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	53A050	A. BUILDING _____ B. WING _____	02/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STAR VALLEY CARE CENTER	110 HOSPITAL LANE AFTON, WY 83110

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F 000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys on 2/21/17 through 2/24/17. The following common abbreviations are used throughout this document: DON- Director of Nursing MAR- Medication Administration Record mg- milligrams PRN- Latin phrase "pro re nata" which translates to as needed RN- Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 167 SS=B	483.10(g)(10)(i)(11) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE (g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with	F 167		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
RM, BSN, NHA	Nursing Home Administrator	3/22/17

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

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Healthcare Licensing and Surveys

Changed note per phone call with Derek Greenwood, NHA on 3/17/17 @ 10:02 a.m. POC accepted. Janelle Cox

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F 167	Continued From page 1 respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to publicly display the availability of facility surveys, certifications, and complaint investigations for the 3 preceding years for 4 of 4 days during the survey. The findings were: 1. Observation on 2/21/17 at 4:45 PM showed the entrance hall near the nursing station had a wall-mounted display with a binder which contained the Form CMS-2567 2016 survey results and plan of correction. However, there was no display to indicate the availability of the facility surveys, certifications and complaint investigations for all of the preceding three years. 2. Interview on 2/23/17 at 3:35 PM revealed the facility administrator was not aware of the requirement for the facility to prominently post a notice regarding the availability of facility surveys, certifications and complaint investigations for the preceding three years.	F 167	The facility will ensure that facility surveys, certifications, and complaint investigations for the 3 preceding years are publicly displayed. This will be accomplished by: A) Facility Surveys, certifications, and complaint investigations for the 3 preceding years have been placed in our survey binder for public display. B) The Office Manager will ensure that facility surveys are publicly displayed for the 3 preceding years. C) Education to be provided to the Office Manager on ensuring 3 preceding years of surveys are available for public display. DON or designee will perform audits monthly for 12 months to ensure 3 years of survey results are available to the public.	~~2/25/2017~~ 4/1/17 4/1/17 JE
F 226 SS=D	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 483.12 (b) The facility must develop and implement	F 226		

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F 226	Continued From page 2 written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on review of facility policies and staff interview, the facility failed to revise policies related to reporting allegations of abuse, neglect or misappropriation of resident property in accordance with federal regulations. The findings were: During an interview on 2/23/17 at 3:35 PM the	F 226	The facility will ensure that all allegations of abuse involving harm are reported within 2 hours. This will be accomplished by: A) The facility policy "Abuse Prohibition Program" has been revised to specify that all allegations of abuse and other allegations involving harm are to be reported within 2 hours. B) There are no current allegations or suspicion of abuse present at this time. C) Education will take place for all care center staff on the new allegation of abuse rule, specifying that allegations must be reported to the state within 2 hours by the DON or designee. D) DON or designee will perform audits weekly for 4 weeks, then monthly for 6 months to ensure that all allegations of abuse are reported within 2 hours. The results will be recorded on the quality calendar and reported to the Quality Advisory Committee. The results will be included in the facility-wide continuous quality improvement program.	3/16/2017 3/16/2017 4/1/17 4/1/17

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F 226	Continued From page 3 administrator and DON stated they were aware of the new federal regulations for nursing homes effective November 28, 2016. However, they stated they were not aware that allegations of abuse and other allegations involving harm were to be reported within 2 hours. The administrator stated the facility's policies had not been updated. Review of the facility's policy "Abuse Prohibition Program" (revised 11/2016) revealed allegations would be reported "immediately," but did not define what that meant. During the interview on 2/23/17 at 3:35 PM the administrator stated immediately meant within 24 hours.	F 226		
F 253 SS=E	483.10(l)(2) HOUSEKEEPING & MAINTENANCE SERVICES (l)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure 2 of 3 resident areas (resident hallways, activities room) were clean and in good repair. The findings were: 1. Observation on 2/23/17 between 9:44 AM and 10:17 AM revealed the following environmental concerns in the resident hallways: a. The wall between the doors labeled "Electrical" and "DON conference room" had a 2 inch scrape with exposed drywall which could not be cleaned effectively. b. The wall between rooms #205 and #206 had 2 holes measuring 1/2 inch each that resulted in a surface that could not be cleaned effectively.	F 253	**The facility will ensure that all resident areas are clean and in good repair. This will be accomplished by:** **A) Scrape identified in observation between "Electrical" and "DON conference room" will be repaired. Holes between rooms #205 and #206 will be repaired. Wall hooks identified at the entrance of rooms #206, #207, #208, #210 and #211 will be secured. Ceiling vents in the shared bathrooms of rooms #219/220 and #221/222 will be cleaned. Wallpaper in activity room will be secured and repaired.** **B) All walls will be checked to ensure that there are no scrapes or exposure to drywall preventing cleanable surfaces. All hooks in hallways will be checked to ensure they are secure. All ceiling vents will be placed on a cleaning schedule to prevent dust buildup. All other offices in the facility will be checked to ensure walls are intact and cleanable.**	4/1/17 4/1/17

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F 253	Continued From page 4 c. The brass-colored wall hooks with metal screws and plastic wall anchors at the entrance of rooms #206, #207, #208, #210 and #211 were not secured to the wall, creating a safety hazard. d. The shared bathrooms of rooms 219 and 220, and rooms 221 and 222 had ceiling vents which were soiled with dust. 2. Observation on 2/23/17 10:03 AM showed the wall near the bird cage in the activity room had wallpaper peeling from the wall, measuring 5 feet across, which created a surface that could not be cleaned effectively. 3. Interview on 2/23/17 at 10:18 AM with the maintenance director revealed the facility had identified some of the areas; however, there was no timeline for correction. He stated that he was not sure the ceiling vents in the bathrooms were on a cleaning schedule. Further, he confirmed the areas reviewed were visibly dirty and/or in disrepair and required maintenance.	F 253	C) Education to take place for all care center staff on using the ticket system to identify environmental concerns at the facility. Maintenance staff to be educated on ensuring all surfaces are cleanable, with no scuff marks or exposed drywall. Maintenance will also be educated on ensuring hooks and items attached to the wall are all secured. Environmental services educated on cleaning schedules for vents in the resident rooms and bathrooms. D) Audits will be initiated by the Maintenance Department weekly for 4 weeks, then monthly for 6 months on ensuring all surfaces are cleanable and all items on walls are secured. Audits will be initiated by Environmental Services weekly for 4 weeks, then monthly for 6 months on ensuring that all ceiling vents in the Care Center are on a cleaning schedule, and that the schedule is being followed appropriately. The results will be recorded on the quality calendar and reported to the Quality Advisory Committee. The results will be included in the facility-wide continuous quality improvement program.	4/1/17 4/1/17
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25	F 309		

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F 309	Continued From page 5 (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. (l) Dialysis. The facility must ensure that residents who require dialysis receive 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 medical record review, staff and family interview, and review of policies, the facility failed to ensure the effectiveness of PRN pain medication was evaluated and documented for 1 of 7 sample residents (#16) who required pain management. The findings were: 1. Review of the physician's progress note (history and physical) dated 1/9/17 showed resident #16 had severe Parkinson's disease causing uncontrolled spasms. The physician documented "...As a result of this it has been difficult to keep [his/her] pain controlled." During an interview on 2/23/17 at 4:30 PM, a family member stated the resident had severe spasms which s/he received pain medication to manage. Review of physician orders showed, in addition to routine medications, the resident had orders for morphine sulfate 10 mg every 4 hours and acetaminophen 650 mg every 6 hours PRN for pain. Review of the MAR from 1/11/17 through 2/21/17 revealed the resident received the morphine sulfate 33 times and the acetaminophen 25 times. Further review of the	F 309	**The facility will ensure all residents are assessed for the effectiveness of pain medication and the results of this assessment documented in the electronic medical record (EMR). This will be accomplished by:** **A) Resident #16 has been assessed by the nurse to verify that her pain goals are being met with the current pain management regimen. Since survey, resident #16 has also discharged to another facility closer to family.** **B) All residents have been assessed by the nurse to verify that their pain goals are being met with their current pain management regimen. All other residents currently have follow-up assessments following pain administration.**	~~3/20/17~~ ~~3/20/17~~

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F 309	Continued From page 6 MAR showed no documentation of the effectiveness of the pain medication. Review of nursing notes for that time period (1/11/17-2/21/17) revealed the effectiveness of the PRN pain medications was only documented 10 times. 2. Review of the facility's policy "Pain Management Program" (revised 6/16) revealed "Following administration of analgesic drugs, including scheduled and PRN medications: The resident will have a follow-up assessment by the nurse addressing pain medication effectiveness. This will be documented in the resident's Electronic Medical Record." 3. During an interview on 2/23/17 at 4:45 PM the administrator stated nursing staff should document the effectiveness of PRN pain medications on the MAR. He stated there was a pop-up field in the electronic MAR to remind nursing staff to do that, but for some reason it was not working with resident #16. He stated nursing staff had not communicated to him, pharmacy, or maintenance that it was not working properly.	F 309	C) Education to all nurses regarding the pain medication effectiveness assessment and the EMR documentation of this assessment. Emphasis will be placed on ensuring that this assessment is completed regardless of whether or not the EMR reminds them. D) DON or designee will perform audits 3x/week for 2 weeks, then weekly for 1 month, then monthly on completion and documentation of pain medication effectiveness assessments for one new pain medication order (if applicable) and one medication order previously placed. The results will be recorded on the quality calendar and reported to the Quality Advisory Committee. The results will be included in the facility-wide continuous quality improvement program.	4/1/17 4/1/17
F 387 SS=D	483.30(c)(1)(2) FREQUENCY & TIMELINESS OF PHYSICIAN VISIT (c) Frequency of Physician Visits (1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter. (2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required.	F 387	The facility will ensure physician visits occur as required (once every 30 days for the first 90 days and every 60 days after). This will be accomplished by: A) Resident #16 has since been discharged from the facility to be closer to family. Resident #10 has been assessed by the physician and has had a documented visit placed in the Electronic Medical Record.	~~3/20/17~~

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F 387	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure physician visits occurred as required (once every 30 days for the first 90 days and every 60 days after) for 2 of 8 sample residents (#10, #16). The findings were: 1. Review of the medical record showed resident #16 was admitted on 1/9/17. The medical record showed only one physician visit on 1/9/17. During an interview on 2/23/17 at 3:19 PM the DON confirmed there was no evidence of another physician visit after the 1/9/17 visit. 2. Review of the medical record for resident #10 revealed a physician visit on 11/23/16. The next physician visit was not until 2/17/17. During an interview on 2/23/17 at 11:46 AM the DON confirmed there was no evidence of a physician visit between 11/23/16 and 2/17/17.	F 387	B) All residents in the facility longer than 90 days have been checked to ensure they have had a physician visit within 60 days. All residents in the facility less than 90 days have been checked to ensure they have had a physician visit every 30 days for the first three months of admission. Those who do not fall within these timeframes will have a scheduled visit with their primary physician. C) The Care Center Office Manager, DON, Social Worker, physicians' MA staff and MDS nurse will be educated on the necessity of physician visits at least every 60 days for all residents present longer than 90 days, and at least every 30 days for all residents present within the first 3 months. D) DON or designee will perform audits monthly for 12 months on the following: All residents in the facility longer than 90 days have been checked to ensure they have had a physician visit within 60 days. All residents in the facility less than 90 days have been checked to ensure they have had a physician visit every 30 days for the first three months of admission. The results will be recorded on the quality calendar and reported to the Quality Advisory Committee. The results will be included in the facility-wide continuous quality improvement program.	4/1/17 4/1/17 4/1/17
F 428 SS=D	483.45(c)(1)(3)-(5) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON c) Drug Regimen Review (1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. (3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant;	F 428		

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F 428	Continued From page 8 (iii) Anti-anxiety; and (iv) Hypnotic. (4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. (5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure the	F 428	**The facility will ensure the pharmacist sends a separate written report of potential irregularities identified during the drug regimen review (DRR) to the physician and the medical director, and ensure the physician documents his/her rationale when no changes were made in the medication. This will be accomplished by:** **A) Resident #16 has since been discharged from the facility to be closer to family.** ~~3/20/17~~ **B) Resident #10 has had pain addressed by MD and pharmacist, and has since been placed on additional pain medication.** ~~3/28/17~~ **C) DON or designee will ensure that all other residents have had the most recent pharmacy review checked for concerns requiring action by the physician. Those items that have been identified will be addressed by the physician in the resident's Electronic Medical Record.** 4/1/17 **D) Education to be provided to the residents' physicians on findings of survey and the necessity of physician documentation regarding actions of pharmacy review. Education to be provided to DON and pharmacist on communication to the residents' physician and Care Center Medical Director, as well as ensuring follow-through of physicians on necessary actions of pharmacy review.** 4/1/17

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F 428	Continued From page 9 pharmacist sent a separate written report of potential irregularities identified during the drug regimen review (DRR) to the physician and the medical director, and failed to ensure the physician documented his/her rationale when no changes were made in the medication for 2 of 8 sample residents (#10, #16). The findings were: 1. Review of the 1/10/17 DRR for resident #16 showed the pharmacist documented under "action taken" to "Discuss with provider if potassium can be changed to liquid (multiple drug interactions)." Further review of the medical record showed no evidence a written report of the identified potential irregularity was sent to the physician and the medical director. The DRR for the following month (dated 2/17/17) showed "Staff is noted to be crushing medications, with provider and staff reporting that resident would refuse liquid potassium..." However, there lacked evidence in the medical record that the physician reviewed the identified potential irregularity or that the physician documented his rationale for not making a change. 2. Review of the DRRs for resident #10 showed the following identified potential irregularities: a. 11/21/16 - "Will discuss pain with provider." b. 1/4/17- "Will talk to provider that the addition of a long-acting pain medication appears to be needed." Review of the medical record showed no evidence the physician and the medical director were sent a written report of the identified potential irregularities. 3. During an interview on 2/23/17 at 1:41 PM the pharmacist stated the "action plan" in the DRR was where she documented identified potential	F 428	**E) DON or designee will perform audits monthly x12 months to ensure proper communication to the physician and Medical Director, as well as ensuring physician documentation takes place on necessary actions of pharmacy review. The results will be recorded on the quality calendar and reported to the Quality Advisory Committee. The results will be included in the facility-wide continuous quality improvement program.**	4/1/17

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F 428	Continued From page 10 irregularities. She stated if the physician was active in the electronic medical record (EMR), then she sent a note in the computer to the physician and medical director. However, she stated some physicians did not like to use the EMR, and for those physicians she would have a face-to-face conversation with them, and then document the results of the conversation in the next DRR. She stated for residents #10 and #16 there was no evidence a separate report was sent to the physician and medical director of the identified irregularities. Furthermore, she stated physicians did not document in the medical record that they had reviewed the report, nor did they document their rationale when they did not want to make a medication change.	F 428		
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (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 (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to:	F 441		

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F 441	Continued From page 11 (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 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. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the	F 441		

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F 441	Continued From page 12 spread of infection. (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, staff interview, and review of standards of practice, the facility failed to follow infection prevention standards for two of two observed medication administrations where medications were dropped. The findings were: 1. Observation on 2/22/17 at 12:36 PM showed RN #1 was preparing medications. A half tablet of the medication quetiapine fumarate was dropped and fell onto the top drawer edge of the medication cart. The nurse used her bare hand to pick up the half tablet and place it into a medication cup. The medication was then consumed by resident #14. Further, on 2/23/17 at 9:26 AM RN #1 was observed preparing medications and dropped a tablet of the medication Paxil onto the top of the medication cart. The nurse used her bare hand to pick up the tablet and place it into a medication cup. The medication was crushed with other medications, and then consumed by resident #1. 2. During interview on 2/23/17 at 9:41 AM with RN #1 in regard to medication disposal, she stated "I keep my cart and hands clean, but if they [the pills] hit the floor, there is no five second rule, they're done." 3. Interview on 2/23/17 at 5:44 PM with the DON revealed the expectation for infection control concerning medications was staff should not touch pills with their bare hands when preparing	F 441	**The facility will follow infection prevention standards for all medication administrations. This will be accomplished by:** **A) Resident #1 and #14 have had medications administered by the nurse following proper infection control guidelines.** **B) All residents in the facility have had medication administration performed by the nurse following proper infection control guidelines, specifically passing medications without touching them with bare hands.** **C) Education will be provided for all Nurses at the Care Center on ensuring all med passes are performed following proper infection control guidelines. At no time is it acceptable to touch medications with bare hands and then administer them.** **D) DON, Pharmacy or designee will perform audits 3x/week for 2 weeks, then weekly for 4 weeks, then monthly for 6 months to ensure medication pass follows proper infection control guidelines and protocol. During these audits, all nurses working will be audited at least once. The results will be recorded on the quality calendar and reported to the Quality Advisory Committee. The results will be included in the facility-wide continuous quality improvement program.**	3/20/17 3/20/17 4/1/17 4/1/17

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F 441	Continued From page 13 for resident consumption. 4. Review of the textbook Fundamentals of Nursing, Ninth Edition, copyright 2017, showed skills for administering oral medications included "To prepare tablets or capsules from a floor stock bottle, pour required number into bottle cap and transfer medication to medication cup. Do not touch medication with fingers..." and "When using blister pack, 'pop' medications through foil or paper backing into a medication cup" with the rationale of "Avoids contamination and waste of medication."	F 441		
F 526 SS=D	483.70(o)(1)-(4) Hospice (o) Hospice services. (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. (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	F 526		

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F 526	Continued From page 14 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	F 526		

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F 526	Continued From page 15 for any condition. (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions. (I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and 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.	F 526		

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F 526	Continued From page 16 (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. (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	F 526		

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F 526	Continued From page 17 provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family. (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms,	F 526		

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F 526	Continued From page 18 and record keeping requirements, to hospice staff furnishing care to LTC residents. (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 §483.20. This REQUIREMENT is not met as evidenced by: Based on review of written agreements, staff interview, and medical record review, the facility failed to ensure the written agreement with hospice included all of the required elements and failed to ensure hospice staff received orientation to the policies of the facility. In addition, the facility failed to ensure the care plan included the hospice plan of care for 1 of 1 sample residents (#16) receiving hospice services. 1. Review of the "Hospice and Nursing Facility Services Agreement" (dated 5/14/15) revealed the following required elements were not included: a. A communication process, including how communication will be documented between the LTC [long term care] facility and the hospice provider, to ensure the needs of the resident are addressed and met 24 hours per day. b. 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 origin, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes	F 526	**The facility will ensure the written agreement with hospice includes all required elements, ensure the care plan includes the hospice plan of care, and ensure that hospice staff receive orientation to the policies of the facility. These will be accomplished by:** **A) The Hospice and Nursing Facility Services Agreement will be updated to include a communication process, including how communication will be documented between the LTC facility and the hospice provider, to ensure the needs of the resident are addressed and met 24 hours per day. It will also include 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 origin, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation.**	4/1/17
			B) Hospice staff involved in care of current or potential residents will be oriented to the applicable policies of the facility, such as fire safety, abuse, and infection control.	4/1/17
			C) Resident #16 has since been discharged to another facility to be closer to family.	4/1/17

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F 526	Continued From page 19 aware of the alleged violation. 2. During an interview on 2/24/17 at 8:51 AM, the DON stated she was the designated staff person to collaborate and coordinate with hospice. She stated there was no evidence that hospice staff furnishing care in the facility had received orientation to the policies of the facility. 3. Review of the care plan dated 2/23/17 for resident #16, who was receiving hospice services, revealed the hospice plan of care was not included. During an interview on 2/24/17 at 8:51 AM the DON confirmed the hospice plan of care was not included in the facility's care plan.	F 526	**D) No other residents are currently on hospice.** **E) Education provided to Office Manager, MDS Nurse, Social Worker and DON on ensuring all Hospice staff are oriented to applicable policies of the facility. Educational packet will be prepared to ensure uniform orientation of hospice staff members. Education to DON, MDS Nurse and Social Worker on ensuring hospice patients have the hospice plan of care included in the facility's care plan. Education to Office Manager and DON on addendum to the Hospice and Nursing Facility Services Agreement.** **F) DON or designee will perform audits monthly for 12 months to ensure that identified required documentation is provided from Hospice personnel such as hospice election forms, physician certification/recertification of terminal illness, instructions on how to access hospice 24 hour system. DON or designee will perform audits monthly for 12 months to ensure all hospice staff have documented orientation prior to working at the facility, and all hospice residents have a hospice plan of care included in the facility's plan of care. The results will be recorded on the quality calendar and reported to the Quality Advisory Committee. The results will be included in the facility-wide continuous quality improvement program.**	~~3/20/17~~ 4/1/17 4/1/17