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	345489	A. BUILDING _____ B. WING _____	C 07/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SATURN NURSING AND REHABILITATION CENTER	1930 WEST SUGAR CREEK ROAD CHARLOTTE, NC 28262

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F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication	F 636		8/14/18

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

Electronically Signed | 08/13/2018

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F 636	Continued From page 1 with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on observation, staff and family member interviews and record review, the facility failed to conduct a comprehensive assessment to identify and analyze how condition affected function and quality of life related to communication and behavior for 1 of 3 sampled residents with behavior problems (Resident #65). The findings included: Resident #65 was admitted to the facility on 03/14/18 with diagnoses which included seizures and unspecified intellectual disabilities. Review of Resident #65's admission Minimum Data Set (MDS) dated 03/21/18 revealed an assessment of severely impaired cognition. The	F 636	This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusion set forth on the statement of deficiencies. This plan of correction is prepared and submitted solely because of requirement under state and federal law, and to demonstrate the good faith attempts by the provider to continue to improve the quality of life of each resident. F636 Root Cause Analysis	

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F 636	Continued From page 2 MDS indicated Resident #65 demonstrated verbal behavior directed toward others with rejection of care in the past 1 to 3 days. The MDS triggered the Communication and Behavioral Symptoms Care Area Assessments (CAA). Review of Resident # 65's Communication CAA dated 03/21/18 revealed no documentation of findings with a description of the problem, contributing factors, and risk factors related to communication. The CAA did not describe or analyze Resident #65's impaired communication, hearing impairment or reason for speech therapy. The was no documentation of input from Resident #65's family and/or representative. There was no documentation of an analysis of findings supporting the decision to proceed or not to proceed to the care plan. Review of Resident # 65's Behavioral Symptoms CAA dated 03/21/18 revealed no documentation of findings with a description of the problem, contributing factors, and risk factors related to behavior. The CAA did not describe or analyze Resident #65's rejection of care. The CAA indicated Resident #65 refused medication on 03/15/18 and screamed at staff on 03/20/18. The was no documentation of input from Resident #65's family and/or representative. There was no documentation of an analysis of findings supporting the decision to proceed or not to proceed to the care plan. Observation on 07/17/18 at 11:52 AM revealed Resident #65 in bed with the left arm elevated on a pillow. Resident #65 was alert, confused and shouted unintelligible words. Telephone interview with Resident #65's family	F 636	Based on root cause analysis by facility administrative staff and nursing administrative staff, facility staff did not conduct a comprehensive assessment to identify and analyze behavior and communication for resident #65. Although staff were providing necessary care to meet the resident needs, it was not documented in the resident CCA as required. Immediate Action On 7/23/2018 the Interdisciplinary Care team reviewed the plan of care for resident #65. The MDS coordinator updated resident #65 CAA to reflect impaired communication, hearing impairment, factors and risk related to behaviors and rejection of care. The resident's family was also contacted and involved with the analysis and decision to proceed with the plan of care. Identification of Others A 100% audit was started on 7/23/2018 of all resident CAA assessments for current resident needs, strengths, goals, life history and preferences. The 100% resident CAA audit was finished on 7/31/2018 with identified necessary changes being made by 8/14/2018 to reflect current resident's needs strengths, goals, life history and preferences. Systemic Changes Measures put into place to ensure the plan of correction is effective and remains in compliance are: Effective 7/26/2018 nursing, social services, dietary, therapy and activity staffs were in-serviced on facility policy/procedures for CAA accuracy to reflect current resident	

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F 636	Continued From page 3 member on 07/17/18 at 3:24 PM revealed Resident #65 resisted care when approached suddenly. Resident #65's family member explained Resident #65 responded to a soft, gentle approach. Resident #65's family member reported facility staff frequently reported inability to transfer Resident #65 out of bed due to care rejection. Observation on 07/18/18 at 10:38 AM revealed Resident #65 seated in a geriatric chair with his right hand in his mouth. Interview with Nurse Aide #1 on 07/18/18 at 10:45 AM revealed Resident #65 became upset frequently with care. NA #1 explained Resident #65 frequently pulled off a hand splint and Resident #65's mood varied from happy to sad during the day. Interview with NA #2 on 07/19/18 at 9:43 AM revealed Resident #65 accepted care when approached slowly and with a soft voice. NA #2 explained Resident #65 used understandable words at times. Interview with Nurse #1 on 07/19/18 at 10:46 AM revealed Resident #65 refused splint application and required two nurse aides for care due to agitation. Nurse #1 explained Resident #65's behaviors varied from cooperative to angry. Interview with Nurse #2 on 07/20/18 at 9:44 AM revealed Resident #65 rejected care such as showers or meals. Nurse #2 explained staff approached Resident #65 at a later time when his mood changed to deliver care. Interview with MDS Coordinator #1 on 07/20/18 at	F 636	information. The in-service will be provided for all necessary staff, to include full time, part time and as needed employees. The education was completed by 7/31/2018. Any staff member not educated by 7/31/2018 will not be allowed to work until receiving education. The education will also be added to the orientation of new hired staff that requires CAA knowledge processes, effective 7/31/2018. Starting 7/31/2018 a weekly CAA audit form, CAA Accurate Audit Form, will be conducted weekly for 10 residents for 8 weeks, and weekly 6 more weeks for 5 residents. The CAA Audit Form will be conducted by the nursing administrative staff, social service staff, and other facility department heads until a pattern of compliance is maintained. Any negative findings will be addressed immediately with staff for corrective action. Monitoring Process Starting 7/31/2018 the CAA Audit will be conducted weekly for 8 weeks for accuracy on 10 residents per week. The audit will be conducted by the nursing administrative staff, social service staff and other facility department heads weekly for 8 weeks for 10 residents and weekly for 6 more weeks for 5 residents or until a pattern of compliance is maintained. Any negative findings will be addressed immediately with staff for corrective action. Administrator and or the DON will report monthly findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for 3 months or	

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F 636	Continued From page 4 1:55 PM revealed Resident #65's Communication CAA did not contain an analysis of findings or included input from Resident #65's family members. MDS Coordinator #1 explained she did not realize documented descriptions, contributing factors, risk factors and analysis of findings were required on the CAAs. Interview with the social service director on 07/20/18 at 2;08 PM revealed the Communication CAA, written by the facility's social worker, did not contain an analysis of findings or included input from Resident #65's family members. Telephone interview with the social worker on 07/20/18 at 2:12 PM revealed Resident #65's Behavior CAA did not contain input from Resident #65's family members. The social worker reported the Behavior CAA did not contain documented descriptions, contributing factors, risk factors and analysis of findings. Interview with the Administrator on 07/20/18 at 2:19 PM revealed he expected staff to follow the Resident Assessment Instrument process. The Administrator reported the CAAs should contain documentation of descriptions, contributing factors, risk factors and analysis of findings.	F 636	until corrective action is achieved.	
F 679 SS=E	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities,	F 679		8/13/18

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F 679	Continued From page 5 designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observations, family and staff interviews and record review, the facility failed to provide an ongoing activity program which met the individual interests and needs to enhance the quality of life for 2 of 4 sampled residents with cognitive deficits (Residents #82 and #10). Findings included: 1. Resident #82 was admitted to the facility on 9/3/16. Resident #82 has diagnoses that included chronic kidney disease, hypertension, and dementia. Review of the care plan dated 7/2/18 revealed that Resident #82 had a problem of little involvement in activities. The goal identified for Resident #82 was that she would show signs of enjoyment in the activities that she attended or the in-room activity that was provided. The interventions included offer opportunities for success and praise as often as possible, offer schedule of activities for choices/ preferences, and give verbal reminders of the activity before commencement. Review of the comprehensive Minimum Data Set (MDS) dated 7/3/18 revealed that Resident #82 was cognitively impaired. Review of Section F	F 679	F 679 Based on Root Cause Analysis by facility administrative staff, Minimum Data Set Coordinator (MDS) and Activity Director, the activity program failed to provide ongoing activities to meet resident individual needs and interest to enhance the quality of care. Immediate Action Corrective action was accomplished for resident #82 and #10 with the review of each resident MDS and plan of care with residents, staff and family. Changes for resident activity likes and preferences were updated and staff in-serviced on changes by 7/31/2018. Identification of Others On 7/25/2018 facility administrative staff, MDS Coordinator and Activity Director started a 100% audit for all residents' activity comprehensive assessments and plan of care. Interviews with residents, families and staff were done to identify resident's individual needs and interest to enhance the quality of life and care. Consideration was taken for resident participation in group and individual activities and independent activities to meet the resident physical, mental and psychosocial well-being to encourage both independence and interaction in the community. The 100% audit of all residents' comprehensive assessment	

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F 679	Continued From page 6 (Preferences for Customary Routines) revealed that Resident #82 enjoyed being around groups of people, participating in religious activities and listening to music were indicated as being very important to Resident #82. An observation on 7/17/18 at 10:45am revealed Resident #82 in the common area with her eyes closed. The television was tuned in to a talk show. An observation on 7/17/18 at 2:38pm revealed Resident #82 in the bed with her eyes open. Resident #82 had no television or music turned on. An observation on 7/18/18 at 2:34pm revealed Resident #82 in the common area with her eyes closed. The television was tuned in to a talk show. An interview on 7/19/18 at 8:47am with Resident #82's primary nursing staff (nurse and nurse aide) revealed that Resident #82 required total assistance with activities of daily living (ADLs). Resident #82 also required staff assistance with meals. Nursing Staff stated that Resident #82's spouse would visit in the evenings and Resident #82's daughter would visit throughout the week depending on her work schedule. Resident #82 would be up daily in her wheelchair. Staff would take Resident #82 to the common area so that she was out of her room. Nursing staff was not aware of any activities provided to Resident #82.	F 679	and plan of care was completed by 8/3/2018. Systemic Changes Measures put into place to ensure the plan of correction is effective and remains in compliance are: A 100% audit of current residents Activity comprehensive assessment plan of care was completed on 8/3/2018 to identify resident's individual needs and interest to enhance the quality of life and care. Identified concerns were addressed and changes made to the effected residents with a completion date of 8/13/2018. MDS and Activity staff were in-serviced on 7/27/2018 on facility policy and procedures for care planning resident activities for individual needs, and interest to enhance the quality of life and care. To ensure residents admitted after 8/3/2018 will receive the same review with documentation and implementation, the same in-service education will be given to any new hires after 8/3/2018 for MDS and activity staff orientation. Starting 8/3/2018 and continuing for 8 weeks, a weekly activity audit will be conducted for 10 residents and then weekly for 6 more weeks for 5 residents to verify resident individual needs and interest to enhance the quality of life and care are being met. The audit will be conducted by the nursing administrative staff, activity service staff, and other facility department heads. Any negative findings will be addressed immediately with staff for corrective action or until a pattern of compliance is maintained. Monitoring Process Starting 8/3/2018 and continuing for 8	

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F 679	Continued From page 7 An observation and interview on 7/19/18 at 5:3pm with Resident #82's family revealed that Resident #82 was in bed when the family arrived to visit. The family stated that the facility does not engage Resident #82 in activities. Family stated that Resident #82 would usually be in bed when they came to visit her in the evenings. Family stated that Resident #82 would enjoy singing, music and other large socials that the facility offered. Family stated that they have not seen facility staff converse or interact with Resident #82. Family stated they would like to see more activity programming for Resident #82. An interview on 7/20/18 at 9:43am with the Activity Director (AD) revealed that Resident #82 attended some activities via staff escort. The AD revealed that she does some lower functioning activities for cognitively impaired residents in their rooms. The AD stated that she does not always capture all the activities that the residents are doing. The AD stated that she can only do so much by herself and that she knows there are things left undone. The AD stated that she needs more help. An interview on 7/20/18 at 10:06am with the Administrator revealed that his expectation was that every residents needs are met. Every resident should have their likes and dislikes assessed and their activity programming addressed.	F 679	weeks the weekly activity audit will be conducted for 10 residents and then weekly for 6 more weeks for 5 residents to verify resident individual needs and interest to enhance the quality of life and care are being met. The audit will be conducted by the nursing administrative staff, activity staff, and other facility department heads until a pattern of compliance is maintained. Any negative findings will be addressed immediately with staff for corrective action. The Administrator and or DON will report findings monthly for 3 months to the Quality Assurance Committee with necessary changes being made to ensure corrective action is achieved and sustained.	

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F 679	Continued From page 8	F 679		

2. Resident #10 was admitted to the facility on 02/05/16 with diagnoses which included anxiety and dementia with behavioral disturbance.

Review of Resident #10's annual Minimum Data Set (MDS) dated 11/29/17 revealed an assessment of severely impaired cognition. The MDS indicated it was very important to Resident #10 to listen to music and go outside in good weather. The MDS did not trigger the Activity Care Area Assessment.

Review of Resident #10's Activity Assessment dated 11/29/17 revealed Resident #10's activity interests included games, sports, music, time outdoors, watching television/radio, talking and social events.

Review of Resident #10's care plan dated 07/10/18 revealed interventions for meaningful activities due to dementia diagnosis included in-room activity of choice, enjoyment of animals, social visits by volunteers and invitation to activities with assistance of escort. The care plan included inclusion in appropriate activities to prevent leaving the facility.

Observation on 07/17/18 at 9:35 AM revealed Resident #10 awake and alert in bed.

Observation on 07/17/18 at 11:54 AM to 12:22 PM revealed Resident #10 seated in a wheel chair in a line of residents with appointments with facility consultant dentist.

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F 679	Continued From page 9	F 679		

Observation on 07/17/18 at 2:51 PM revealed Resident #10 seated in a wheel chair at the side of his bed.

Observation on 07/18/18 at 8:43 AM revealed Resident #10 consumed the breakfast meal in bed and announced the meal tasted good.

Observation on 07/18/18 at 10:46 AM revealed Resident #10 self-propelled into the main dining room. Resident #10 watched a group of residents participate in a game and self-propelled out of the dining room. Resident #10 did not actively participate in the game and no staff member engaged Resident #10 in an activity.

Observation on 07/18/18 at 2:26 PM revealed Resident #10 self-propelled in the hallway and into his room. At 3:17 PM, Resident #10 slept in the wheel chair at the side of the bed.

Observation on 07/19/18 at 9:28 AM revealed Resident #10 seated in a wheel chair in his room. Resident #10 self-propelled out of the room and into the hallway.

Interview with Nurse Aide (NA) #2 on 07/19/18 at 9:40 AM revealed Resident #10 independently self-propelled in a wheel chair. NA #2 explained Resident #10 spent the day going from unit to unit.

Interview with Nurse #1 on 07/19/18 at 10:51 AM revealed Resident #10 wandered independently in a wheel chair. Nurse #1 explained Resident #10 used to be able to play games such as bingo but his dementia worsened. Nurse #1 reported Resident #10 wheeled into his room and removed bed linens to signal a desire to go to bed.

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F 679	Continued From page 10 Observation on 07/19/18 at 2:09 PM revealed Resident #10 seated in wheel chair on another unit with a stack of folded hospital gowns on his lap. Interview with NA #3 on 07/19/18 at 3:25 PM revealed Resident #10's collected linen from carts on units and wandered in a wheel chair. NA #3 explained this was Resident #10's usual routine when awake. Observation on 07/19/18 at 3:45 PM revealed Resident #10, seated in a wheel chair at the side of his bed. Resident #10 pulled down the bed covers. Interview with the Activity Director (AD) on 07/20/18 at 9:08 AM revealed Resident #10 attended group activities but did not remain. The AD explained Resident #10 did not participate in group activities but appeared content to independently travel the hallways. The AD could not recall the last time Resident #10 went outdoors. The AD recalled Resident #10 used to have a Compact Disc (CD) player at his bedside but did not know if the CD player remained. Interview with the Administrator on 07/20/18 at 9:35 AM revealed he expected each resident to have an on-going activity program which addressed interests and needs.	F 679		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and	F 692		7/31/18

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F 692	Continued From page 11 percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and review of the menu, the facility failed to provide a 4 ounce portion of meat (pureed and mechanical soft) to 2 of 6 sampled residents reviewed for nutrition due to a history of weight loss (Resident #96 and 165). The findings included: 1. Resident #96 was admitted to the facility on 6/27/18 with a physician order for a pureed diet. Diagnoses included adult failure to thrive and dementia, among others. A care plan dated 7/2/18 identified Resident #96 at risk for nutritional decline with an intervention to offer a diet as ordered. A quarterly minimum data set dated 7/4/18	F 692	F692 Root Cause Analysis Based on root cause analysis by facility administrative staff and dietary staff, the facility dietary cook did not follow the approved menu and used a 3.5 ounce scoop instead of the required 4 ounce scoop for resident #96, #164, #74 and #165 Immediate Action On 7/17/2018 resident #96 and #165 had 1 ounce pureed pork added to their lunch tray. Identification of Others A 100% audit was started on 7/17/2018 of the 6 residents that have physician orders and receive pureed diets. The 4 other residents had 1 ounce pureed pork added to their lunch tray on 7/17/2018.	

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	345489	A. BUILDING _____ B. WING _____	C 07/20/2018

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F 692	Continued From page 12 assessed Resident #96 with severely impaired cognition, poor appetite and dependent on staff for assistance with eating. On 7/5/18 the physician ordered 120 ml of a high calorie supplement three times daily due to weight loss. Review of her weight history revealed an admission weight of 126 pounds and a weight on 7/16/18 of 124 pounds. An observation on 07/17/18 at 11:40 AM of the lunch meal tray line revealed dietary staff #1 plated 3.25 ounces of pureed meat for Resident #96. The meal was placed on a delivery cart and taken to Resident #96 at 11:48 AM. Review of the menu signed by the registered dietitian (RD) revealed residents on a physician prescribed pureed diet should receive 4 ounces of pureed meat. An observation of the lunch meal delivery on 07/17/18 at 11:50 AM revealed Resident #96 received 3.25 ounces of pureed meat instead of 4 ounces as per the menu. The certified dietary manager (CDM) stated on 07/17/18 at 11:50 AM that Resident #96 should have received 4 ounces of pureed pork per the menu and that dietary staff should serve portions of food according to the approved menu. The CDM further stated that he did not monitor portions served on the tray line that day for lunch. Dietary staff #1 was interviewed on 07/17/18 at 12:20 PM and stated that she set up the lunch meal tray line that day and her usual practice was to use the menu and therapeutic spreadsheet as a guide when determining which serving utensils to use. She further stated "I made a mistake", and did not review or follow the menu that day to	F 692	Systemic Changes Measures put into place to ensure the plan of correction is effective and remains in compliance are: Effective 7/17/2018 an in-service on following the facility menu and using the correct serving utensils was provided to all dietary staff, to include full time, part time and as needed employees. The education was completed by 7/31/2018. Any dietary staff members not educated by 7/31/2018 will not be allowed to work until receiving education. The education will also be provided to the orientation of new hired dietary staff. Monitoring Process Starting 7/23/2018 the Utensil Audit will be conducted 5 times weekly for 8 weeks and weekly for 6 more weeks 2 times a week for accuracy on correct utensils used in accordance with the menu. The audit will be conducted by the Dietary Administrative staff and other facility department heads until a pattern of compliance is maintained. Any negative findings will be addressed immediately with staff for corrective action. Administrator and or the DON will report monthly findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for 3 months or until corrective action is achieved.	

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F 692	Continued From page 13	F 692		

know which serving utensils to use.

A telephone interview was conducted on 07/19/18 at 09:33 AM with the registered dietitian (RD). The RD stated that Resident #96 currently had stable weights and received a nutritional supplement due to her risk for weight loss. The RD also stated that she visited the facility twice monthly and on her past visits she provided in-services regarding portions. The RD stated this was a concern that came up at times, but was corrected immediately. The RD further stated dietary staff would require ongoing education/reminders about the importance of following menus and serving correct portions to meet nutritional needs. She stated that she reviewed/approved menus and expected the dietary staff to follow the menus for foods/portions.

During a telephone interview on 07/20/18 at 04:25 PM, the administrator stated that Resident #96 was followed by the RD and received nutritional supplements in response to her weight loss. He further stated that he expected dietary staff to know/serve correct portions of foods.

2. Resident #165 was admitted to the facility on 7/5/18 with a physician's order for a mechanical soft diet. Diagnoses included dysphagia and cognitive communication deficit, among others.

On 7/11/18 the physician ordered 120 ml of a high calorie supplement two times daily due to weight loss. Review of his weight history revealed an admission weight of 177 pounds and a weight on 7/12/18 of 175 pounds.

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An admission minimum data set dated 7/12/18 assessed Resident #165 with intact cognition, poor appetite and required minimum staff assistance with eating.

A care plan dated 7/13/18 identified Resident #165 at risk for nutritional decline with an intervention to offer a diet as ordered.

An observation on 07/17/18 at 11:40 AM of the lunch meal tray line revealed dietary staff #1 plated 3.25 ounces of mechanical soft meat for Resident #165. The meal was placed on a delivery cart and taken to Resident #165 at 11:48 AM. Review of the menu signed by the registered dietitian (RD) revealed residents on a physician prescribed mechanical soft diet should receive 4 ounces of mechanical soft meat.

An observation of the lunch meal delivery on 07/17/18 at 11:50 AM revealed Resident #165 received 3.25 ounces of mechanical soft meat instead of 4 ounces as per the menu. The certified dietary manager (CDM) stated on 07/17/18 at 11:50 AM that Resident #165 should have received 4 ounces of mechanical soft meat per the menu and that dietary staff should serve portions of food according to the approved menu. The CDM further stated that he did not monitor portions served on the tray line that day for lunch.

Dietary staff #1 was interviewed on 07/17/18 at 12:20 PM and stated that she set up the lunch meal tray line that day and her usual practice was to use the menu and therapeutic spreadsheet as a guide when determining which serving utensils to use. She further stated "I made a mistake", and did not review or follow the menu that day to know which serving utensils to use.

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F 692	Continued From page 15 A telephone interview was conducted on 07/19/18 at 09:33 AM with the registered dietitian (RD). The RD stated that Resident #165 currently had stable weights and received a nutritional supplement due to his risk for weight loss. The RD also stated that she visited the facility twice monthly and on her past visits she provided in-services regarding portions. The RD stated this was a concern that came up at times, but was corrected immediately. The RD further stated dietary staff would require ongoing education/reminders about the importance of following menus and serving the correct portions to meet nutritional needs. She stated that she reviewed/approved menus and expected the dietary staff to follow the menus for foods/portions. During a telephone interview on 07/20/18 at 04:25 PM, the administrator stated that Resident #165 was followed by the RD and received nutritional supplements in response to his weight loss. He further stated that he expected dietary staff to know/serve correct portions of foods.	F 692		
F 745 SS=D	Provision of Medically Related Social Service CFR(s): 483.40(d) §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews and review of the medical record, the facility failed to provide medically-related social services to a resident who requested assistance	F 745	F745 Based on Root Cause Analysis by facility administrative staff, Minimum Data Set Coordinator and Social Service Director,	8/6/18

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with obtaining diabetic shoes for 1 of 7 sampled diabetic residents (Resident #33).

The findings included:

Resident #33 was admitted to the facility on 5/30/14 and re-admitted on 5/22/16. Diagnoses included diabetes mellitus type 2, atherosclerotic heart disease, hypertension, gout, pain in right knee, lymphedema, and hyperlipidemia, among others.

A care plan dated 5/17/18, identified Resident #33 with problems to include increased need for assistance from staff with activities of daily living regarding general debility, pain in her right knee due to gout and generalized weakness. Interventions included therapy screens as needed.

Review of physical therapy (PT) notes revealed Resident #33 was referred for PT services, evaluated and treated on 5/8/18 due to a decline in functional mobility with decreased strength and increased bilateral lower extremity pain. Resident #33 presented with a functional decline in overall functional mobility, and PT services were deemed necessary for strengthening, transfers, bed mobility, ambulation, poor balance and safety awareness. A physician's order dated 6/28/18 extended skilled PT services for an additional 6 weeks regarding continued right knee pain, left knee pain, weakness and poor balance. Review of PT notes revealed Resident #33 ambulated 15 - 50 feet during her PT sessions.

A quarterly minimum data set dated 07/12/18 assessed Resident #33 with clear speech, able to be understood/understands, intact cognition, no

the social service staff failed on 7/7/2018 to provide assistance to resident #33 to obtain diabetic shoes.

Immediate Action
Corrective action was accomplished for resident #33 on 7/19/2018 with facility staff making an appointment for resident #33 with Carolina Foot and Ankle Specialist in Gastonia. Resident had diabetic shoes ordered on 8/7/2018 from Carolina Foot and Ankle Specialist.

Identification of Others
On 7/19/2018 facility Nursing Administrative staff, MDS Coordinator and Social Service Director started a 100% audit for all 26 facility diabetic residents that maybe eligible for diabetic shoes. The audit was completed on 8/3/2018.

Systemic Changes
Measures put into place to ensure the plan of correction is effective and remains in compliance are: A 100% audit completed 8/3/2018 for 26 current diabetic residents for diabetic shoes. On 7/24/2018 an In-service was provided to social service staff on providing residents who request assistance with obtaining medically-related services to enhance the quality of life and care. To ensure residents admitted after 8/3/2018 will be provided assistance with obtaining medically-related services; the same in-service education will be given to any new hires for social service staff orientation.

Monitoring Process
Starting 8/6/2018 a resident needs audit will be conducted weekly for 10 residents for 8 weeks and for 5 residents for 6 more

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F 745	Continued From page 17 mood/behaviors, required extensive staff assistance with bed mobility, dressing, transfers, toileting and hygiene, unsteady balance moving on/off toilet, and without limitations in range of motion. Resident #33 was observed in her room on 07/17/18 at 04:48 PM and stated she had diabetic shoes that were old and had caused blisters on her feet in the past because the shoes were so "old and worn out." Resident #33 stated that her feet hurt when she wore her diabetic shoes and that she had previously reported this to nursing. The resident stated she had requested assistance getting new diabetic shoes, but was told that because she did not walk regularly and did not live in an assisted living facility (ALF), the facility could not help her obtain new diabetic shoes. On 07/19/18 at 11:00 AM Resident #33 was observed in her room wearing diabetic shoes that were ripped, torn and the shoe material thinning both on the interior and exterior of the shoes. Her feet were assessed by Nurse #3 without blisters observed. Nurse #3 stated that she was informed by Resident #3 that her feet hurt when she wore her diabetic shoes and that she wanted new shoes. Nurse #3 said she told the social worker (SW). An interview on 07/19/18 at 11:28 AM with the SW revealed Nurse #3 informed her on Saturday, 07/07/18 that Resident #33 requested assistance obtaining new diabetic shoes because her current diabetic shoes were old and hurt her feet. The SW stated she went and observed that Resident #33's diabetic shoes were "old and very worn." The SW stated she contacted a provider to obtain	F 745	weeks to verify resident individual needs and interest to enhance the quality of life and care are being met. The audit will be conducted by the nursing administrative staff, social service staff, and other facility department heads until a pattern of compliance is maintained. Any negative findings will be addressed immediately with staff for corrective action. The Administrator and or DON will report findings monthly for 3 months to the Quality Assurance Committee with necessary changes being made to ensure corrective action is achieved and sustained.	

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new diabetic shoes for Resident #33 but received written correspondence dated 07/10/18 which stated that this provider only worked with patients who were able to ambulate and lived in an ALF. The SW stated she did not pursue this any further and informed Resident #33 that she did not meet the criteria to obtain new diabetic shoes from this provider. The SW further stated that she should have contacted another provider. The SW also stated that Resident #33 last obtained diabetic shoes during her stay at the facility in May 2016 as a recommendation from the podiatrist.

During an interview with PT assistant (PTA) #1 on 07/19/18 at 11:47 AM, he revealed that Resident #33 complained of ongoing knee and leg pain during PT that had affected her progress. PTA #1 stated that Resident #33 ambulated between 30 - 80 feet during PT and efforts to reduce her pain were unsuccessful. He further stated that he did not recall any complaints of foot pain and that he could not be certain that new diabetic shoes would have reduced her pain level during ambulation.

An interview on 07/19/18 at 11:50 AM with the director of nursing revealed she was not aware that Resident #33 ambulated during therapy, but that she expected the SW to assist with obtaining diabetic shoes by referring to therapy or contacting other providers.

The administrator stated on 07/20/18 at 04:29 PM during a telephone interview that he expected staff to assist residents with obtaining medically-related social services and contact other providers in order to find one who would fit Resident #33 for new diabetic shoes.

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F 803	Continued From page 19	F 803		
F 803 SS=D	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on an observation of the lunch meal tray line, staff interviews and review of menus, the facility failed to serve 4 ounces of pureed and mechanical soft meat according to the menu to 4 of 6 sampled residents reviewed for nutrition (Residents #96, 164, 74 and 165). The findings included:	F 803	F803 Root Cause Analysis Based on root cause analysis by facility administrative and dietary staff, facility dietary cook did not follow the approved menu and used a 3.5 ounce scoop instead of the required 4 ounce scoop for resident #96, #164, #74 and #165	7/31/18

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F 803	Continued From page 20 An observation on 07/17/18 at 11:40 AM of the lunch meal tray line revealed dietary staff #1 plated 3.25 ounces of pureed meat for Residents #96 and #164 with diet orders for a pureed diet and plated 3.25 ounces of mechanical soft meat for Residents #74 and #165 with diet orders for mechanical soft diets. The meals were placed on a delivery cart and taken to the unit for delivery to these residents at 11:48 AM. Review of the menu signed by the registered dietitian (RD) revealed residents on a physician prescribed pureed or mechanical soft diet should receive 4 ounces of pureed or mechanical soft meat. An observation of the lunch meal delivery on 07/17/18 at 11:50 AM revealed Resident #164 and #96 received 3.25 ounces of pureed meat and Residents #74 and #165 received 3.25 ounces of mechanical soft meat instead of 4 ounces as per the menu. The certified dietary manager (CDM) stated on 07/17/18 at 11:50 AM that Residents #164, #96, #74 and #165 should have received 4 ounces of meat per the menu and that dietary staff should serve portions of food according to the approved menu. The CDM further stated that he did not monitor portions served on the tray line that day for lunch. Dietary staff #1 was interviewed on 07/17/18 at 12:20 PM and stated that she set up the lunch meal tray line that day and her usual practice was to use the menu and therapeutic spreadsheet as a guide when determining which serving utensils to use. She further stated "I made a mistake", and did not review or follow the menu that day to know which serving utensils to use. A telephone interview was conducted on 07/19/18	F 803	Immediate Action On 7/17/2018 resident #96, #164, #74 and #165 had 1 ounce protein added to their lunch tray. Identification of Others A 100% audit was started on 7/17/2018 of the 6 residents that have physician orders and receive pureed diets. The 2 other residents had 1 ounce pureed protein added to their lunch tray on 7/17/2018. Systemic Changes Measures put into place to ensure the plan of correction is effective and remains in compliance are: Effective 7/17/2018 an in-service on following the facility menu and to meet the nutritional needs of residents in accordance with established national guidelines and using the correct serving utensils was provided to all dietary staff, to include full time, part time and as needed employees. The education was completed by 7/31/2018. Any staff member not educated by 7/31/2018 will not be allowed to work until receiving education. The education will also be provided to the orientation of new hired dietary staff. Monitoring Process Starting 7/23/2018 the Utensil Audit will be conducted 5 times weekly for 8 weeks and 6 more weeks for 2 times a week for accuracy on correct utensils used in accordance with the menu. The audit will be conducted by the dietary administrative staff and other facility department heads until a pattern of compliance is maintained. Any negative findings will be addressed immediately with staff for corrective action. Administrator and or	

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F 803	Continued From page 21 at 09:33 AM with the registered dietitian (RD). The RD stated that she visited the facility twice monthly and on her prior visits she provided in-services regarding portions. The RD stated this was a concern that came up at times, but was corrected immediately. The RD further stated dietary staff would require ongoing education/reminders about the importance of following menus and serving correct portions to meet nutritional needs. She stated that she reviewed/approved menus and expected the dietary staff to follow the menus for foods/portions. During a telephone interview on 07/20/18 at 04:25 PM, the administrator stated that he expected dietary staff to know/serve correct portions of foods.	F 803	the DON will report monthly findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for 3 months or until corrective action is achieved.	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and	F 812		7/31/18

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F 812	Continued From page 22 serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations of the walk-in refrigerator thermometer and review of refrigeration temperature logs, the facility failed to maintain a working thermometer to monitor refrigeration temperatures for 6 months of recorded temperatures reviewed (January 2018 - June 2018). The findings included: An observation of the walk-in refrigerator occurred on 07/17/18 at 09:54 AM. The thermometer inside the walk-in refrigerator read 32 degrees Fahrenheit. There were no food items observed frozen during this observation. A new thermometer was placed in the walk-in refrigerator by the certified dietary manager (CDM) and a follow up observation of the walk-in refrigerator on 07/17/18 at 12:00 PM revealed the thermometer read 40 degrees Fahrenheit. Review of refrigeration temperature logs revealed temperatures were recorded at/below freezing of 28 - 32 degrees Fahrenheit from January 2018 - June 2018. During an interview with the CDM on 07/18/18 at 04:07 PM, he stated that he did not typically review the refrigeration temperature logs recorded by staff, but that on Mondays, Tuesdays, Thursdays and Fridays, he checked the temperature of the walk-in refrigerator when he placed food orders or when he put stock away. The CDM stated that he had observed the thermometer read between 28 - 40 degrees	F 812	F 812 Root Cause Analysis Based on Root Cause Analysis by facility administrative staff and the Director of Dietary Services, the dietary staff failed to notify dietary administrative staff that the thermometer in the walk in cooler was not properly functioning when they recorded the daily temperature on the temperature log form. Immediate Action On 7/17/2018 the temperature of the walk in cooler was taken with a new thermometer by the certified dietary manager (CDM) at 12:00 PM and revealed the temperature to be 40 Fahrenheit. Food was inspected and was safe in accordance with professional standards for food service safety. Corrective action was accomplished to ensure dietary staff store, prepare, distribute and serve food in accordance with professional standards for food service safety by placing a new thermometer in the walk in cooler on 7/17/2018. On 7/17/2018 dietary staff were also in-serviced on required temperatures, documentation of temperatures and reporting inaccurate temperatures and concerns to administrative staff. Identification of Others Corrective action was accomplished to ensure dietary staff store, prepare,	

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F 812	Continued From page 23 Fahrenheit, and that no food items were noted frozen. He further stated that he had not changed the thermometer in the walk-in refrigerator or verified its accuracy in the past 6 months. An interview with the registered dietitian (RD) occurred on 07/19/18 at 09:33 AM. The RD stated that she visited the facility twice monthly and during her visits she reviewed refrigeration temperature logs to ensure they were complete. She further stated that she had not noticed that the logs recorded temperatures that were 32 degrees or below. The RD also stated that if the recorded temperatures were correct there would have been some evidence that foods/produce were frozen.	F 812	distribute and serve food in accordance with professional standards for food service safety by placing a new thermometer in the walk in cooler on 7/17/2018. On 7/17/2018 dietary staff were also in-serviced on required temperatures, documentation of temperatures and reporting inaccurate temperatures and concerns to administrative staff. On 7/17/2018 all other facility refrigerator thermometers were inspected by facility administrative staff and CDM to make sure they were in good working condition. There were no other thermometers found to be giving inaccurate readings and temperature logs were recorded in the proper range for food service safety. Systemic Changes Measures put into place to ensure the plan of correction is effective and remains in compliance are: A 100% audit on 7/17/2018 for all other facility refrigerator thermometers was done by facility administrative staff and CDM to make sure they were in good working condition. Starting 7/18/2018, four times a week a Temperature Accuracy audit will be conducted for 100% off facility thermometers and temperature logs to verify correct and accurately recorded temperatures to meet professional standards for food service safety. The Temperature Accuracy audit will be conducted by facility administrative staff and dietary administrative staff for 8 weeks 4 times a week and for 6 more weeks 2 times a week until a pattern of	

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F 812	Continued From page 24	F 812	compliance is maintained. Any negative findings will be addressed immediately with staff for corrective action or until a pattern of compliance is maintained. On 7/17/2018 dietary staff were also in-serviced on required temperatures, documentation of temperatures and reporting inaccurate temperatures and concerns to administrative staff. Any staff member not educated by 7/31/2018 will not be allowed to work until receiving education. The education will also be provided to the orientation of new hired dietary staff. Monitoring Process Starting 7/18/2018, four times a week a Temperature Accuracy audit will be conducted for 100% of facility thermometers and temperature logs. The Temperature Accuracy audit will be conducted by facility administrative staff and dietary administrative staff for 8 weeks 4 times a week and for 6 more weeks 2 times a week until a pattern of compliance is maintained. Any negative findings will be addressed immediately with staff for corrective action or until a pattern of compliance is maintained. The Administrator and or DON will report findings monthly for 3 months to the Quality Assurance Committee with necessary changes being made to ensure corrective action is achieved and sustained.	
F 849 SS=D	Hospice Services CFR(s): 483.70(o)(1)-(4)	F 849		7/30/18

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F 849	Continued From page 25 §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished 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	F 849		

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that the needs of the resident are addressed and met 24 hours per day.
(E) A provision that the LTC facility immediately notifies the hospice about the following:
(1) A significant change in the resident's physical, mental, social, or emotional status.
(2) Clinical complications that suggest a need to alter the plan of care.
(3) A need to transfer the resident from the facility for any condition.
(4) The resident's death.
(F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided.
(G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs.
(H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including 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

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delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility.
(J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation.
(K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff.

§483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to 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

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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, 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.

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F 849	Continued From page 29 This REQUIREMENT is not met as evidenced by: Based on record review and staff and family interviews the facility failed to communicate revocation of hospice services for 1 of 2 residents. (Resident #102) Findings included: Review of Resident #102's medical record revealed no order for termination of hospice services. Review of Resident#102's Minimum Data Set (MDS) dated 06/30/2018 documented in Section 0 a significant change with hospice services no longer documented. Review of the hospice revocation of service form from hospice revealed Resident #102's family member revoked hospice services on 06/19/2018. Review of the Nurse Practitioner (NP) progress note dated 07/16/2018 documented Resident #102 was receiving hospice services. Review of the NP's progress note dated 07/18/2018 documented Resident #102 was on hospice services. Review of the Registered Dietician's (RD) progress note dated 07/19/2018 documented Resident # 102 was on hospice. Review of the Pharmacist's note dated 7/19/2018 documented Resident #102 was on hospice. An interview on 07/20/2018 at 3:20 PM with	F 849	F849 Root Cause Analysis Based on Root Cause Analysis by facility administrative staff, Director of Nursing (DON), Resident Care Coordinator (RCC) and Social Service Director; the nursing department failed on 6/19/2018 to communicate to the social service department the revocation of hospice services for resident #102. Immediate Action Corrective action was accomplished for resident #102 with the resident physician being notified of the revocation of hospice services on 6/19/2018 and the resident physician writing on 7/20/1018 an order for revocation off hospice services for resident #102. There were no other orders or changes in plan of care from the resident physician. Identification of Others On 7/20/2018 facility administrative staff, DON, RCC and Social Service Director started a 100% audit of physician orders for all facility residents with hospice services. The 100% hospice physician order audit was finished on 7/20/2018 with no other errors being found. Systemic Changes Measures put into place to ensure the plan of correction is effective and remains in compliance are a 100% audit on 7/20/2018 of physician orders for facility residents receiving hospice services. Beginning 7/20/2108 an in-service for nursing staff and social service staff was given on the facility communication	

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F 849	Continued From page 30 hospice Staff #1 revealed Resident #102 was on hospice Services 05/24/2018 -06/19/2018. She stated Resident #102's family member had revoked hospice services. An interview on 07/20/2018 at 4:00 PM with the NP revealed that she got a list the beginning of the month of who was on hospice. She stated she wasn't told Resident #102 was off hospice. An interview on 07/20/2018 at 4:15 PM with Samantha Scruggs Registered Dietician (RD) revealed she was not aware Resident #102 was not on hospice. She stated she usually looked at the resident's orders that would include that change in service. An interview on 7/20/2018 at 4:32 PM with Resident #102's family member revealed she revoked hospice services in June 2018. An interview on 7/20/2018 at 4:47 PM the Pharmacist revealed she was not aware resident was no longer on hospice services. She stated she would usually see an order in the chart to discharge resident from hospice or a note in progress or general notes with that information. She stated she did a month look back at orders and would have seen a discharge from hospice order there if there was one. An interview on 7/20/2018 at 4:51PM with the Director of Nursing (DON) revealed there was no designated hospice person for the facility. If someone came off hospice an order was put in the medical record. Hospice would come and pull the front sheet out (the yellow or pink sheet) and they let business office know about it. There was an expectation that there would be an order in the	F 849	process, notification of revocation of hospice services and physician orders. Nursing and social service staff not in-serviced by 7/28/2018 to include full time, part time and as needed employees will not be allowed to work until receiving education. The education will also be added to the orientation of new hired staff. Monitoring Process Starting 7/30/2018 a weekly hospice physician orders audit will be conducted for 100% of hospice residents to verify resident physician orders are correct. The audit will be conducted by the nursing administrative staff, social service staff, and other facility department heads 2 times weekly for 8 weeks	

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chart to discharge a resident from hospice services so the team members would know the services were no longer being provided. We discussed this in the morning meeting. The SW would be the person to notify the doctor to place an order in the medical record to dischargea resident from hospice services. The Social Worker (SW) would notify nursing regarding need for that order and nursing would follow up to get the order from the doctor.

An interview on 7/20/2018 at 5:13 PM with the SW revealed she was not involved with Resident #102 when she was discharged from hospice services. She stated she was not the person who received that information for Resident #102. Whoever receieved the information had the responsibility to give that information to the doctor and get the order on the resident's chart. Hospice had contacted someone here regarding Resident #102 being discharged from hospice services.

An interview on 7/20/2018 at 5:32 PM with the Administrator revealed there needed to be follow up with Resident #102's responsible party regarding their desire to cancel hospice services. There needed to be an order to discontinue hospice services. This needed to be done in a timely manner. He stated they go over all those things in their morning meeting. He did not know how this breakdown in communication with hospice had occurred.