STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355057	A. BUILDING _____ B. WING _____	01/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEMBILIER NURSING CENTER	**500 DELANO AVE WALHALLA, ND 58282**

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F 000	INITIAL COMMENTS The standard Medicare/Medicaid recertification survey started on 01/22/24 and concluded 01/25/24.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or	F 580		

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

Electronically Signed | 02/07/2024

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F 580	Continued From page 1 State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on information from the facility reported incident, record review, review of facility policy, and staff interview, the facility failed to notify the resident's physician and resident's authorized representative of a change in condition for 1 of 1 closed record (Resident #83) who had a positive COVID-19 test. Failure to notify the physician of this change may have prevented the physician from altering the treatment/care provided to the resident and the representative's ability to make informed decisions regarding medical care. Findings include: The survey team determined a deficient practice existed on 05/01/23. The facility implemented corrective action on 05/05/23 and completed nursing education on 05/11/23. Review of the facility policy titled "Notification of	F 580	Past noncompliance: no plan of correction required.	

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F 580	Continued From page 2	F 580		

Changes" occurred on 01/23/24. This policy, dated, 10/12/22, stated, "Policy: The purpose of this policy is to ensure the facility promptly informs the resident, consults the resident's physician; and notifies, consistent with his or her authority, the resident's representative when there is a change requiring notification. . . . Circumstances requiring notification include: . . . Significant change in the resident's physical, mental or psychosocial condition . . ."

Review of the facility policy titled "Physician, Physician Assistant, Nurse Practitioner or Clinical Nurse Specialist Lab Notification" occurred on 01/23/24. This policy, dated, 10/12/22, stated, "The facility must promptly notify the attending physician, physician assistant, nurse practitioner or clinical nurse specialist of lab results that fall outside of clinical reference ranges . . . Delayed notification may contribute to delays in changing the course of treatment or care plan. . . ."

Review of Resident #83's medical record occurred on January 24-25, 2024. The progress notes showed the following:
* 05/01/23 4:13 p.m. "Res [resident] c/o [complained of] of not feeling well. She could not sit on the edge of her bed by herself. VS: [vital signs] T [temperature] 99.8, P [pulse] 112, RR [respiratory rate] 20. BP [blood pressure] 122/77. O2 sats [oxygen saturation] 95% R/A [room air]. Res settled into bed & told to stay in her room for the rest of the day. Res was tested for Covid this AM & was negative."
* 05/02/23 6:14 a.m. "Covid test positive this morning. Resident remains afebrile [without an elevated temperature] and on room air. . . ."

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F 580	Continued From page 3 The medical record lacked documentation the facility notified Resident #83's physician or authorized representative regarding the positive COVID-19 test. During an interview on 01/25/24 at 10:00 a.m., two administrative staff members (#1 and #3) agreed the facility failed to notify the resident's physician and family of positive Covid result. Based on the following information, non-compliance at F580 is considered past non-compliance. The facility implemented the corrective action for the resident affected by the deficient practice by: * Completing an investigation with interviews of staff who cared for the resident from 05/02/23 to 05/05/23. * Determining the investigation showed staff failed to notify the physician and authorized representative of resident's irregular lab results on 05/02/23. * Reviewing the facility policies regarding notification of physician and authorized representative in place at the time of the incident and finding them to be up to date. * Educating nursing staff of notification policies at a meeting held on 05/11/23 as multiple staff were involved in the communication breakdown. The facility addressed measures put in place and implemented systemic changes to ensure the deficient practice does not recur by: * Adding a quality assurance program titled, "Family/Physician Notification - Purpose: Notification to family/physician of resident issues/events is required, including but not	F 580		

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F 580	Continued From page 4 limited to: fall events, skin issues, change of condition, change of medication or treatment, appointments, infections. This will be monitored via nurse's notes and reports, notifications must be documented for each occurrence." Facility audits began on 06/01/23 and continued monthly. * Providing education to all nursing staff on 05/11/23. * Implementing new nurse training requirements on 11/01/23 requiring a review of notification of changes, transfer & discharge, and lab notification policies with subsequent written testing.	F 580		
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, review of professional reference, and review of facility policy, the facility failed to provide care and services to maintain the resident's highest level of well-being for 1 of 1 closed record (Resident #83) transferred to the emergency room (ER) for a change in health status. Failure to monitor and assess the resident's condition on a continuing basis resulted in a worsening of symptoms delay in hospitalization, and possible death.	F 684	1. Resident #83 medical record was reviewed by the Administrator and DON on 02/05/2024. A new form titled "Protocol Checklist for all residents placed in quarantine or experiencing a sudden change in condition" was developed. The form initiates notification of physician and family representative and also requires two hour checks by nursing staff. The form requires charting of all repositioning, intake/output, skin	2/16/24

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F 684	Continued From page 5 Findings include: Kozier & Erb's "Fundamentals of Nursing: Concepts, Process, and Practice," 11th Edition eText, 2021, Pearson, Boston, Massachusetts, page 189, stated, ". . . Nurses have responsibilities related to both medical and nursing diagnoses. Nursing diagnoses relate primarily to the nurse's independent functions, that is, the areas of healthcare that are unique to nursing and separate and distinct from medical management. However, the nurse is still responsible for identifying and responding to data that indicate real or potential medical problems. . . . Independent nursing interventions for a collaborative problem focus mainly on monitoring the client's condition and preventing development of the potential complication. Definitive treatment of the condition requires both medical and nursing interventions. . . ." Review of the facility policy titled "Notification of Changes" occurred on 01/23/24. This policy, dated, 10/12/22, stated, "Policy: The purpose of this policy is to ensure the facility promptly informs the resident, consults the resident's physician; and notifies, consistent with his or her authority, the resident's representative when there is a change requiring notification. . . . Circumstances requiring notification include: . . . Significant change in the resident's physical, mental or psychosocial condition . . ." Review of the facility policy titled "Physician, Physician Assistant, Nurse Practitioner or Clinical Nurse Specialist Lab Notification" occurred on 01/23/24. This policy, dated, 10/12/22, stated, "The facility must promptly notify the attending	F 684	issues, medication administration, pain management and underlying symptoms. This information will be recorded into the residents medical record by the charge nurse daily. 2. All nursing staff attended the monthly nursing meeting on 02/13/2024. The policies "Notification of changes" and "Pain Management" were reviewed by all nursing staff as well as the protocol checklist form that was developed for all residents in quarantine or having a sudden change in condition. 3. The DON will continue to audit the medical record of all residents for timely family/physician notification. The DON will also complete daily audits of the protocol checklist forms for all residents who are placed in quarantine or have a sudden change in condition. (Ex: fever or vomiting) 4. A QA on timely family/physician notification will continue monthly for 1 year. A QA of protocol checklist forms will occur daily for all resident who are placed in quarantine or have a sudden change in condition until quarantine period ends and symptoms have resolved. This will occur indefinitely. 5. 02/16/2024	

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F 684	Continued From page 6	F 684		

physician, physician assistant, nurse practitioner or clinical nurse specialist of lab results that fall outside of clinical reference ranges . . . Delayed notification may contribute to delays in changing the course of treatment or care plan. . . ."

Review of Resident #83's medical record occurred on January 24-25, 2024. Diagnoses included a history of rheumatoid arthritis, cerebral infarction (stroke) without residual deficits, neoplasm of breast, in remission, and respiratory bronchiolitis/interstitial lung disease. A quarterly Minimum Data Set (MDS), dated 02/09/23, identified extensive assist with activities of daily living (ADLs) such as bed mobility, transfers, dressing, toileting, hygiene, and bathing, assist with wheelchair mobility, and not ambulating due to progressive rheumatoid arthritis to feet/knees.

A document titled, "Resuscitation Guidelines" signed by Resident #83 on 08/10/21 and signed by the resident's physician on 08/26/21, stated, ". . . By signing this part of the form, I am requesting a status of DNR [do not resuscitate] DNR means no CPR [Cardiopulmonary resuscitation]. You call 911 except for a cardiac arrest [stoppage of heart]. Active treatment up to the point of cardiac arrest is given. . . ."

Review of Resident #83's primary physician's most recent progress note, dated 04/20/23, stated, "Physical exam . . . lungs clear, heart sinus rhythm in 70's [sic] without murmur [irregular heart sound]. Abdomen scaphoid [inward], no signs of pain with palpation . . . Assessment and Plan: Rheumatoid Arthritis . . . history of left lower extremity deep vein thrombosis . . . Plan: follow up in one month. She

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F 684	Continued From page 7 has as needed Tramadol 50 mg [milligrams] up to three times a day for pain. . . ." Current physician's orders included: * Complete daily and record oxygen level and temperature * Eliquis (an anti-platelet blood thinner) 5 mg twice a day * Methotrexate Sodium (anti-cancer drug) 2.5 mg, 8 tablets once a day on Wednesday * Arthritic strength extended-release Acetaminophen (Tylenol) (pain/fever reducer) 1300 mg three times a day * Tramadol (pain medication) 50 mg three times a day-as needed (PRN) Resident #83's nurses' notes showed the following: * 04/26/23 5:08 p.m. ". . . is alert & [and] oriented with confusion noted. Speech is clear, able to make her needs known. Limited to extensive assist needed with washing, dressing. Independent, assist as needed with toileting & transfers. . . . No SOB [shortness of breath] noted. No c/o's [complaints of] pain." * 04/28/23 10:41 a.m. ". . . is a close contact and is not experiencing any COVID symptoms. She tested negative for COVID on 4/27." * 04/29/23 7:20 a.m. "Test for COVID performed on day 3 after exposure. Results negative. No symptoms." * 05/01/23 4:13 p.m. "Res [resident] c/o of not feeling well. She could not sit on the edge of her bed by herself. VS [vital signs]: T [temperature] 99.8, P [pulse]112, RR [respiratory rate] 20. BP [blood pressure] 122/77. O2 [oxygen] sats [saturation] (a measure of oxygen in the blood) 95% R/A. [room air]. Res settled into bed & told	F 684		

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F 684	Continued From page 8	F 684		

to stay in her room for the rest of the day. Res was tested for Covid this AM & was negative."
*05/01/23 7:13 p.m. ". . . has temp of 99.6 and O2 saturation on [sic] 97% on room air. She is alert but has some confusion. Scheduled Tylenol given tonight with other medication crushed in pudding. Encouraged oral intake while in room."
* 05/02/23 6:14 a.m. "Covid test positive this morning. Resident remains afebrile [without a fever] and on room air. She is alert with confusion at this time."
* 05/02/23 12:07 p.m. ". . . refused both breakfast & lunch. Resident has been resting in bed with c/o's tired/weakness. Extensive assist needed with washing, dressing, toileting & transfers. Temp. 98.6 O2-93%."
* 05/02/23 7:30 p.m. ". . . is afebrile and 02 saturation 93% on room air. She has had some confusion noted this evening. . . . has had increased weakness but has improved and is able to pivot transfer to wheelchair and self-propel in room. Scheduled medication given tonight."
*05/03/23 12:14 p.m. ". . . is more tired and continues to be weak. She is afebrile and 02 saturation 94% on room air. Confusion noted. Denies SOB no c/o pain. Took meds as normal. Has been resting in bed. Has been yelling out for help, rather than use call light. Is confused and not making sense at times. . . ."
* 05/03/23 7:42 p.m. ". . . has been hollering out for help this evening. When nurse went to check on resident and she was lying in bed. . . . requested her HS [hour of sleep-bedtime] medication. call-light is within reach."
* 05/03/23 8:32 p.m. ". . . is afebrile, 94% on room air."
* 05/04/23 5:05 a.m. ". . . could be heard

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F 684	Continued From page 9 hollering out for help in her room. Nurse entered room and resident requested to use bathroom. Call-light was within reach, . . . confused and didn't use call-light. Resident taken to bathroom, she was very weak and needed a lot of assistance with pivot transferring to wheelchair and toilet." * 05/04/23 3:20 p.m. ". . . continues to be weak. She is afebrile and 02 saturation 94% on room air. Denies SOB. Took [sic] spooned to her. Has been restless, is yelling out for help rather than use call light does not know what she wants most of the time. Has been back and forth between bed and w/c [wheelchair] several times. Isn't comfortable in either place for long. . . . C/o pain in bilateral l/e [both lower extremities] this afternoon, Tramadol given prn." * 05/05/23 12:05 a.m. ". . . has been very restless tonight. Hollering out for help constantly. States she is uncomfortable. Scheduled tylenol administered earlier and tramadol given at this time. Different positioning attempted, with no results. Resident does calm down when staff sit and talk with her, but then starts hollering again. Afebrile at 98.9 tympanic [by ear]. 02 sat 91% on RA. Fresh ice water given, will monitor." * 05/05/23 12:53 a.m. "Checked on resident. She is resting in bed, quietly at this time." * 05/05/23 3:24 a.m. "Resident continues to holler out all night. When asked what she needs, just states she "wants to get up", no other specific needs. When talked to, she calms down for a short while. Afebrile. Respirations even, non-labored. Voices [sic] is very raspy, resident is weak. Oral hydration offered." * 05/05/23 7:26 a.m. ". . . condition remains same. Continues to yell out "help" throughout the night. Resident checked on frequently. Unable to	F 684		

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F 684	Continued From page 10 voice specific need/concern. Oral fluids encouraged/offered. Voice is raspy. Complains of generalized pain/aches throughout her body. Scheduled tylenol given at the time." * 05/05/23 2:25 p.m. ". . . condition remains same. She remains confused & continues to call out "help" periodically T/O [throughout] the day shift. When asked what she needs she is unable to voice specific need/concern. Oral fluids encouraged/offered. Voice is raspy. Complains of generalized pain/aches throughout her body. Scheduled tylenol & PRN Tramadol given for same." * 05/05/23 7:48 p.m. ". . . is constantly yelling "help". Appears very dehydrated. Mucosa dry. Skin turgor delayed. Confused, disoriented. Unable to take medicine/fluids orally. Everything just leaks out the side of her mouth. Called physician on call, [physician name] and received order to send her in for evaluation. Called emergency contact, [family name] and he is ok with the plan as well." * 05/05/23 7:56 p.m. "Resident is noted to have scant amount of bright red blood around her lips/mouth at this time. Perhaps from dry mouth/constant yelling. Will monitor." * 05/05/23 8:04 p.m. "Call placed to ambulance at this time." * 05/05/23 8:05 p.m. "Unable to take BP with our machine at this time, upon several attempts. May attempt a manual later. O2 sats in the 80's on RA. afebrile at 97.7 temporal, [forehead] respirations raspy, 22 rpm [respirations per minute], unable to tell me her name, just hollers "help" all the time, not able to respond to questions. Pale." * 05/05/23 8:19 p.m. "resident left facility via ambulance to [facility name]."	F 684		

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F 684	Continued From page 11 * 05/06/23 5:28 p.m. "[Family name] called to inform nurse that resident expired [passed away] @ [at] 1:30 pm @ [facility name]." Resident #83's vital signs and point of care records identified the following: * Intakes: - 05/01/23: Fluids: 300 ml (milliliters); Meals: Breakfast: 76-100%; Lunch and Dinner: no documentation - 05/02/23: Fluids: 120 ml; Meals: Breakfast and Lunch: refused; Dinner: no documentation - 05/03/23: Fluids: no documentation; Meals: Breakfast, Lunch, and Dinner: no documentation - 05/04/23: Fluids: 180 ml; Meals: Breakfast and Lunch: no documentation; Dinner: None - 05/05/23: Fluids: no documentation; Meals: Breakfast, Lunch, and Dinner: no documentation Resident #83's May 2023 medication administration record (MAR) identified the following pain medications administered: * Tylenol 1300 mg PRN administered three times a day from 5/01/23 to 5/4/23 and twice a day on 5/05/23. * Tramadol 50 mg PRN administered: - 05/01/23 - 7:06 p.m. - 05/03/23 - 1:54 a.m. and 8:20 p.m. - 05/04/23 - 2:56 p.m. and 11:24 p.m. - 05/05/23 - 11:46 a.m. Documentation before and after Tramadol showed "restless," "yelling help," and complaints of "generalized aches and pains." Facility staff failed to notify the resident's physician of the positive COVID-19 test on 05/01/23, symptoms of increased pain and confusion, and decreased intakes, until the	F 684		

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	355057	A. BUILDING _____ B. WING _____	01/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEMBILIER NURSING CENTER	500 DELANO AVE WALHALLA, ND 58282

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F 684	Continued From page 12 emergency room transfer on 05/05/23.	F 684		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to ensure safe and secure storage of controlled medications for 1 of 1 medication cart. Failure to store medications securely may result in unauthorized access to medications and/or medication errors.	F 761	1. The medication cart was reviewed by charge nurse and DON on 01/24/2024. All controlled medication were placed in the lock narcotic box on the medication cart. 2. All medications in the medication cart	1/26/24

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F 761	Continued From page 13 Findings include: Review of the facility policy titled "Controlled Substance Administration and Accountability" occurred on 01/24/24. This undated policy, stated, ". . . Patient specific controlled substances (e.g. [such as] narcotic/epidural infusions, tablets etc.) are stored under double lock until administered to the patient. . . ." Observation of medication pass on 01/24/24 at 8:07 a.m. showed a staff nurse (#4) administered Resident #29's morning medications. The resident received two controlled medications, alprazolam (an antianxiety) and gabapentin (nerve pain medication). Observation showed staff failed to double lock these controlled medications. During an interview on the morning of 01/25/24 an administrative nurse (#1) confirmed staff failed to double lock the controlled medications.	F 761	were reviewed by DON on 01/24/2024 to ensure all controlled medication were properly placed in lock box in medication cart. All controlled medications were double locked in the cart. A memo was distributed to all nurses on 01/24/2024 explaining the new requirement and they will also be in serviced on 02/13/2024 at the monthly nurses meeting. 3. The DON will review/monitor the controlled medication weekly for 3 months to ensure that all controlled medications are stored in the lock box in the medication cart and that both locks are secure at all times when nurse is not present at the cart. 4. A QA study will be completed weekly for 3 months, then monthly for 1 year to ensure requirements are met and all controlled medications continue to be kept in the medication cart double locked in the lock box. 5. 01/26/2024	
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	F 849		1/26/24

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F 849	Continued From page 14 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 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.	F 849		

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F 849	Continued From page 15 (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions. (I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility. (J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property	F 849		

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F 849	Continued From page 16	F 849		

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 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

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F 849	Continued From page 17 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. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure resident's records contained the certification of a terminal illness for 1 of 1 sampled resident (Resident #27) receiving hospice services. Failure to have these documents in the resident's records limits staff's ability to ensure coordination of care between the	F 849	1. The medical record for resident #27 was reviewed on 01/25/2024 by the SSD and DON. The certification of terminal illness form which was waiting for physician signature was placed into the resident's chart.	

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F 849	Continued From page 18 facility and hospice. Findings include: Review of Resident #27's medical record occurred on all days of survey. Resident #27 elected hospice services on 12/15/23. The medical record lacked the physician's certification of a terminal illness. During an interview on 01/24/24 at 4:23 p.m., an administrative nurse (#1) confirmed the medical record lacked the certification of terminal illness related to hospice.	F 849	2. All hospice patients will have a review of record by DON upon admission to hospice services to ensure that all required documents are complete and placed in the chart, to include the certification of terminal illness form. 3. A checklist form was developed for all hospice patients to ensure that all criteria (care plan, hospice election form, certification of terminal illness form, contact information for hospice nurse/on-call service) is included in the chart upon admission to hospice services. In review of resident #27 chart, all criteria were met. 4. DON will review hospice checklist form for all residents upon admission to hospice services to ensure that all hospice patients have the required documents in their chart. A checklist will be kept on all hospice residents. 5. 01/26/2024	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program.	F 880		2/16/24

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F 880	Continued From page 19 The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct	F 880		

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F 880	Continued From page 20 contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to follow standards of infection control for 2 of 8 sampled residents (Resident #9 and #14) observed during perineal cares. Failure to follow infection control standards during perineal cares has the potential to transmit infections to residents, staff, and visitors. Findings include: Review of the policy/procedure titled "Handwashing/Hand Hygiene" occurred on 01/25/24. This undated policy stated, "Hand hygiene is indicated . . . After contact with blood, body fluids or contaminated surfaces; d. after touching a resident; e. after touching the resident's environment; . . . g. immediately after glove removal . . ."	F 880	1. The DON and IP reviewed the policy on hand hygiene on 02/05/2024. A root-cause analysis was conducted to identify and address the reasons for non-compliance related to failure to complete hand hygiene in accordance with CDC guidelines. 2. The policy on hand hygiene and root-cause analysis findings were reviewed with all nursing staff including certified nursing assistants at the staff meeting on 02/13/2024. Education was provided on proper hand hygiene after perineal care, after removing glove and before exiting a room. 3. The DON and IP will complete a QA to include proper hand hygiene after	

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F 880	Continued From page 21 - Observations for Resident #14 showed the following: * 01/23/24 at 9:45 a.m., showed two certified nurse aides (CNA) (#5 and #6) assisted Resident #14 onto the toilet using a mechanical lift. After toileting, the CNA (#6) performed perineal care, and without removing her gloves, applied a new brief, pulled up the resident's pants, and straightened the resident's clothes. The CNA (#6) pushed the lift out of the bathroom and lowered the resident into the wheelchair. The CNA (#6) removed her gloves and without performing hand hygiene applied the resident's protective boot, tied up the garbage bag and left the room with the garbage. The CNA (#6) failed to remove gloves and perform hand hygiene before assisting the resident and leaving the room. * 01/24/24 at 10:30 a.m., showed two CNAs (#7 and #8) assisted Resident #14 onto the toilet using a mechanical lift. After toileting, the CNA (#8) performed perineal cares, discarded the perineal wipes in a garbage bag and tied up the bag. The CNA (#8) pulled up the resident's pants, removed her gloves, and held the gloves and garbage bag in her hands while the CNA (#7) pushed the lift out of the bathroom and lowered the resident into the wheelchair. The CNA (#8) still holding the soiled gloves and garbage in her hand, offered the resident a canister with wipes for her hands. The resident took a wipe, and the CNA placed the canister back on the nightstand. The CNA (#8) failed to perform hand hygiene and exited the room with the garbage bag and soiled gloves. - Observation on 01/23/24 at 10:50 a.m. showed	F 880	perineal care, after removing gloves and before leaving a room weekly for 3 months, then monthly for 1 year. This will occur at random times and during all shifts. 4. All staff will be educated annually on proper hand hygiene and it will also continue to be included in the orientation program and skills validation checks for employees including new hires and agency staff. 5. 02/16/2024	

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F 880	Continued From page 22 two CNAs (#6 and #8) assisted Resident #9 onto the toilet using the mechanical lift. The CNA (#6) donned gloves, performed perineal care, removed the gloves, and without performing hand hygiene, obtained a sweater from the closet and assisted Resident #9 with the sweater, and adjusted the oxygen tubing. The CNA (#6) failed to perform hand hygiene after perineal care and before assisting the resident with other tasks. During an interview on 01/25/24 at 10:05 a.m., an administrative nurse (#1) stated she expected staff to perform hand hygiene after removing gloves.	F 880		