STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	1098	A. BUILDING: _____ B. WING _____	11/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHARDTON HEALTH CENTER INC	8885 HIGHWAY 10 RICHARDTON, ND 58652

(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) COMPLETE DATE
L1872	33-07-03.2-18,7b PHARMACEUTICAL SERVICES Medications for "external use only" must be kept in a locked area and separate from other medications. This State Licensing Rule is not met as evidenced by: Based on observation and staff interview, the facility failed to store medications for "external use only" separate from other medications in 1 of 1 medication cart observed during medication administration. Findings include: Observation of the medication cart occurred on 11/06/23 at 4:25 p.m. and showed several Ziploc bags located in the top drawer of the medication cart. The bags labeled with individual resident's names contained eye drops, topical creams, and nasal sprays not separated within each bag. During an interview on 11/08/23 at 8:45 a.m., an administrative nurse (#1) stated, "I was unaware that they [meaning external use medications] should be stored separately."	L1872	L 1872 a. Plan of Correction i. The director of nursing and other clinical staff took immediate corrective action on 11/7/2023 as follows: all medications for all residents were checked and properly labeled and stored in separate packaging to keep “external use only” medications separate from other medications. ii. The director of nursing reviewed and revise the medication storage policy and procedure as titled, Medication Storage; the policy communicates correct medication storage including external medications as of 11/9/2023; education was provided to all appropriate clinical staff at the nursing staff meeting on 11/14/2023. iii. Through the QA program the director of nursing or designee will monitor and document compliance weekly for the first four weeks then monthly thereafter. Medication storage QA to include checking for expired meds; open dates on all medications, insulin appropriately labeled and dated, medication stored appropriately refrigerated if needed, E-Kit Expiration dates, all external medication stored in separate packaging. iv. Date of Completion: December 11, 2023	12/11/23

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

Electronically Signed | 11/22/23

North Dakota Health and Human Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 000	INITIAL COMMENTS The standard Medicare/Medicaid recertification survey started on 11/06/23 and concluded 11/08/23.	F 000		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident 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 record review, review of facility policy,	F 625	F 625	12/11/23

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

Electronically Signed | 11/22/2023

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F 625	Continued From page 1 and staff interview, the facility failed to provide the resident or resident's representative a written bed hold notice for 1 of 2 residents (Resident #21) and the notice failed to include the reserve bed payment amount for 2 of 2 residents (Resident #2 and #21) reviewed for hospital transfers. Failure to provide a written copy of the bed hold notice and include the reserve bed amount does not allow the resident and/or their representative to make an informed decision regarding their rights. Findings include: Review of the facility policy "Bed Hold and Transfer Notice Policy" occurred on 11/08/23. This policy, dated October 2019, stated, ". . . The facility will have a process in place to ensure residents and/or their representatives are made aware of the facility's bed-hold and reserve bed payment amount at the time of admission to the facility and prior to transferred to the hospital . . . The facility will provide written information about these policies to residents and/or resident representatives . . . upon transfer . . ." - Review of Resident #21's medical record occurred on all days of survey. A hospital transfer occurred on 07/03/23. The bed hold notice identified facility staff obtained verbal consent to hold the bed. The record lacked documentation the facility provided the resident and/or their representative with a written bed hold notice or the reserve bed hold amount. - Review of Resident #2's medical record occurred on all days of survey. Hospital transfers occurred on 06/30/23 and 07/19/23. The bed	F 625	a. Plan of correction: i. The Business Office Manager and other administrative staff shall do the following: review and revise policy and procedure as titled Bed Hold and Transfer Notice Policy; the policy will communicate correct procedure for effectively completing the bed hold and transfer notice policy, including the bed hold reserve amount. The deficient practice will be corrected on or before December 11, 2023; the documentation, review and adoption will be discussed with administrator; to provide education on or before December 11, 2023, for all business office staff to be informed and educated on this deficiency and plans to address. ii. This deficiency has the potential to affect all residents. An audit was conducted of all bed hold notifications from 01/01/2023 to 11/28/2023, including residents #2 and #21. Corrective action was taken by attaching a document to each bed hold notification for resident #2 and resident #21 indicating what the bed hold reserve amount was at the time of the leave. All bed holds from 01/01/2023 to 11/28/2023 have been reviewed and are in compliance. iii. An updated bed hold notification form was drafted and the reserve bed amount was prepopulated on the form for all future bed hold notifications. Education was provided multiple times: 11/14/2023 at nurses meeting, 11/21/2023 at All-staff meeting, 11/28/2023 to nurses through verbal education and an example for an	

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F 625	Continued From page 2 hold notices lacked the reserve bed hold amount. During an interview on 11/08/23 at 9:20 a.m., an administrative staff member (#1) confirmed the bed hold notices lacked the reserve bed hold amount.	F 625	accurate and complete bed hold notification form was placed in communication binder for all nurses to refer to. Also, additional step by step instructions were placed in the bed hold notification folder at the nurse's station. The bed hold notification will be given to the business office manager to review. The business office manager has been provided education by the administrator on accuracy and completeness of the form. A double check will be done by the BOM by checking the daily census report for any type of leave; ensure the business office received the bed hold notification, reviewed it for accuracy, scanned form into EMR and placed a copy of the bed hold into the bed hold folder for the current year. iv. Date of completion: December 11, 2023 v. Through the QAPI program the business office manager shall be responsible for the following: To develop a QA to monitor the following: bed hold and transfer notice policy accuracy and completeness; to monitor and report initially documenting compliance in addressing the deficiency; to monitor and report weekly for the first four weeks then bi-monthly for one month and the monthly for 2 quarters or until 100% compliance is achieved; then to monitor and report thereafter as appropriate.	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans	F 658		12/11/23

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F 658	Continued From page 3 The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and review of facility policies/procedures, the facility failed to ensure staff followed standards of practice for 1 of 5 sampled residents (Resident #9) with an indwelling catheter and 1 of 2 sampled residents (Resident #229) with a dressing change. Failure to update the resident's medical record with physician's orders for an indwelling catheter and failure to follow physician's orders for a dressing change may result in delayed treatment, pain and/or worsening of resident's condition. Findings include: Review of the facility policy titled "Medication Orders" occurred on 11/08/23. This policy, revised 10/08/19, stated, ". . . The order should be recorded on the physician order sheet, and the Medication Administration Record (MAR). . . Transcribe newly prescribed medications on the MAR or treatment record. . . ." Review of Resident #9's medical record occurred on all days of survey and included a quarterly minimum data set (MDS) dated 10/31/23 coded for an indwelling catheter. A Hospice Certification and Plan of Care document dated 11/01/23 identified, ". . . Hospice nurse for insertion of foley catheter using 16 french/10cc [cubic centimeter] balloon. Change every 6 weeks and PRN [as needed] dislodgement or stoppage . . ."	F 658	F 658 a. Plan of Correction: i. For Resident #229 immediate corrective action was taken. Orders for the hospice catheter change were placed in E-MAR as ordered by the director of nursing on 11/8/2023. To ensure no other residents were affected, all other hospice orders were reviewed and clarified by the director of nursing on 11/9/2023.All licensed staff were given education on Medication/Physician Order policy on 11/14/2023 in a nursing department meeting. ii. The director of nursing has implemented corrective action to monitor and ensure all hospice orders will be entered timely into the E-MAR, all orders will be tripled checked by three licensed staff (admitting nurse, charge nurse, and DON or designee) and all orders verified to ensure correct orders are in with each hospice update. iii. All hospice residents have the potential to be affected. Through the QA program the director of nursing or designee shall be responsible for the following corrective action through a QA beginning on 11/27/23 documenting compliance in addressing the deficiency; to monitor and report daily for five days then weekly for two months and monthly	

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F 658	Continued From page 4 Review of Resident #9's physician order report and the MAR and treatment administration record (TAR) dated 10/08/23 through 11/08/23 failed to identify an order for an indwelling catheter. Observation on 11/07/23 at 12:54 p.m. showed Resident #9 with an indwelling catheter. During an interview on the afternoon of 11/08/23, an administrative staff member (#1) confirmed the staff failed to transcribe the orders for an indwelling catheter onto the resident's orders and TAR following admit to hospice. Review of the facility policy titled "Clean Dressing Change" occurred on 11/08/23. This undated policy, stated, "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. . . " Kozier & Erb's "Fundamentals of Nursing: Concepts, Process, and Practice," 11th Edition eText, 2021, Pearson, Boston, Massachusetts, page 63, states, ". . . Carrying Out a Physician's Orders . . . If the order is neither ambiguous nor apparently erroneous, the nurse is responsible for carrying it out. . . ." - Review of Resident #229's medical record occurred on all days of survey. Current physician's orders identified, ". . . Orders to Apply Mepilex [dressing] to open areas on Left mid back; monitor for signs/symptoms of infection; change Q72hrs [every 72 hours] and PRN . . ." The current care plan included, ". . . I have a	F 658	thereafter. iv. Date of Completion: December 11, 2023 b. Plan of Correction i. Corrective action was immediately upon notification for resident #9, and immediate education provided to the charge nurse on duty at time of occurrence to ensure placement of dressing and timely dressing changes are completed. All staff on duty at the time of occurrence were educated in notifying nurses if the dressing is not in place to ensure appropriate treatments are provided. ii. Identification of other resident having the potential to be affected was accomplished by adding a general order to all dressing changes for all residents with dressings to have placement check at every shift change (BID) by the Charge Nurse with placement being confirmed and signed off by the nurse. All general orders were placed in the TAR by 11/27/2023. iii. All licensed professionals were provided education on the dressing change policy and procedure at the nursing staff meeting on 11/14/2023 and the plan for corrective action to prevent further incidents. iv. This will be monitored through QA daily x 5 days starting on 11/27/2023 and weekly x2 months and monthly thereafter. The QA will include: All dressing change orders have an order in the TAR to check placement every shift, all placement is verified by the charge nurse every shift,	

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F 658	Continued From page 5 potential for alteration in my skin integrity R/T [related to] my Braden Scale Assessment. . . . I am at risk for sheering with my hoyer lift transfers and currently have an area of sheering to my back. Please follow the orders in the TAR for dressing changes and measure the area weekly with my skin assessments. . . ." A progress note, dated 11/05/23, stated, "Two open areas noted to left middle back, which were noted upon CNA [certified nurse aide] washing resident up this morning; superior open area measures: 0.8cm [centimeter] x 0.3cm x 0cm; inferior area measures: 1.1cm x 0.8cm x 0cm; both areas are beefy red, with surrounding skin being blanchable light purple; small amount of sanguineous [containing blood] drainage noted on bedding. . . . Orders to apply Mepilex and change Q72hrs and PRN . . ." During an observation on 11/06/23 at 12:28 p.m., two CNAs (#3 and #4) performed personal cares on Resident #229. The resident's back was exposed and did not identify a Mepilex dressing on the resident's left mid back. During an observation on 11/07/23 at 1:04 p.m., two CNAs (#5 and #6) performed personal cares on Resident #229. The resident's back was exposed to show a small red sheering of the skin and did not identify a Mepilex dressing on the resident's left mid back. During an interview on 11/08/23 at 11:00 a.m., an administrative staff member (#1) stated she would expect staff to continue with current physician orders.	F 658	all missing dressings placed in a timely manner. v. Date of Completion: December 11, 2023	
F 697	Pain Management	F 697		12/11/23

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F 697 SS=D	Continued From page 6 CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to provide treatment and services in a manner that maintained the highest practicable physical well-being for 1 of 1 resident (Resident #22) observed experiencing pain during cares. Failure to report and act on the resident's pain resulted in unresolved pain and decreased quality of life. Findings include: Review of the facility policy titled "Pain Management" occurred on 10/08/23. This undated policy stated, "The facility must ensure that pain management is provided to residents who require such services . . . In order to help a resident attain or maintain his/her highest practicable level of well-being and to prevent or manage pain, the facility should: Recognize when the resident is experiencing pain and identifies circumstances when the pain is anticipated. . . . Manages or prevents pain, consistent with the comprehensive assessment and plan of care, current professional standards of practice . . ." Review of Resident #22's medical record	F 697	F697 a. Plan of Correction: i. For Resident #22, her pain regimen was reviewed immediately, and provider updated on 11/8/2023, new orders obtained to allow administration of PRN narcotic 2 hours before or after scheduled narcotic. Resident scheduled to see provider on rounds on 11/14/2023 and further orders obtained for pain management. Identification for other residents having potential pain was accomplished by completing a pain interview on all residents by the director of nursing designee on 11/21/2023; Communication regarding pain control, pain control policy and education on pain management was provided to all licensed and clinical staff on 11/14/2023 at the nursing staff meeting. ii. Through the QA program the director of nursing or designee monitor and document compliance in addressing the deficiency. The QA will include: Were assessments completed, was pain managed, was treatment provided for unmanaged pain, was provider notified	

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F 697	Continued From page 7 occurred on all days of survey. Diagnoses included osteoarthritis, left ankle ulcer, and history of a pelvic fracture. A quarterly minimum data set (MDS), dated 08/10/23, indicated a brief interview of mental status (BIMS) score of "8" (moderately impaired cognition). A facility pain assessment, completed on 08/10/23, identified the resident experienced chronic pain almost all day, the pain rated as severe via a visual descriptor scale, and increased pain during wound treatments. The assessment also indicated pain decreases the resident's energy, socialization, and appetite and limits the resident's day-to-day activities. Resident #22's physician's orders included the following: *Wound Care: - Cleanse left ankle wound with 0.25% Dakins solution [an antiseptic], apply a small piece of iodoform [an antiseptic] gauze loosely in wound bed, and cover with foam dressing. Change daily and as needed (PRN). *Pain Medications: - Acetaminophen 650 milligrams (mg) scheduled twice a day - Oxycodone Extended Release 20 mg scheduled twice a day - Voltaren Arthritis Pain topical gel scheduled twice a day to shoulders, spine, knees, elbows, and ankles. - Acetaminophen 650 mg every 4 hours PRN. - Oxycodone 5 mg every 6 hours PRN. Observations of Resident #22 during cares showed the following: * 11/06/23 at 12:26 p.m., Two certified nurse aides (CNAs) (#6 and #8) transferred the	F 697	about unmanaged pain, does resident currently have pain, has resident had pain in last 5 days, were interventions provided in last 5 days. Six random pain assessments to include are current pain and having pain in the last 5 days will be completed on residents weekly for the first five weeks then monthly thereafter. iii. Date of completion: December 11, 2023	

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F 697	Continued From page 8	F 697		

resident from the wheelchair to the bed utilizing a full body mechanical lift. During the transfer and when rolling the resident back and forth in bed to remove the lift sling, the resident repeatedly moaned and stated, "Ouch" and "Oh. Oh. Oh."
* 11/07/23 at 1:46 p.m., Two CNAs (#3 and #6) transferred the resident from the wheelchair to the bed to prepare the resident for a bath. The resident moaned and groaned throughout the transfer process. As the CNAs lowered the head of the resident's bed, the resident repeated, "Oh my back. Ohhhhh my back." The CNA (#3) stated, "She has so much pain all over. We use two to work with her so we can carefully roll her." As the CNAs rolled the resident from side to side to remove the sling, the resident moaned and groaned. As the CNAs pulled down the resident's pants, the resident twice stated, "Don't touch my ankle." The resident continued to express pain throughout the brief change and placement of the bath sling. As the CNAs transferred the resident from the bed to the shower chair, the resident placed her right hand to the right side of her neck and repeated, "Oh My Head" and "Ouch Ouch" while motioning her hand up and down the right side of her neck.
* 11/07/23 at 2:25 p.m., following the resident's bath, a staff nurse (#2) completed the resident's left ankle wound treatment. The resident stated, "Ouch Ouch" and groaned throughout the treatment.

Review of Resident #22's November 1-7, 2023 MAR identified the resident received the scheduled pain medications, PRN oxycodone on 7 occasions, and no PRN acetaminophen.

During an interview on 11/08/23 at 7:50 a.m., an

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F 697	Continued From page 9 administrative staff member (#1) stated Resident #22's direct care staff failed to report the residents increased pain with cares to the nurse and agreed staff failed to effectively use PRN medications to help control Resident #22's pain. The facility failed to report and effectively manage Resident #22's pain during times of care and wound treatments.	F 697		
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 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	F 849		12/11/23

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	355122	A. BUILDING _____ B. WING _____	11/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHARDTON HEALTH CENTER INC	8885 HIGHWAY 10 RICHARDTON, ND 58652

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F 849	Continued From page 10 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) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including	F 849		

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F 849	Continued From page 11 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 State scope of practice act, and have the ability to	F 849		

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F 849	Continued From page 12 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	F 849		

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F 849	Continued From page 13 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 record review and staff interview, the facility failed to ensure residents' records contained the hospice election form and the certification of a terminal illness for 2 of 3 sampled residents (Resident #2 and #229) receiving hospice services. Failure to obtain these documents limits staff's ability to ensure coordination of care between the facility and the hospice. Findings include: - Review of Resident #2's medical record occurred on all days of survey. Resident #2 elected Hospices services on 08/29/23. The medical record lacked the hospice election form and the physician's certification of the terminal illness. - Review of Resident #229's medical record occurred on all days of survey. Resident #229 elected Hospices services on 11/01/23. The medical record lacked the hospice election form and the physician's certification of the terminal	F 849	F 849 a. Plan of Correction i. For Resident #2 and #229 immediate correction action was taken by obtaining hospice election form and the certification of terminal illness related to hospice from hospice services; all required records were obtained on 11/8/2023 provided to the survey team and scanned in to the EHR on 11/8/2023. ii. All current hospice resident records were reviewed by the director of nursing and designee to ensure all necessary documents were obtained; A hospice service and facility agreement policy has been created by the director of nursing on 11/13/2023 and education provided to the nursing staff on 11/14/2023 at the nursing staff meeting. Hospice provided a copy of the policy on 11/20/2023 and staff provided education on 11/21/2023 at the ALL-STAFF meeting. The director of nursing provided education to the interdisciplinary team on 11/14/2023.	

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F 849	Continued From page 14 illness. During an interview the afternoon of 11/07/23, an administrative nurse (#1) confirmed the medical records lacked the election form and the certification of terminal illness related to hospice.	F 849	iii. Through the QA program the director of nursing will monitor and document compliance through a QA. The QA will include: Most recent POC for each resident on hospice; Hospice Election form in EHR, Initial Physician Certification and Recertifications in EHR, Hospice and attending physician order in EHR, Names and contact information for Hospice personnel available, contact number for 24hr on-call system available, medication information. In addressing the deficiency, the QA to monitor and report weekly for the first four weeks then monthly thereafter and upon every hospice admission. iv. Date of completion: December 11, 2023	