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JNH-JEFFERSON INN	3550 HWY 468 WEST WHITFIELD, MS 39193

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Amended 2/6/23 The State Agency conducted an Annual Recertification survey at the facility from 01/23/2023 through 01/26/2023. During the survey, the SSA determined that the facility was not in compliance with the requirements for participation in Medicare and Medicaid and cited F679, F804, and F849. The facility had a census of 71 and held a license for 101 beds.	F 000		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based observations, interviews, record review, and facility policy review, the facility failed to implement an ongoing resident-centered activities program that incorporates the resident's interests for two (2) of 35 residents in building #31. Resident # 51, Resident # 64 Findings Include:	F 679	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice On 01/26/2023, immediate in-service education by the Therapeutic Team Supervisor was provided to the Recreation staff on providing engaging activities for the residents. On	3/3/23

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

Electronically Signed | 02/09/2023

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F 679	Continued From page 1 Review of the facility's policy, "Residents Rights", dated May 2021, revealed, "The resident has the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility ... The resident has the right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interest, assessment, and plan of care. The resident has the right to interact with members of the community and participate in community activities both inside and outside the facility ... The resident has the right to organize and participate in resident groups in the facility ... The resident has the right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility ..." Review of the facility's Recreational Therapy guidelines, "Procedure Guide," undated, revealed "Recreational Therapy is a treatment service designed to restore, remediate and rehabilitate a person's level of functioning and independence in life activities, to promote health and wellness as well as reduce or eliminate the activity limitations and restrictions to participation in life situations caused by illness or disabling condition ... A recreational therapist utilizes a wide range activity and community based interventions and techniques to improve the physical, cognitive, emotional, social, and leisure needs of their clients. Recreational therapists assist clients to develop skills, knowledge, and behaviors for daily living and community involvement. The therapist works with the client and their family to incorporate specific interests and community resources into therapy to achieve optimal	F 679	01/26/2023, the Pastoral Service staff visited the residents and provided church services for the group. Recreation staff showed movies in the dining room for residents. 02/07/2023, Resident #51 and #64 were assessed for their individual interests in activities by the Recreation staff. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. The facility has determined by the census that 71 residents had the potential to be affected. 3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. On 01/27/2023, the Therapeutic Team Supervisor was verbally counseled by the Nursing Home Administrator on understanding the need to provide resident centered activities, following the publicized calendar of activities, incorporating resident□s interests, hobbies and cultural preferences. On 01/27/2023, the Therapeutic Team Supervisor in-serviced the Recreation staff on providing resident centered activities, group and individual activities designed to meet the residents□ interest and support their physical, mental and psychosocial well-being. On Beginning 02/06/2023, the Nursing Home Administrator in-serviced the Recreational staff on the effective use of the It□s Never Too Late Senior Engagement Technology system, its library of content and how to	

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F 679	Continued From page 2 outcome that transfer to their real life situation ... Engaging in meaningful, purposeful activities, with roles and routines eliminate boredom, loneliness, improves self-esteem, independence and gives people something to look forward to every day." Resident # 51 A record review of the "Resident Care Plan Update," for Resident #51, revealed a problem related to poor decision-making skills. The goals to address this identified problem was for the resident to improve his cognitive level and decision-making skills by participating in outdoor activities, board games, group therapy and a one-on-one weekly therapy session one (1) time a week for 30-45 minutes. A record review of the facility's, "Quarterly Recreation Note," dated 12/8/22, revealed, "The resident has made slight progress towards his care plan goal ... The resident has been more active in activity group attending 2x (times) to 3x weekly for 25-30 minutes. The resident participates in chapel, art and crafts, special events and socials. The resident also enjoys being outside for leisure time. RT (Recreational Therapy) will continue to provide activities for leisure interests and socialization so that the resident won't become isolated. RT will continue to offer praise and encouragement for active participation in group activity ..." A record review of the facility's, "Recreation Assessment," dated 12/8/22, revealed Resident #51's activity preference is church activities, small groups, music, one on one, large groups, watching TV and outdoor outings.	F 679	increase participation using the system. Newly hired recreation staff will be in-serviced upon hire, quarterly, and as needed by the Therapeutic Team Supervisor on providing engaging and resident centered activities. 4. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated in to the quality assurance system. Beginning on 02/06/2023, the Therapeutic Team Supervisor will monitor the recreation staff to address the issues and understanding of providing engaging and resident centered activities, following the publicized calendar and increasing resident participation in activities two (2) times a week for one month, then one (1) time a month for one month, using the Group Facilitation Monitoring Log/Audit. Beginning 02/13/2023 the Nursing Home Administrator will review audit documentation weekly for 30 days. Beginning on 03/01/2023, the Nursing Home Administrator will report all audit findings to the Quality Assurance Performance Improvement (QAPI) committee monthly for action until consistent substantial compliance has been achieved as determined by the committee. Should systemic changes not be effective QAPI will investigate and will determine if further action(s) need to be	

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F 679	Continued From page 3 Review of the facility's posted "Activity Calendar," dated 1/23/23, revealed the Computer Lab was scheduled for 10:30 AM. During a general observation on 1/23/23, at 10:31 AM, several residents, including Resident #51 were observed propelling themselves in their wheelchairs up and down the hallway. Three (3) residents were observed coloring in the dining room. Several residents were observed lying in bed, with no activities noted. There were no other resident activities observed in progress. During an interview on 1/23/23, at 10:59 AM with Resident #51, he complained of boredom with nothing to do. Resident #51 revealed that he enjoyed cooking, listening to music, watching movies, reading newspapers, and going outside. Review of the "Activity Calendar," dated 1/23/23, revealed popcorn/movies were scheduled for 2:00 PM. An observation on 1/23/23, at 2:00 PM, revealed Resident #51 propelling himself in his wheelchair up and down the hallway. There were no activities observed in the dining room. Review of the "Activity Calendar," dated 1/23/23, revealed one on one bed visits were scheduled for 3:30 PM. There were no visits or activities observed at that time. An observation on 1/23/23, at 3:30 PM, revealed Resident #51 propelling himself up and down the hallway. Resident #51 was not observed interacting with peers.	F 679	implemented. The actions from QAPI meeting will be reported to the JNH Executive Committee.	

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F 679	Continued From page 4	F 679		

Review of the "Activity Calendar," dated 1/24/23, revealed Art Therapy was scheduled for 10:30 AM. There were three (3) residents observed coloring in the dining room.

An observation on 1/24/23, at 10:34 AM, revealed Resident #51 in the hallway, propelling himself in his wheelchair up and down the hallway.

Review of the "Activity Calendar," dated 1/24/23, revealed board games were scheduled for 2:00 PM.

An observation on 1/24/23, at 2:15 PM, revealed Resident #51 propelling himself in his wheelchair up and down the hallway. Resident #51 was not observed interacting with his peers.

Review of the "Activity Calendar," dated 1/24/23, revealed card/table games were scheduled for 3:00 PM.

An observation on 1/24/23, at 3:39 PM, revealed Resident #51 sitting in the hallway, not interacting with his peers. There were no activities observed taking place in the dining room.

Review of the "Activity Calendar,' dated 1/25/23, revealed a van ride was scheduled for 10:00 AM, and Computer Lab was scheduled for 10:30 AM.

An observation on 1/25/23, at 10:30 AM, revealed Resident #51 propelling himself in his wheelchair up and down the hallway. There were no activities going on in the dining room.

Review of the "Activity Calendar," dated 1/25/23, reveal Crash/Cards were scheduled for 2:00 PM.

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F 679	Continued From page 5	F 679		

An observation on 1/25/23, at 2:00 PM, revealed Resident #51 propelling himself in his wheelchair up and down the hallway. There were no activities observed taking place in the dining room.

During an interview on 1/25/23, at 2:10 PM with the Director of Nursing (DON) and the Clinical Nursing Administrator, they confirmed Resident #51 had been propelling himself up and down the hallway all week. The Clinical Nursing Administrator said she didn't know why the Recreational Therapist had not been providing therapeutic activities, because she had the resources and special software to assist in selecting appropriate activities based on the resident's interest.

Review of the "Activity Calendar," dated 1/25/23, revealed Trivia/Crafts were scheduled for 3:00 PM.

An observation on 1/25/23, at 3:40 PM, revealed Resident #51 propelling himself in his wheelchair up and down the hallway. There were no activities observed in the dining room.

A record review of the "Identification Summary Sheet," revealed the facility admitted Resident #51 to the facility on 3/24/2021, with diagnoses that included Coronary Artery Disease, Advanced Dementia, and Hypertension.

A record review of the Annual Minimum Data Set (MDS) with the Assessment Reference Date (ARD) of 3/10/22, revealed Resident #51 had a Brief Interview for Mental Status (BIMS) score of 9, that indicated Resident #51 had moderate cognitive impairment. Review of Section F, revealed it is very important for Resident #51 to

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have books, newspapers, and magazines to read, that he is able to listen to music, do group activity, go outside, and participate in religious services.

Resident #64

A record review of the "Resident Care Plan Update," for Resident #64 revealed a problem of low cognition functioning. The identified goal to address this problem included attending and participating in activities to improve his cognitive functioning. The activities identified to assist with reaching this goal included reminiscing, memory games, reality orientation, chapel, word trivia, music therapy, and word search twice weekly for 15- 35 minutes.

A record review of the facility's, "Quarterly Recreation Note," dated 12/12/22, revealed, ... "RT (Recreational Therapy) will continue to provide activities 2x to 3X weekly for 20-25 minutes for resident leisure interest and socialization. RT will continue to offer chapel, music therapy, arts and crafts, table games, card games (Crash), special events, and socials to help keep the resident engaged, and not become isolated ..."

Review of the "Activity Calendar," dated 1/23/23, revealed the Computer Lab was scheduled for 10:30 AM, however, there were no activities in progress at that time.

During an interview on 1/23/23, at 11:19 AM, Resident #64 complained he was bored with nothing to do. Resident #64 said he sits in the dining room every day and watches the staff come in and out. The resident revealed he doesn't care for coloring, but he enjoys church

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F 679	Continued From page 7	F 679		

services, music, arts and crafts, and card games.

Review of the "Activity Calendar," dated 1/23/23, revealed popcorn/movies were scheduled for 2:00 PM.

An observation on 1/23/23, at 2:00 PM, revealed Resident #64 propelling himself in his wheelchair up and down the hallway. There were no activities observed in progress at this time.

Review of the "Activity Calendar," dated 1/23/23, revealed one on one bed visits were scheduled for 3:30 PM, however, there were no visits or activities observed at that time.

An observation on 1/23/23, at 3:30 PM, revealed Resident #64 propelling himself in his wheelchair up and down the hallway.

Review of the "Activity Calendar," dated 1/24/23, revealed Art Therapy were scheduled for 10:30 AM.

An observation on 1/24/23, at 10:34 AM, revealed Resident #64 sitting in dayroom. There were three (3) residents observed coloring in the dining room.

Review of the "Activity Calendar," dated 1/24/23, revealed board games were scheduled for 2:00 PM.

An observation on 1/24/23, at 2:15 PM, revealed Resident #64 propelling himself in his wheelchair up and down the hallway. The resident was not observed interacting with his peers.

Review of the "Activity Calendar," dated 1/24/23,

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revealed card/table games were scheduled for 3:00 PM.

An observation on 1/24/23, at 3:39 PM, revealed Resident #64 sitting in the hallway. There were no activities observed in progress.

Review of the "Activity Calendar," dated 1/25/23, revealed a van ride was scheduled for 10:00 AM, and Computer Lab at 10:30 AM.

An observation on 1/25/23, at 10:30 AM, Resident #64 was observed sitting in his room. There were no activities observed in progress at this time.

Review of the "Activity Calendar," dated 1/25/23, revealed Crash/cards were scheduled for 2:00 PM.

An observation on 1/25/23, at 2:00 PM, revealed Resident #64 propelling himself in his wheelchair up and down the hallway. There were no activities observed in progress at this time.

Review of the "Activity Calendar," dated 1/25/23, revealed Trivia/crafts were scheduled for 3:00 PM.

An observation on 1/25/23, at 3:40 PM, revealed Resident #64 propelling himself in his wheelchair up and down the hallway. There were no activities observed at this time.

A record review of the "Identification and Summary Sheet," Resident #64 was admitted by the facility on 3/26/21, with diagnoses that included Alzheimer's Dementia, Schizoaffective Disorder, and Depression.

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F 679	Continued From page 9	F 679		

A record review of the Annual MDS, with the ARD of 3/31/22, revealed Resident #64 had a BIMS score of 7, that indicated Resident #64 had severe cognitive impairment. Review of section F revealed it is very important for Resident #64 to have books, newspapers, and magazines to read, the ability to listen to music, be around pets and animals, do group activity, go outside, and participate in religious services.

During an interview on 1/25/23, at 3:44 PM with the Recreational Therapist, she revealed she had included the van ride on the calendar. The Therapist stated it took two recreational employees to take one (1) resident around town, so no other residents received activities that day. However, she revealed that when the activity department is out of the building with residents, the Certified Nurse Aides (CNAs) are responsible for providing activities for the other residents. The Therapist also revealed that she only receives a budget of $140.00 a year for activities. As far as the one-on-one bed visits scheduled on the calendar for today, the Therapist confirmed she had other things to do and was unable to provide those visits today. The Therapist also revealed that if the residents don't come to the dining room, they don't get to participate in the activities that are done.

In an interview on 1/25/23, at 3:55 PM with CNA #1, she confirmed she has not provided activities for residents, because she doesn't have time. CNA #1 said she has to bathe her residents, feed them, make beds, and keep them clean.

During an interview on 1/25/23, at 4:04 PM with CNA #2, she said she turns the television on in the resident's room to provide activities. CNA #2

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F 679	Continued From page 10 revealed she's busy most of the day providing Activities of Daily Living (ADL) care. The CNA stated the activity department needs to provide more activities for the residents. During an interview on 1/25/23, at 4:15 PM, the Administrator revealed the Recreational Therapist is supposed to provide a list of things needed for activities to the Administrator for approval. Once purchases are approved, the Administrator gives the recreational department a facility credit card to make the purchases. The Administrator said the Recreational Therapist is not limited to a yearly budget of $140.00 and has resources, but is not utilizing them. During an interview on 1/26/23, at 1:10 PM with the Director of Recreation and the Recreation Supervisor, they confirmed that calendars are done by each building Therapist and should be done according to each resident's interests. The Director revealed she doesn't know why the Therapists have not provided activities in building #31 because she has not been making rounds. The Director confirmed the yearly budget is not limited to $140.00. The Recreation Supervisor said she thought the therapist was following the calendar and providing activities for all the residents. Both the Recreational Director and the Supervisor confirmed all the residents in the facility should be provided activities of interests, even on days that the therapists take other residents on a ride in the van.	F 679		
F 804 SS=F	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides-	F 804		3/3/23

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F 804	Continued From page 11 §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record review, and facility policy review, the facility failed to ensure the resident's meals maintained a palatable temperature. This had the potential to affect 34 of the 34 residents receiving meals in building 31. Findings include: Review of the facility's policy, "Isolation Meals, Food Storage and Service," dated June 2021, revealed ... "This policy establishes procedures for the safe handling of meals during isolation and during food storage and service. It applies to all Jaquith Nursing Home (JNH) employees ... Food delivered for meal service: ...Length of time, rather than temperature levels, will be used to control, ready-to eat food from the resident pantries ... Immediately on receipt of hot food in resident care buildings the temperature will be taken using the bimetallic stem thermometer and recorded on the MSH Food Temperature Log (MSH 51). The food will be placed in the pre-heated stem table to maintain a palatable temperature. The temperature should be at or above 135 degrees F (Fahrenheit). If the food is received below 135 degrees, reheat in microwave to 165 degrees F for 15 seconds or contact the Food Services Contractor to request additional food ..."	F 804	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice On 01/24/2023, immediate action(s) taken for the resident(s) #38 and #44 found to have been affected include: the Food Services Contractor was notified of the deficient temperature of the individual Styrofoam plated food. The Food Services Contractor notified the facility that the next meals will be delivered first drop off on the route and plated on Oliver trays that can maintain heat longer than Styrofoam plates. The Pantry Construction Contractor halted work to allow partial use of pantry steam tables to heat the Oliver trays. On 01/24/2023, the Director of Nurses observed residents during lunch meal and noted no negative outcomes related to the deficient practice. Pantry staff immediately began checking individual Oliver trays for palatable temperature during the next meal service. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. The facility has determined by the census that 71 residents had the potential to be affected.	

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F 804	Continued From page 12 An observation on 1/23/23 at 12:51 PM, revealed residents eating lunch that was served in individual Styrofoam plates. The SA was informed that the food was being transported on a cart from the main campus. The residents were served sloppy Joe's, potato chips, squash casserole, coleslaw, and marble cake. During interviews with Resident #44 and Resident #38 on 1/23/23, at 12:53 PM, both residents complained that their food was cold. The residents revealed that their food had been cold for the last six (6) days. During an observation with the Director of Nursing (DON) on 1/24/23, at 12:54 PM, the food was observed being brought in from the main campus on individual Styrofoam plates. The residents were received popcorn shrimp, oven fried crinkle cut fries, Capri vegetables, corn salad, rolls, and lemon shortbread bars. During an interview with residents in the dining room on 01/24/23, at 12:54 PM, they confirmed the food was cold when served. The Director of Nursing (DON) was present during the interviews. Resident # 38 gave the State Agency (SA) and the DON a piece of zucchini to touch. The zucchini felt cold to the touch. During an interview on 1/24/23 at 2:00 PM, with the DON and the Clinical Nursing Administrator, the DON confirmed the lunch was cold. The Clinical Nursing Administrator said maintenance was working on the pantry in this building (Building #31), which probably required the foods to be served in Styrofoam plates. The Clinical Nursing Administrator stated she was going to	F 804	3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. On 01/27/2023, the Coordinator of Unit Operations was verbally counseled by the Nursing Home Administrator on serving food at a palatable temperature, monitoring food temperatures and ensuring residents enjoy their meals. On 01/31/2023, the Coordinator of Unit Operations in-serviced all pantry staff on providing meals that are attractive and at a safe and appetizing temperature. On 02/06/2023, the Coordinator of Unit Operations in-serviced all pantry staff on serving food at an appetizing temperature and using the Plated Temperature Monitoring Log. Newly hired pantry staff will be in-serviced upon hire, quarterly, and as needed by the Coordinator of Unit Operations on proper food service and temperature monitoring. 4. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated in to the quality assurance system. Beginning on 02/10/2023, the Coordinator of Unit Operations will monitor the pantry staff to address the issues and understanding of serving meals at an appetizing temperature and importance of reporting when temperatures continues to	

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F 804	Continued From page 13 notify the Administrators. During an interview on 1/24/23 at 2:30 PM, with the Pantry Food Service Tech she stated did not know the food was cold. The Pantry Tech said she doesn't temp the food when it's sent to the building in individual Styrofoam trays. The Pantry Tech said it's the responsibility of the Certified Nursing Assistants (CNAs) to let her know the residents complained of cold food. During an interview on 1/24/23 at 3:00 PM, with the Administrator and the Director of the Nursing Home Administrator, they revealed the maintenance Department has been working on the pantry for the last 2 weeks. The Administrator said the resident's food is normally sent in steam pans and served by the pantry workers on regular plates. The Administrator stated that she was unaware the food was being served cold and will have the pantry workers warm the resident's food in the microwave until the pantry maintenance is completed. During an interview on 01/25/23 at 3:55 PM, CNA #1 confirmed the residents have complained about the food being cold and that she had previously reported the complaints to the pantry worker. A record review of the facility's "Identification Summary Sheet," revealed, the facility admitted Resident #38 to the facility on 3/18/2021, with diagnoses that included Arthritis and Hypothyroidism. A record review of the Quarterly Minimum Data Set (MDS) with the Assessment Reference Date (ARD) of 11/10/22, for Resident #38 revealed, a	F 804	fall below the recommend degrees two (2) times a week for one month, then 1 time a month for one month, using the Plated Temperature Log/Audit. Beginning 02/06/2023, the Social Worker will discuss with residents at Resident Council□s meeting meal services, appealing food temperatures and importance of reporting concerns of meals. Beginning 02/13/2023 the Nursing Home Administrator will review audit documentation weekly for 30 days. Beginning on 03/01/2023, the Nursing Home Administrator will report all audit findings to the Quality Assurance Performance Improvement (QAPI) committee monthly for action until consistent substantial compliance has been achieved as determined by the committee. Should systemic changes not be effective QAPI will investigate and will determine if further action(s) need to be implemented. The actions from QAPI meeting will be reported to the JNH Executive Committee.	

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F 804	Continued From page 14 Brief Interview for Mental Status (BIMS) score of 15, which indicated Resident #38 was cognitively intact. A record review of the facility's "Identification Summary Sheet," revealed, the facility admitted Resident #44 to the facility on 3/18/2021, with diagnoses that included Diabetes Mellitus, Dementia and Hypertension. A record review of the Quarterly MDS, with the Assessment Reference Date (ARD) of 11/03/22, revealed Resident #44 had a BIMS score of 11, which indicated Resident #44 had moderate cognitive impairment.	F 804		
F 849 SS=D	Hospice Services CFR(s): 483.70(o)(1)-(4) §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply	F 849		3/3/23

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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

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provided is appropriately based on the individual resident's needs.
(H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions.
(I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility.
(J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, 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

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coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident.
The designated interdisciplinary team member is responsible for the following:
(i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services.
(ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family.
(iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the 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

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F 849	Continued From page 18 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. This REQUIREMENT is not met as evidenced by: Based on interviews, record review, and facility's policy review, the facility failed to designate a staff member of the interdisciplinary team responsible for working with the hospice representative to coordinate care provided by the hospice service and the facility for one (1) of one (1) sampled residents receiving hospice care. Resident #63 Findings include: A record review of the facility's policy, "Routine Hospice Home Care Services," undated, revealed "Based upon the needs of the Resident and family as determined and prior approved by Hospice, ... services related to the management of the terminal illness will be provided to eligible Residents by Hospice ... IV. Cooperation in Professional Management ... 4.3 ... d. Designate a member of the Nursing Home's interdisciplinary group to be responsible for working with Hospice	F 849	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice On 01/27/2023, the Interdisciplinary team recommended that the Minimum Data Set (MDS) Nurse will be designated as the hospice coordinator. The MDS Nurse will be responsible for collaborating with the hospice representative to coordinate care provided by the hospice service and the facility. On 01/27/2023, the Registered Nurse noted no negative outcomes for resident #63 related to the deficient practice. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. The facility has determined by the census	

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representatives to coordinate care to the Resident provided by the Nursing Home and Hospice Staff ... The designated interdisciplinary team member is responsible for the following:.. i. Collaborating with Hospice representatives and coordinated Nursing Home staff participation in the hospice care planning process for those residents receiving these services; ii. Communicating with Hospice representatives and other healthcare providers ... to ensure quality of care for the patient and family; iii. Ensuring that the Nursing Home 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 ..."

On 01/23/23 at 03:17 PM, during an interview with the Resident Representative (RR) of Resident #63, she explained Resident #63 has been receiving hospice services for several months. The RR revealed that although there are times that hospice and the facility correspond with her regarding the resident's care, it's not very often.

On 01/24/23 at 09:15 AM, during an interview with Licensed Practical Nurse (LPN) #1, she explained that she has worked at the facility through a contract agency for one (1) year. LPN #1 revealed that the hospice nurse comes and visits the resident regularly and informs the nurse who is working of the findings before leaving.

On 01/25/23 at 10:10 AM, during an interview with LPN #2, she explained the Hospice nurse comes once a week and a certified nurse aide (CNA) comes three (3) times a week. Hospice

that 71 residents had the potential to be affected.

3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.
On 01/27/2023, the Interdisciplinary team designated the Minimum Data Set (MDS) Nurse to serve as the Hospice Coordinator for the facility. On 01/27/2023 the Director of Nursing was verbally counseled by the Nursing Home Administrator on the facility□s designated hospice coordinator. On 01/27/2023, the Director of Nursing in-serviced the MDS Nurse on the responsibilities of the hospice coordinator. On 02/06/2023, the Director of Nursing in-serviced the nursing staff on understanding the role of the hospice coordinator, communicating changes to the resident□s condition that may reflect the need to modify or revise the coordinated care plan to the MDS Nurse and resident□s physician and acceptance into hospice services. Newly hired nursing staff will be in-serviced upon hire, quarterly, and as needed by the Director of Nursing on communicating changes in the resident□s condition that may need hospice services.

4. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated in to the quality

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F 849	Continued From page 20 also has a Chaplin and a Social Worker that come once a month. The nurse explained when the Hospice nurse and CNAs come and visit with Resident #63, they report to the nurse on duty. On 01/25/23, at 11:00 AM, during an interview with the Administrator, she revealed the facility does not have a Hospice Coordinator that coordinates the resident's care with hospice. The Administrator explained the doctor is the staff member who determines if hospice is appropriate for a resident and discusses his recommendations with the family. If the family decides that they are interested in hospice, a consult is sent to the hospice of the family's choice. The Administrator confirmed that the facility nurses working with the resident consult with the hospice nurse, aides, and physicians as needed. On 01/25/23, at 11:50 AM, during a phone interview with Registered Nurse (RN) #1/Hospice Nurse, she explained this has been her first week seeing Resident #63, but the resident has been on Hospice services since August 2021. She explained the resident is seen by a RN once a week and by a CNA three times a week. After each visit, RN #1 stated the hospice nurse should call family members and report any findings or changes. The hospice staff report to Resident #63's facility nurse after each visit. RN #1 revealed the facility has their own care plan meetings, with the Hospice staff attending when possible. She confirmed (Proper Name) Hospice has its own care plan meetings every two weeks and reports any changes to the facility nurse on their next visit. On 1/25/23 at 11:57 AM, during an interview with	F 849	assurance system. Beginning on 02/06/2023, the Director of Nursing will monitor the MDS Nurse to address the issues of communicating concerns regarding the provision of care between the resident□s physician, hospice services, and nursing staff two (2) times a week for one month, then 1 times a month for one month, using the facility□s Hospice Notification Log/Audit. Beginning 02/13/2023 the Nursing Home Administrator will review audit documentation weekly for 30 days. Beginning on 03/01/2023, the Nursing Home Administrator will report all audit findings to the Quality Assurance Performance Improvement (QAPI) committee monthly for action until consistent substantial compliance has been achieved as determined by the committee. Should systemic changes not be effective QAPI will investigate and will determine if further action(s) need to be implemented. The actions from QAPI meeting will be reported to the JNH Executive Committee.	

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the facility's Director of Nursing (DON), she reported to her knowledge the facility does not have a staff member that is the facility's Hospice Coordinator.

On 1/25/23 at 12:03 PM during an interview, the Administer revealed the hospice nurses do not attend the facility's care plan meetings for Resident #63.

On 1/25/23 1:20 PM, during an interview with Social Services #1, she explained she sets up Resident #63's care plan meetings quarterly, and as needed. She explained (Proper Name) Hospice is invited to all the care plan meetings, but she doesn't recall that they have attended any of the meetings. She revealed that Resident #63's RR is invited and attends per telephone.

Record review of Resident #63's "Identification and Summary Sheet," revealed the facility admitted the resident to the facility on 4/01/2019. The resident's diagnoses included Advanced Huntington Disease, Depression, Psychosis, and Debility due to Chronic Disease.

Record review of Resident #63's Significant Change Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/16/22, revealed " ... Section C Staff Assessment for Mental Status revealed short-term and long-term memory problems ... moderately impaired cognitive skills ... Section O ... resident received hospice care ..."

Record review of "Physician Orders" revealed orders for DNR (Do Not Resuscitate), no hospitalization, comfort care only at nursing home, and (Proper Name) Hospice.

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