| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 495350 | A. BUILDING _____ B. WING _____ | C 02/10/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| HERITAGE HALL WISE | 9434 COEBURN MOUNTAIN ROAD WISE, VA 24293 |

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| E 000 | Initial Comments<br><br>An unannounced Emergency Preparedness survey was conducted 02/08/22 through 02/10/22. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. | E 000 | | |
| F 000 | INITIAL COMMENTS<br><br>An unannounced COVID-19 Focused Infection Control Survey and abbreviated Medicare/Medicaid survey was conducted 02/08/2022 through 02/10/2022. Three complaints were investigated during the survey: VA00054275 was unsubstantiated, VA00053100 was substantiated with deficient practice and VA00054276 was unsubstantiated with unrelated deficient practice. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements.<br><br>On 02/08/2022, the census in this 97 certified bed facility was 89. The survey sample consisted of 6 current residents Residents #1, #2, #3, #4, #7 and #8, and 2 closed record reviews, Residents #5 and #6.<br><br>Of the 89 current residents, none were currently positive for COVID-19. Seven staff had members had tested positive for COVID-19. | F 000 | | |
| F 580 SS=D | Notify of Changes (Injury/Decline/Room, etc.)<br>CFR(s): 483.10(g)(14)(i)-(iv)(15)<br><br>§483.10(g)(14) Notification of Changes.<br>(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-<br>(A) An accident involving the resident which | F 580 | **F580**<br>**Corrective Action(s)**<br>Resident #6's responsibility party has been notified that the resident experienced significant weight loss identified on 7/1/21 and 9/1/21. | |

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

Administrator — 3/9/22

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 participation.

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| F 580 | Continued From page 1<br>results in injury and has the potential for requiring physician intervention;<br>(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);<br>(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<br>(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).<br>(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.<br>(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-<br>(A) A change in room or roommate assignment as specified in §483.10(e)(6); or<br>(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.<br>(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).<br><br>§483.10(g)(15)<br>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 | F 580 | **Identification of Deficient Practices & Corrective Action(s):**<br>All other residents may have potentially been affected. The DON/designee will conduct a 100% review of all resident records to identify residents who have not had RP notification regarding changes in resident status in the past 60 days. Negative findings will be corrected at the time of discovery.<br><br>**Systemic Change(s):**<br>The facility policy and procedure have been reviewed and no changes are warranted at this time.<br>Licensed staff will be inserviced by the DON regarding notification of physicians and responsible party when there is a change in resident condition.<br><br>**Monitoring:**<br>The DON is responsible for maintaining compliance. The DON will complete weekly chart audits coinciding with the care plan calendar to monitor for compliance. Any/all negative findings will be corrected at time of discovery. Aggregate findings of these audits will be reported to the QA committee for review, analysis and recommendation for changes in facility policy, procedure and/or practice.<br><br>**Completion Date: 3/25/22** | |

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| F 580 | Continued From page 2<br>part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview, clinical record review, and facility document review, the facility staff failed to notify a resident's responsible party of changes in condition for one of eight sampled residents, Resident #6. Resident #6's responsible party was not notified of significant weight losses.<br><br>The findings include:<br><br>Resident #6's diagnoses included, but were not limited to: high blood pressure, diabetes, thyroid disorder, lung disease, and dementia.<br><br>Resident #6's minimum data set (MDS) assessment, with an assessment reference date (ARD) of 8/27/21, was dated as being completed on 8/30/21. Resident #6 was assessed as sometimes being able to make themself understood and as usually able to understand others. Resident #6 was assessed as having problems with short-term memory and as having problems with long-term memory. Resident #6 was documented as requiring assistance with bed mobility, transfers, dressing, eating, toilet use, and personal hygiene.<br><br>Resident #6's facility documentation indicated the resident had the following weight fluctuations:<br><br>6/6/21 - 111.5 pounds<br>7/1/21 - 99.4 pounds (10.8% loss)<br>8/4/21 - 102.2 pounds<br>9/1/21 - 84.5 pounds (17.3% loss) | F 580 | | |

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| F 580 | Continued From page 3<br><br>No evidence was found to indicate Resident #6's responsible party was notified of the 7/1/21 and 9/1/21 significant weight losses.<br><br>Resident #6's care plan for "NUTRITION / DEHYDRATION/ FLUID MAINTENANCE" (with a problem onset date of 8/27/21) included an approach/intervention of "INFORM MD/RESPONSIBLE PART (sic) OF SIGNIFICANT WEIGHT LOSS/GAINS".<br><br>On 2/10/22 at 9:58 a.m., the facility's Regional Nurse Consultant reported Resident #6's responsible party had not been notified of the resident's significant weight losses. The facility's Administrator and Director of Nursing was present during this interview.<br><br>The following information was found in a facility policy titled "Change in a Resident's Condition or Status" (with a revised date of December 2016): "Our facility shall promptly notify the resident, his or her Attending Physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status ..."<br><br>On 2/10/22 at 12:52 p.m., the failure of facility staff to notify Resident #6's responsible party of weight changes was discussed, for a final time, with the facility's Administrator, Director of Nursing, and Regional Nurse Consultant. | F 580 | | |
| F 842 SS=D | Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5)<br><br>§483.20(f)(5) Resident-identifiable information.<br>(i) A facility may not release information that is resident-identifiable to the public. | F 842 | **F842**<br>**Corrective Action(s):**<br>Resident #1's attending physician has been notified that the resident's clinical record did not accurately reflect a decline in the resident's condition. The resident's VS were not documented in the clinical record for 1/22/22, 1/23/22, and 1/24/22. | |

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| F 842 | Continued From page 4<br>(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.<br><br>§483.70(i) Medical records.<br>§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-<br>(i) Complete;<br>(ii) Accurately documented;<br>(iii) Readily accessible; and<br>(iv) Systematically organized<br><br>§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-<br>(i) To the individual, or their resident representative where permitted by applicable law;<br>(ii) Required by Law;<br>(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;<br>(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.<br><br>§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or | F 842 | Resident #5's attending physician has been notified that the resident's clinical record did not accurately reflect a decline in the resident's condition on 1/21/22.<br><br>**Identification of Deficient Practices & Corrective Action(s):**<br>All other residents may have potentially been affected. The DON and Unit Manager will conduct a 100% review of all resident records to identify residents in the past 90 days who have not had resident to resident incidents documented in their record.<br><br>A 100% review of all resident records will be conducted to ensure that the resident's current comprehensive plan of care is accurately reflected in the record.<br><br>**Systemic Change(s):**<br>The facility policy and procedure has been reviewed and no changes are warranted at this time. All licensed nursing staff will be inserviced by the DON or regional nurse consultant on clinical documentation standards and maintaining complete and accurate clinical records.<br><br>**Monitoring:**<br>The DON is responsible for maintaining compliance. The DON and/or designee will audit medical records weekly coinciding with the care plan calendar to monitor for compliance. Any/all negative findings will be clarified and corrected at time of discovery and disciplinary action will be taken as needed. The results of this audit will be provided to the Quality Assurance Committee for analysis and recommendations for change in facility policy, procedure, and/or practice.<br><br>**Completion Date: 3/25/22** | |

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| F 842 | Continued From page 5<br>unauthorized use.<br><br>§483.70(i)(4) Medical records must be retained for-<br>(i) The period of time required by State law; or<br>(ii) Five years from the date of discharge when there is no requirement in State law; or<br>(iii) For a minor, 3 years after a resident reaches legal age under State law.<br><br>§483.70(i)(5) The medical record must contain-<br>(i) Sufficient information to identify the resident;<br>(ii) A record of the resident's assessments;<br>(iii) The comprehensive plan of care and services provided;<br>(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;<br>(v) Physician's, nurse's, and other licensed professional's progress notes; and<br>(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview, clinical record review, and facility document review, the facility staff failed to maintain a complete an accurate clinical record for 2 of 8 residents, Residents #5 and #1.<br><br>For Resident #5, the facility staff failed to document a decline in condition.<br><br>Resident #1 tested positive for COVID-19 on 1/17/22. Resident #1's clinical record failed to include vital signs for 1/22/22, 1/23/22, and 1/24/22 per facility policy for COVID-19 monitoring.<br><br>The findings included: | F 842 | | |

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| F 842 | Continued From page 6<br><br>1. Resident #5's diagnoses included, malignant neoplasm of unspecified part of bronchus or lung, chronic obstructive pulmonary disease, asthma, gastroesophageal reflux disease, and major depressive disorder.<br><br>Section C (cognitive patterns) of Resident #5's quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 01/05/22 included a BIMS (brief interview for mental status) summary score of 15 out of a possible 15 points. Section G (functional status) had been coded to indicate the resident required supervision of two staff (1/3) for bed mobility, transfers, and locomotion on unit. Walk in room, corridor, and locomotion off the unit was coded (1/1) for supervision with set up help only. Section J (health conditions) was coded (0) to indicate the resident had not had any falls since admission/entry or reentry or the prior assessment. Section O (special treatment/procedures/programs) was coded to indicate the resident was receiving hospice services.<br><br>Resident #5's comprehensive care plan included the problems areas of ADL's (activities of daily living), falls/injuries, and hospice.<br><br>Resident #5 expired at the facility on 01/21/22.<br><br>The nursing staff had documented the following progress notes:<br><br>01/21/22 at 5:41 p.m., LPN (licensed practical nurse) #6 "Resident lying in bed with eyes closed, skin cool and dry, respirations even. Hospice services continue as ordered O2 (oxygen) @ (at) | F 842 | | |

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| F 842 | Continued From page 7<br>3lm/nc (liters per minute per nasal cannula) prn (as needed). Medicated for pain as scheduled and as needed, verbalizes all needs without difficulty. PO (by mouth) fluids and call bell in reach."<br><br>01/21/22 at 6:57 p.m., LPN #3 "Resident is in bed, call light at reach and o2 bnc (nasal cannula)...is sleeping at this time and prn medication administered...consumed 0% of...supper will continue to monitor...remains on hospice and has a DNR (do not resuscitate) code status."<br><br>01/21/22 at 10:53 p.m., LPN #3 "Called to room per CNA (certified nursing assistant) resident is noted without vital signs and unresponsive. Hospice notified and awaiting hospice arrival."<br><br>On 01/22/22 at 3:11 a.m., LPN #6 "LE (late entry) for 1255am funeral home for resident...was released to...funeral home."<br><br>The facility provided documentation that one set of vital signs were obtained on 01/21/22: temperature 97.6, blood pressure 108/68, oxygen saturation 82%, heart rate 90, and respirations 12. The facility also provided a document that referenced this resident "not ok, general decline." This document was not part of the clinical record.<br><br>On 02/08/22 at 2:15 p.m., LPN #3 was interviewed and stated when they entered Resident #5's room, Resident #5 was on the floor beside of the bed with no visible signs of injury, had a decline in condition, they had expected the resident to pass away, and they had checked on this resident every 15 minutes or so on the day Resident #5 expired. | F 842 | | |

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| F 842 | Continued From page 8<br><br>On 02/08/22 at 5:20 p.m., NA (nursing assistant) #2 stated they had found Resident #5 on the floor beside the bed. NA #2 had notified the nurse and put Resident #5 back in the bed. NA #2 stated Resident #5 had been confused that day, had a death rattle, was not doing well, and they "believed" they had checked them every single hour. NA #2 added Resident #5 was very independent.<br><br>On 02/09/22 at 10:25 a.m., the DON (director of nursing) stated when a resident expired if the nurse working the hall was not an RN (registered nurse) the RN in the building would document a note in the resident's clinical record. The DON confirmed there was no nursing note documented by a staff RN when Resident #5 expired.<br><br>On 02/10/22 at 9:50 a.m., the DON stated the nursing staff should have documented Resident #5's change in condition, documented the resident was found in the floor, and that the physician had been notified that Resident #5 had expired.<br><br>On 02/10/22 at 1:45 p.m., the facility provided a copy of their policy titled, "Charting and Documentation" which read in part, "All services provided to the resident...or any changes in the resident's medical, physical, functional...condition, shall be documented in the residents medical record...Documentation in the medical record will be...complete and accurate...Documentation of procedures and treatments will include care-specific details, including...The date and time the procedure/treatment was provided...The assessment data and/or any unusual findings obtained during the | F 842 | | |

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| F 842 | Continued From page 9<br>procedure/treatment...Notification of family, physician, or other staff, if indicated..."<br><br>Resident #5's "FACE SHEET' indicated the resident was their own responsible party.<br><br>No further information regarding this issue was provided to the survey team prior to the exit conference on 02/10/22.<br>2. Resident #1's diagnoses included, but were not limited to: anemia, high blood pressure, diabetes, thyroid disorder, and malnutrition.<br><br>Resident #1's minimum data set (MDS) assessment, with an assessment reference date (ARD) of 1/12/22, was dated as being completed on 1/21/22. Resident #1 was assessed as usually able to make themself understood and as usually able to understand others. Resident #1 was assessed as having problems with short-term memory and as having problems with long-term memory.<br><br>The following information was found in a facility policy/procedure titled "Coronavirus" (with an effective date of 2/2020 and a revised date of 1/4/2022): "Actively monitor all residents upon admission and at least daily for fever and respiratory symptoms (shortness of breath, new or change in cough, and sore throat). If respiratory symptoms noted, document in resident medical record."<br><br>The facility's "DAILY CHARTING FOR FOLLOW - UP OCCURRENCES" forms were reviewed. These forms included the vital signs of multiple residents on the same page. Resident #1's vital signs for 1/22/22, 1/23/22, and 1/24/22 were included on these forms. (The vital signs | F 842 | | |

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| F 842 | Continued From page 10<br>included the resident's blood pressure, heart rate, respiratory rate, temperature, and pulse oximeter reading.)<br><br>On 2/10/22 at 10:15, the facility's Director of Nursing (DON) was asked about the monitoring of residents after testing positive for COVID-19. The DON reported residents who are COVID-19 positive would be monitored at least daily for signs and symptoms of COVID-19 including a full set of vital signs (blood pressure, heart rate, respiratory rate, temperature, and pulse oximeter reading).<br><br>At this time, the aforementioned "DAILY CHARTING FOR FOLLOW - UP OCCURRENCES" forms were reviewed with the DON. The DON confirmed Resident #1's vital signs for 1/22/22, 1/23/22, and 1/24/22 were not documented in the resident's clinical record.<br><br>During an interview on 2/10/22 at 12:20 p.m., the DON reported they would expect vital signs to be obtained as part of this assessment.<br><br>The following information was found in a facility policy titled "Charting and Documentation" (with a revised date of July 2017): "All services provided to the resident, process toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the residents medical record."...The following information is to be documented in the resident medical record: ... Objective observations ... Changes in the resident's condition ...Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate." | F 842 | | |

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| F 842 | Continued From page 11<br>On 2/10/22 at 12:52 p.m., the failure of Resident #1's vital signs to be documented as part of the clinical record was discussed with the facility's Administrator, Director of Nursing, and Regional Nurse Consultant. The "DAILY CHARTING FOR FOLLOW - UP OCCURRENCES" forms not including a time for when the vital signs were obtained and the name of the individual who obtained the vital signs was also discussed. | F 842 | | |
| F 849 SS=D | Hospice Services<br>CFR(s): 483.70(o)(1)-(4)<br><br>§483.70(o) Hospice services.<br>§483.70(o)(1) A long-term care (LTC) facility may do either of the following:<br>(i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices.<br>(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.<br><br>§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:<br>(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.<br>(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 | F 849 | **F849**<br>**Corrective Action(s):**<br>Resident #5's attending physicians have been notified that the facility failed to integrate hospice clinical documentation into the resident's clinical record.<br><br>**Identification of Deficient Practice(s) & Corrective Action(s):**<br>All other residents with Hospice Services may have potentially been affected. A 100% audit of residents receiving Hospice Services will be completed by DON and/or designee to identify residents at risk. All negative findings will be corrected at the time of discovery.<br><br>**Systemic Changes:**<br>The facility policy and procedure has been reviewed and no changes are warranted at this time. All Licensed staff will be inserviced by the Administrator and Hospice Director on the policy and procedure for coordinating care and services with the Hospice Agency for all residents receiving Hospice Services. | |

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| F 849 | Continued From page 12<br>any resident. The written agreement must set out at least the following:<br>(A) The services the hospice will provide.<br>(B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter.<br>(C) The services the LTC facility will continue to provide based on each resident's plan of care.<br>(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.<br>(E) A provision that the LTC facility immediately notifies the hospice about the following:<br>(1) A significant change in the resident's physical, mental, social, or emotional status.<br>(2) Clinical complications that suggest a need to alter the plan of care.<br>(3) A need to transfer the resident from the facility for any condition.<br>(4) The resident's death.<br>(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.<br>(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.<br>(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 | F 849 | **Monitoring:**<br>The DON is responsible for maintaining compliance. The DON, ADON and/or Unit Managers will review all physician Hospice orders to ensure that the facility has integrated hospice documentation in to resident clinical records for all residents receiving Hospice Services. The results of these audits will be reported to the Quality Assurance Committee for review, analysis, & recommendations for change in facility policy, procedure, and/or practice.<br><br>**Completion Date: 3/25/22** | |

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| F 849 | Continued From page 13<br>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.<br>(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.<br>(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.<br>(K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff.<br><br>§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 | F 849 | | |

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| F 849 | Continued From page 14<br>that has the skills and capabilities to assess the resident.<br>The designated interdisciplinary team member is responsible for the following:<br>(i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services.<br>(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.<br>(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.<br>(iv) Obtaining the following information from the hospice:<br>(A) The most recent hospice plan of care specific to each patient.<br>(B) Hospice election form.<br>(C) Physician certification and recertification of the terminal illness specific to each patient.<br>(D) Names and contact information for hospice personnel involved in hospice care of each patient.<br>(E) Instructions on how to access the hospice's 24-hour on-call system.<br>(F) Hospice medication information specific to each patient.<br>(G) Hospice physician and attending physician (if any) orders specific to each patient.<br>(v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, | F 849 | | |

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| F 849 | Continued From page 15<br>and record keeping requirements, to hospice staff furnishing care to LTC residents.<br><br>§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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview, facility document review, and clinical record review, the facility staff failed to integrate the hospice clinical documentation into the residents clinical record for 1 of 8 residents, Resident #5. The clinical record did not include the "HOSPICE DEATH REPORT SUMMARY/MEDICATION DISPOSAL" documentation.<br><br>The findings included:<br><br>This was a closed record review.<br><br>Resident #5's diagnoses included, malignant neoplasm of unspecified part of bronchus or lung, chronic obstructive pulmonary disease, asthma, gastroesophageal reflux disease, and major depressive disorder.<br><br>Section C (cognitive patterns) of Resident #5's quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 01/05/22 included a BIMS (brief interview for mental status) summary score of 15 out of a possible 15 points. Section O (special treatment/procedures/programs) was coded to | F 849 | | |

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| F 849 | Continued From page 16<br>indicate the resident was receiving hospice services.<br><br>The hospice agreement read in part, "...Facility and Hospice shall each prepare and maintain accurate and complete clinical records concerning each Hospice Patient in accordance with prudent record keeping procedures...Facility and Hospice shall coordinate record keeping..."<br><br>Resident #5's clinical record was reviewed on 02/08/22 and 02/09/22 the surveyor was unable to locate hospice documentation in regards to the resident's death.<br><br>On 02/09/22 at 4:15 p.m., during a meeting with the administrator, RNC (regional nurse consultant), and DON (director of nursing) the missing documentation was reviewed.<br><br>On 02/10/22 at 8:15 a.m., the RNC provided the surveyor with a document titled "HOSPICE DEATH REPORT SUMMARY/MEDICATION DISPOSAL."<br><br>On 02/10/22 at 9:50 a.m., the DON confirmed the hospice information was not in the clinical record and it had been faxed to the facility on 02/09/22.<br><br>No further information regarding this issue was provided to the survey team prior to the exit conference on 02/10/22. | F 849 | | |