LPN #2 stated she does not use the Hospice chart to provide care to the hospice resident (Resident #27). She stated she uses the records in Point Click Care (The facility's electronic computerized medical records). She revealed the Hospice Certified Nurse Assistant (CNA) comes Monday, Wednesday, and Friday, however, she stated she is not sure when the Hospice nurse comes. On 3/27/24 at 2:39 PM, in an interview with LPN #1 stated the Hospice nurse talks to the unit manager and unit manager informs the staff. She stated any changes are passed on shift to shift. She stated she uses the Hospice chart when she has a Hospice resident if they put the records in the chart. On 3/27/24 at 2:54 PM, in an interview with the Director of Nursing (DON) revealed that Resident # 27's Hospice records from 1/3/24 through 2/15/24, were in the resident's facility chart. She stated the nurse cannot use Hospice information	F 849	Nursing for all hospice residents' charts. Any missing documentation will be requested and placed on residents' chart upon next Hospice visit or sent via email/fax. D. The Hospice Coordinator/Director of Nursing, Assistant Director of Nursing, Medical Records Supervisor will audit one hospice chart weekly beginning 4/1/2024 for current and accurate documentation for four (4) weeks. This will be an ongoing process. Findings will be submitted to the Quality Assurance Performance Committee monthly beginning 5/1/2024 for review, revision or resolution of the plan for three (3) months.	

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if it is not in the chart, so one of the prior nurses put the Hospice records in the facility chart to facilitate facility use.

On 03/28/24 at 11:58 AM, in a telephone interview, the Hospice Registered Nurse (RN) stated she comes to see the resident once a week. She does not attend care plan meetings and has never been asked to attend any meeting regarding the resident. She stated she is not aware of how the facility does their Hospice. She commented when she comes to the facility and does the assessment on the resident, she talks with the nurse at the nurse's station or any nurse she sees in the hallway, as she has never been told who to inform of her assessment. The Hospice RN revealed that she would like to talk with the Unit Manager, but sometimes she cannot find her. The RN stated she or the Hospice CNA brings the charting to the facility and gives them to whoever is at the nurse's station. She stated the facility has never informed her to give them to medical records or any specific staff member.

On 03/28/24 12:43 PM in an interview with RN #1, the MDS (Minimum Data Set)/Care Plan Nurse stated the family is advised when the care plan meeting will be. She stated Social Services contacts the family and invites them to come to the care plan meetings. She stated they are held on every Tuesday at 2 PM. She stated they discuss 5-6 residents a week. She stated Resident # 27's Hospice nurse has not attended any of the care plan meetings since she has been here. She stated she has only been at the facility for 6 weeks. She stated they recently conducted Resident # 27's Care Plan Meeting, however, the family nor Hospice were in attendance. She stated Hospice nurses should attend meetings;

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they are part of the plan of care.

On 03/28/24 at 12:50 PM, in an interview the DON stated Hospice communicates with whoever they can find at the nurse's station. She stated Hospice staff are supposed to give the records to the medical records and medical records are responsible for putting them in the Hospice chart. She stated she is aware that the DON should coordinate Hospice, however, she delegates that responsibility to Social Services. The DON revealed she is not sure if Hospice has attended the care plan meetings, but they should because they are part of the plan of care. She stated Hospice records should be in the Hospice chart at the nurse's station, so they are accessible to staff for use in resident care.

On 03/28/24 at 3:09 PM, in an interview the Administrator stated she expects staff to follow up with Hospice. She stated she expects staff to coordinate with the Hospice so the residents can get the best of care from both Hospice and the facility.

Review of the "Admission Record," Resident #27 reveled the facility admitted the resident on 12/3/18, with diagnoses that included Cerebral palsy, Scoliosis, Essential Hypertension, and Dysphagia.

Review of "Order Summary Report," dated 3/29/24 for Resident #27, revealed a physician order, dated 7/29/22, to admit the resident to a local hospice service, due to the diagnosis of Nutritional Deficit.

Review of the Minimum Data Set (MDS), for Resident #27, with Assessment Reference Date

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F 849	Continued From page 19 (ARD) 3/19/24, revealed the resident has severely impaired cognitive skills for daily decision making. Further review of the MDS revealed the resident was coded for Hospice.	F 849		