STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E004	A. BUILDING _____ B. WING _____	08/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEDFORD CO NURSING HOME	1229 COUNTY FARM ROAD BEDFORD, VA 24523

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 08/03/2021 through 08/05/2021. The facility was in substantial compliance with 42 CFR Part 483.73, Requirements for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 8/3/2021 through 8/5/2021. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code report will follow. The census in this ninety certified bed facility was seventy at the time of the survey. The survey sample consisted of eighteen current record reviews and one closed record review.	F 000		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for	F 584		8/27/21

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

Electronically Signed | 08/13/2021

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F 584	Continued From page 1 the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility staff failed to ensure a homelike environment on one of three nursing units. A resident room on unit 2 had damage to the entrance door, paint damage across the width of the restroom door and paint scraped from the wall beside the resident's bed. The findings include: On 8/3/21 at 11:20 a.m., room 211 on nursing unit two was inspected. The entrance door to the room was damaged with a chunk of wood missing from the door edge approximately 8	F 584	1) In room 211 on Unit 2, the entrance door has been repaired and painted, the restroom door has been repaired and painted and the wall beside the bed has been repaired and painted. 2) An audit was completed by Support Services Supervisor of all rooms in facility to identify any other rooms needing repair to doors or walls. Needed repairs have been scheduled. 3) Administrator has educated Support Services Supervisor that all resident	

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F 584	Continued From page 2 inches from the floor. The edges of the entrance doors were scraped and missing paint. An approximate 1-foot section across the width of the restroom door was scraped, damaged and missing paint near the floor. On the wall beside the left bed (left upon entrance to the room) was a section, approximately 2 feet wide, with scrapes and missing paint. This scraped section was irregular in shape and visible above the height of the bed mattress. On 8/5/21 at 8:47 a.m., accompanied by the facility's maintenance director (other staff #1), the wall and door damage in room 211 was observed. The maintenance director was interviewed at this time about room 211. The maintenance director stated the facility had a work order system and staff were supposed to report and/or enter any needed repair projects into the system. The maintenance director stated he had no current work orders for any repairs on unit two, including room 211 and he was not aware of the damaged doors/wall. This finding was reviewed with the administrator and director of nursing during a meeting on 8/5/21 at 9:50 a.m.	F 584	rooms are to be free from damage to doors or walls and any repairs need to be scheduled using TELS system and prioritized. 4) Administrator or designee will audit 5 rooms a week x 4 weeks to ensure rooms are not in need of repair; repairs will be scheduled as needed. Process will be reviewed in QA committee x 3 months for recommendations.	
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health	F 645		8/27/21

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F 645	Continued From page 3	F 645		

authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission,
(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and
(B) If the individual requires such level of services, whether the individual requires specialized services; or
(ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission-
(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and
(B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability.

§483.20(k)(2) Exceptions. For purposes of this section-
(i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.
(ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual-
(A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,

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F 645	Continued From page 4 (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility failed to ensure a Level 1 Preadmission Screening and Resident Review (PASARR) was completed before admission to the facility for one of 19 residents in the survey sample, Resident # 44. The findings were: Resident # 44 was admitted to the facility on 2/14/2020, and most recently readmitted on 7/21/2021 with diagnoses that included Wernicke's Encephalopathy, bipolar disorder, depression, neurogenic bladder, hereditary ataxia, dementia, history of stress fractures of the left fingers, and Vitamin-D deficiency. According to the most recent Quarterly Minimum Data Set, with an Assessment Reference Date of 6/10/2021, the resident was assessed under	F 645	1) PASARR screening has been completed for resident #44 2) An audit was conducted by Admission Director and SW to ensure all residents have a PASARR. A PASARR screening was completed for any residents who were missing a PASARR. 3) Administrator has educated Admission Director all residents accepted for admission to have a completed PASARR prior to admission. SW and or BOM to audit pre-admission paperwork for completed PASARR. 4) SW and or BOM to audit pre-admission paperwork for completed PASARR. Process will be reviewed in QA committee	

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F 645	Continued From page 5 Section C (Cognitive Patterns) as having short and long term memory problems with moderately impaired daily decision making skills. During review of Resident # 44's Electronic Health Record, it was revealed the record did not contain a completed PASARR. At approximately 9:20 a.m. on 8/4/2021, the Director of Nursing (DON) was asked where the PASARR could be located. The DON stated that the Social Worker was in charge of the PASARR's. At 9:25 a.m. on 8/4/2021, LPN # 1 (Licensed Practical Nurse), who served as the Social Worker, was asked about a PASARR for Resident # 44. "He is private pay," LPN # 1 said, "and does not need a PASARR." At approximately 9:40 a.m. on 8/4/2021, in an effort to verify her earlier response, LPN # 1 was asked again about a PASARR for Resident # 44. "(Name of resident) does not need a PASARR because he is private pay." During a meeting at 3:30 p.m. on 8/4/2021 that included the Administrator, the DON, the lack of a PASARR for Resident # 44 was discussed. It was pointed out to the Administrator and DON that a PASARR is required prior to admission for anyone admitted to a nursing facility for long term care, regardless of payer source.	F 645	x 3 months for recommendations.	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of	F 657		8/27/21

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F 657	Continued From page 6 the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to review and revise a comprehensive care plan for one of 19 in the survey sample, Resident #36. Resident #36's care plan was not reviewed and revised for code status change. The findings include: Resident #36 was admitted to the facility on 06/02/2021 with diagnoses that included vascular dementia with behavioral disturbance, bipolar disorder, generalized anxiety disorder, osteoarthritis, edema, aphasia, and hypertension.	F 657	1) The comprehensive care plan for resident #36 code status has been reviewed and updated. 2) An audit was conducted by the MDS Coordinator to ensure all comprehensive care plans reflect the appropriate code status for each resident. No discrepancies identified. 3) the DON educated the MDS Coordinator all care plans must be reviewed and revised for appropriate code status change.	

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F 657	Continued From page 7 The most recent minimum data set (MDS) dated 06/10/2021 was the admission assessment and assessed Resident #36 as severely impaired for daily decision making with a score of 1 out of 15. On 08/04/2021 Resident #36's clinical record was reviewed. Observed on the physician's order report was the following order: " ....Start Date - 06/03/2021. End Date - Open Ended. Code Status: DNR...." Observed on the care plans were the following two code status care plans: "....Code Status: DNR. Edited: 06/17/2021. Code Status: FULL CODE. Edited: 06/17/2021." Observed within the clinical record was a signed durable do not resuscitate (DDNR) order dated 06/03/2021. On 08/04/2018 at 3:18 p.m., the MDS coordinator (registered nurse, RN #1) who was responsible for the care plans was interviewed regarding Resident #36's code status. RN #1 reviewed the clinical record and stated Resident #36's code status was a DNR. RN #1 stated the facility may have been waiting for the signed copy of the DDNR form which is why both the Full Code and DNR care plans were both in the system. RN #1 stated based on the DNR form Resident #36's care plan should have been reviewed and revised to reflect the code status. These findings were reviewed with the administrator and director of nursing during a meeting on 08/04/2021 at 3:30 p.m.	F 657	4) QA/Education Nurse and/or Designee will audit 5 care plans a week x 4 weeks for appropriate code status. Corrections will be made for any identified variances and appropriate staff will be re-educated. Process will be reviewed in QA committee x 3 months for recommendations.	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)	F 658		8/27/21

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F 658	Continued From page 8 §483.21(b)(3) Comprehensive Care Plans 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 observation, staff interview, facility document review and clinical record review, the facility staff failed to clarify a physician's order prior to administration of medication to one of seven residents in the medication pass, Resident #67. Resident #67 was administered ICaps multivitamin when the physician's order was for ICaps AREDS. The findings include: A medication pass observation was conducted on 8/4/21 at 7:27 a.m. with licensed practical nurse (LPN) #3 administering medications to Resident #67. Included in the medications administered to Resident #67 was a softgel ICaps multivitamin (10/2/280). Resident #67's clinical record documented a physician's order dated 7/7/21 for, "ICaps AREDS (vitamins a, c, e-zinc-copper) capsule; 14, 320-226-200 unit-mg-unit; amt: 1 capsule; oral..." The order required one capsule to be administered each day for treatment of macular degeneration. On 8/4/21 at 8:20 a.m., LPN #3 was interviewed about the administration of the ICaps multivitamin instead of the ICaps AREDS formula as ordered. LPN #3 stated sometimes the pharmacy made substitutions but she was not sure about the	F 658	1) the ICAPS for resident #67 was clarified with physician and the order updated in the EMR. 2) An audit was conducted by the Nursing Supervisor to ensure all residents medications directly match physician orders in the EMR. All identified discrepancies were corrected. 3) QA/Education Nurse educated staff nurses to ensure medications directly match the physician's order prior to administration. 4) QA/Education and or Designee will audit 7 residents a week x 4 weeks to ensure there are no discrepancies between the medication ordered and the medication provided by the pharmacy. Variances will be investigated and attending physician will be notified for clarification. Process will be reviewed in QA committee x 3 months for recommendations.	

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AREDS formula. LPN #3 inspected Resident #67's pharmacy supply card for the vitamin. The supply card was labeled from the pharmacy as, "ICaps 10/2/280 MG [milligrams] softgel caps multiple vitamins w/ [with] minerals." LPN #3 stated there was nothing on the label indicating the AREDS formula.

On 8/4/21 at 8:54 a.m., the facility's consultant pharmacist (other staff #3) was interviewed by telephone about Resident #67's ICaps order. The pharmacist stated the ICaps multivitamin and ICaps AREDS "technically had the same ingredients" but with different concentrations of vitamins A, D and E for eye health. The pharmacist was not sure why the multivitamin product was supplied instead of the AREDS.

On 8/4/21 at 10:30 a.m., the facility's pharmacy supervisor (other staff #2) was interviewed by telephone about Resident #67 getting a multivitamin when the order was for AREDS formula. The pharmacy supervisor stated the ICaps AREDS formula was not currently available from their supplier. The pharmacy supervisor stated the pharmacist substituted with the closest product to the AREDS, which was the ICaps multivitamin. When asked about why the order was not changed to match what was provided, the pharmacy supervisor stated the pharmacy did not initiate an order change because it was an over-the-counter product. The pharmacy supervisor stated if the medication required a prescription, pharmacy would have contacted the prescriber for a new order. The pharmacy supervisor stated Resident #67's admission medication regimen review recognized the need to substitute the medicine and sent a recommendation to the facility requesting

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approval of the substitution.

The pharmacy supervisor provided a copy of Resident #67's admission medication regimen review dated 7/7/21. The pharmacy documented, "...Pharmacy chose I-CAPS softgels since it is the only ICAPS on market that has vitamin A as a component..." There was no response to the recommendation from the provider and no order change made in Resident #67's clinical record.

On 8/4/21 at 10:42 a.m., the director of nursing (DON) was interviewed about Resident #67's vitamin order not matching what was supplied by pharmacy. The DON stated she expected nurses to check with pharmacy, contact the provider and update the order if an ordered medication was not available.

On 8/4/21 at 2:30 p.m., the DON stated when Resident #67 was admitted, pharmacy made a recommendation about the substitution of the AREDS formula. The DON stated nurses should have customized the order in the electronic health record after obtaining provider approval. The DON stated she thought the nurse entered the AREDS formula from a list of standard orders options and did not know how to customize the order in the computer.

The facility's policy titled, Preparation and General Guidelines for medication administration (effective 6/9/15) documented, "...Medications are administered in accordance with written orders of the prescriber...If a dose seems excessive considering the resident's age and condition, or a medication order seems to be unrelated to the resident's current diagnoses or conditions, the nurse calls the provider pharmacy for clarification

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F 658	Continued From page 11 prior to the administration of the medication or if necessary contacts the prescriber for clarification..." The Nursing 2017 Drug Handbook documents on page 1585 concerning best practices to avoid common drug errors, "...each order should specify the correct drug name, concentration, dosage, route, and frequency of administration...Clarify all incomplete or unclear orders with the prescriber..." (1) This finding was reviewed with the administrator and director of nursing during a meeting on 8/4/21 at 3:30 p.m. (1) Rader, Janet, Dorothy Terry and Leigh Ann Trujillo. Nursing 2017 Drug Handbook. Philadelphia: Wolters Kluwer, 2017.	F 658		
F 849 SS=E	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	F 849		8/27/21

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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.
(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.

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	49E004	A. BUILDING _____ B. WING _____	08/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEDFORD CO NURSING HOME	1229 COUNTY FARM ROAD BEDFORD, VA 24523

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 849	Continued From page 13 (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 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.	F 849		

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§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 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

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F 849	Continued From page 15 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 staff interview, facility document review and clinical record review, the facility staff failed to ensure professional standards of practice by a hospice provider for one of 19 residents in the survey sample, Resident #14. Records of weekly hospice visits for Resident #14, including nursing assessments and direct-care services were not provided to the facility as required in the hospice services agreement. The findings include: Resident #14 was admitted to the facility on 10/11/18 with diagnoses that included congestive heart failure, dementia, cardiomyopathy,	F 849	1) Records of weekly hospice visits were provided to the facility for resident #14 by hospice provider. 2) An audit of all hospice residents has been completed by Nursing Supervisors to ensure records of weekly visits are provided to facility with credentials of person conducting visit. Corrections were made as necessary. 3) SW educated all hospice providers, in person or via phone, records of weekly visits are to be provided to the facility in a timely manner with credentials of person	

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F 849	Continued From page 16 atherosclerotic heart disease, hypertension, chronic kidney disease, anemia, diabetes, COPD (chronic obstructive pulmonary disease), atrial fibrillation and hypothyroidism. The minimum data set (MDS) dated 5/5/21 assessed Resident #14 with short and long-term memory problems and severely impaired cognitive skills. Resident #14's clinical record documented a physician's order dated 9/10/19 for hospice services. The resident's plan of care (revised 5/13/21) documented coordination of care with the hospice provider for end of life services. The plan of care documented goals for provision of hospice services as, "Resident will receive appropriate care that is coordinated between provider and NF [nursing facility]..." Interventions to coordinate care included contact information for the hospice provider and communication of resident changes as appropriate. Care plan interventions to provide comfort and dignity needs for end of life care included, "Hospice CNA [certified nurses' aide] to assist with personal care weekly...Hospice ancillary staff and CNA visits when appropriate...Hospice nurse...visits every 2 weeks...Nursing facility to communicate resident needs related to terminal condition to Hospice and coordinate care...Hospice nurse to communicate all changes in orders related to terminal condition to unit charge nurse..." Resident #14's clinical record documented a hospice plan of care and recertification dated 6/24/21. This plan documented treatments for Resident #14 included oxygen, assessment of wounds, pain management, medication review, spiritual counseling and safety interventions. Resident #14's clinical record from January 2021	F 849	conducting visit. 4) QA/Education nurse and or designee will audit 4 hospice residents a week x 4 weeks to ensure records of weekly visits are provided to the facility. Variances will be investigated and corrected and hospice provider notified of concerns. Process will be reviewed in QA committee x 3 months for recommendations.	

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through 8/3/21 included only one record of a hospice visit. A routine hospice visit note dated 7/20/21 listed vital signs, a physical assessment of the resident, status of wounds, a pain assessment and documented planned visits for the resident as weekly. A hospice staff person electronically signed the note but there was no indication of the hospice employee's clinical discipline. The record included no other documentation of nursing visits, provider visits/assessments or any direct-care provided by hospice aides.

On 8/4/21 at 2:07 p.m., the licensed practical nurse (LPN #2) that routinely cared for Resident #14 was interviewed about hospice services and care. LPN #2 stated a registered nurse from hospice visited the resident weekly and a hospice CNA came twice per week and provided direct-care to the resident. LPN #2 stated she thought the hospice nurses had notes of their visits but she did not have access to the notes, as they were not part of the resident's clinical record. LPN #2 stated the nurses usually verbally communicated and asked for information about the resident if needed. LPN #2 reviewed the clinical record and stated again, there were no notes or documentation by hospice nurses in the record. LPN #2 stated there was nothing documented about what services or care was provided by the hospice CNAs.

On 8/5/21 at 9:20 a.m., the director of nursing (DON) was interviewed about any evidence of hospice nursing visits and direct-care provided to Resident #14. The DON reviewed the clinical record and stated hospice nurses, a nurse practitioner and aides provided routine care for Resident #14 at the facility but she did not have

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records of their assessments, progress notes or care provided. The DON stated the only note found documenting a hospice visit was on 7/20/21. The DON stated hospice provided copies of recertification and a plan of care but they had not sent visit notes, assessments or records of care provided by aides. The DON stated the hospice provider was supposed to fax all documentation related to the resident's care to the facility weekly for inclusion in the clinical record but this had not been done.

The facility's hospice service agreement signed by the provider on 7/13/20 documented on page 8 concerning compilation of records, "The Nursing Facility and Hospice shall each prepare and maintain complete and detailed clinical records concerning each Residential Hospice Patient receiving Nursing Facility Services and Hospice Services under the Agreement in accordance with prudent record-keeping procedures and as required by applicable federal and state law and regulations and applicable Medicare and Medicaid guidelines. Each clinical record shall completely, promptly and accurately document all services provided to and events concerning, each Residential Hospice Patient (including evaluations, treatments, progress notes, authorizations to admission to Hospice and/or the Nursing Facility and physician orders entered pursuant to the Agreement). The Nursing Facility and Hospice shall cause each entry made for services provided hereunder to be signed by the person providing the services..."

This finding was reviewed with the administrator and DON during a meeting on 8/5/21 at 9:50 a.m.