STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. BUILDING _____ B. WING _____	C 02/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - BURLINGTON	323 BALDWIN ROAD BURLINGTON, NC 27217

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Recertification survey was conducted on 1/29/19 through 2/1/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #Y6CC11.	E 000		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through	F 585		3/1/19

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

Electronically Signed | 02/21/2019

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F 585	Continued From page 1	F 585		

postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;

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F 585	Continued From page 2 (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on record review, family and staff interviews, the facility failed to provide a written grievance summary for 1 of 1 sampled residents (Residents #70) reviewed for grievances and failed to provide residents with the opportunity to file grievances anonymously. Findings include: 1. Resident # 70 was admitted to the facility on 9/5/17 with diagnoses that included chronic obstructive pulmonary disease, diabetes mellitus type II, dementia, major depression disorder, anxiety and mood disorder.	F 585	White Oak Manor-Burlington will ensure grievances are provided in a written summary, and provide residents and families the opportunity to file grievances anonymously. Grievance forms will be filled out appropriately, indicating follow up with the resident and/or representative and the written summary will be reviewed with and provided to the resident and/or representative. Resident #70 concerns\grievances have been addressed to family satisfaction and	

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F 585	Continued From page 3 Review of the grievance report dated 7/23/18 revealed a grievance was submitted by a family member which alleged Resident #70 was not provided incontinent care and the resident's pants and brief was saturated with urine and feces. Resolution indicated the staff was educated on resident care and the resident's family was notified about the interventions. No written grievance summary was provided to the family. The grievance form does not indicate if the resident/ resident representative/ family was satisfied with the resolution. During an interview on 1/28/19 at 9:40 PM, family member indicated on many occasions, Resident # 70 was found in urine and feces and was not changed for long time. The resident's diaper was changed by the family member a couple of times. Review of the most recent quarterly Minimum Data Set (MDS) dated 1/21/19 revealed Resident #70 was cognitively impaired and needed limited to extensive one-person assistance with activities of daily living (ADLs). During an interview on 02/01/19 at 9:36 AM, Assistant Director of Nursing (ADON) stated if concerns were addressed immediately and if action was taken related to the concern then no grievance was written for the concern. ADON also stated the action taken was communicated verbally to the resident or family member. During an interview on 02/01/19 at 9:36 AM, Social Worker (SW) stated the grievance forms were not filled for concerns that were addressed immediately. SW further stated the facility does verbal communication with feedback to family and do not give a written response. All concerns	F 585	written summary given on 2/12/2019. Boxes with grievance forms were placed in areas throughout the facility for anyone wishing to file a grievance anonymously with instruction to place in folder in box by the facility posting in the main entrance. Folder is checked daily by the Administrator or Social Service Director. The facility staff have been re-educated prior to 3/1/19 on the grievance policy and how to fill out a grievance form. Also, that grievance forms may be filled out anonymously and where those boxes are located. Education provided by the Staff Development Coordinator. Any PRN staff will be educated prior to resident care on their next shift. Newly hired staff will be educated on the grievance policy during orientation by the SDC or Social Services Director. Filed grievances will be reviewed during the morning meeting (Monday-Friday) for staff awareness and follow up, investigation, monitoring needs, and\or education to be completed. The facility will educate the residents regarding the ability to file a grievance anonymously during their Resident Council meeting in March. It will also be noted in the monthly newsletter that is shared with residents and families. The Admission Coordinator or Social Services will continue to inform new admissions on how this process works.	

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F 585	Continued From page 4 that were immediately resolved were communicated verbally. SW stated she was unaware that a written response should be provided. 2. During an interview on 02/01/19 at 9:36 AM, Assistant Director of Nursing (ADON) stated the residents needed to ask staff for the grievance/ complaint forms and the staff would assist them to file a grievance. ADON further stated the forms were available at the nursing station. ADON was unable to state how a resident could file a grievance anonymously. During an interview on 02/01/19 at 9:36 AM, Social Worker (SW) stated the grievance forms were available at the nursing station. She indicated the residents could ask any staff for the forms and staff could assist them to file their grievances. SW was unable to state how a resident or family member could file a grievance anonymously. During an interview on 02/01/19 at 12:47 PM, Administrator stated the grievances forms were available at the nursing stations. She specified there was currently no way a resident could file a grievance anonymously and indicated the grievance/complaint forms would be made available throughout the facility for residents who would like to obtain a form without having to request to obtain a form from staff, so they could then file an anonymous grievance.	F 585	Social Services will utilize a monitoring tool that will involve interviewing 5 residents/family members weekly for 8 weeks to ensure they know the grievance process and to ask them if they had a grievance filed in the past week so they can follow up to ensure it has been logged and completed timely. Identified trends or issues noted from the monitoring tool are addressed at the morning meeting weekly for 8 weeks and as needed thereafter when issues arise. During the monthly QA meeting for 2 months the committee will review and discuss the weekly findings and make recommendations for changes as indicated. Further discussion and review will occur when new issues or trends are identified. Social Service Director is responsible for compliance of F 585. Compliance date 3/1/19.	
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry	F 677		3/1/19

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F 677	Continued From page 5 out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, record reviews and staff and family interview the facility failed to provide showers as scheduled for 1 of 6 sampled dependent residents (Resident #59) reviewed for activities of daily living. The findings included: Resident #59 was admitted to the facility on 11/30/18 with diagnosis that included dementia, major depression disorder and chronic pain. Review of the admission Minimum Data Set (MDS) dated 12/6/18 indicated Resident # 59 had severely impaired cognition. Resident # 59 was limited assistance of one staff for transfers, toileting, dressing and personal hygiene and extensive assistance of one staff for bathing. Review of Resident # 59's care plan dated 12/12/18 related to Activities of Daily Living (ADL) revealed the resident requires assistance from staff with grooming and personal hygiene. The Goal indicated the resident will increase in independence and interventions included breaking tasks into smaller steps, giving verbal cues and needing one person assist for grooming. The care plan does not indicate any interventions related to bath and showers. The care plan also included a Certified Nurse aide (CNA) care and data collection guide which indicated Resident # 59 care needs that were identified. The only approach indicated for bathing and showers was to record bathing. It does not	F 677	White Oak Manor-Burlington ensures all residents receive the Activities of Daily Living (ADL) care and receive the necessary services to maintain good nutrition, grooming, and personal oral hygiene. Resident #59 receives bed baths from Hospice aide Monday-Friday and resident would decline to have a shower from facility staff after receiving bed bath and being dressed. The facility nursing staff are to provide resident #59 with showers or report to the charge nurse that the resident refused his shower. The charge nurse and aide offer shower again and document any refusal. A shower sheet will be completed by the facility aide for each resident who is scheduled for a shower for the next 3 months and as needed thereafter if concerns arise. Refusal of care is to be documented by the charge nurse in a nurses note. The nursing staff were re-educated prior to 3/1/19 on ADL care by the Staff Development Coordinator, specifically on scheduled showers\bed baths and reporting refusals of showers. The nursing staff was also educated on hospice involvement of care for the residents under Hospice services.	

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F 677	Continued From page 6 indicate shower schedule and who is provide the resident showers. Review of the Hospice Nurse Aide (NA) assignment/care plan dated 12/18/18 revealed bathing to be provided by hospice NA. Review of a facility document titled "C-Wing Weekly Shower Schedule" indicated that Resident # 59 was scheduled for a shower on Tuesdays and Fridays, on 1st shift. Review of the facility document titled "Bathing report roster" from 12/1/18 to 1/30/19 for Resident # 59 revealed the resident's last shower was provided on 12/4/18. During an interview and observation on 1/29/19 at 9:10 AM, Resident # 59's family member indicated facility and hospice staff were providing Activity of Daily Living (ADL) care to the resident. Family member indicated she was unsure if Resident # 59 was provided showers or had his hair washed as the resident's hair was always greasy. Observation of the Resident # 59's revealed his hair appeared to be shinny and oily. During an interview on 01/30/19 at 10:37 AM, Nurse #7 stated if hospice staff was unable provide any ADL care or did not provide showers then the facility Nurse aides (NA) would complete the task. Nurse # 7 further stated if Resident # 59 refused showers then it should be reported to the nurse. Nurse # 7 also stated Resident # 59 shower refusal was not reported to him. During an interview on 01/30/19 at 11:10 AM, Hospice NA#2 stated the Hospice NA assignment/ care plan for Resident #59 indicated	F 677	Showers are to be provided by the facility nursing staff. Any PRN staff will be educated prior to resident care on their next shift. Newly hired nursing staff will continue be educated on ADL care during orientation by the SDC. The DON, SDC and\or ADON will complete the monitoring tool weekly for 8 weeks and monthly for 2 months and as needed thereafter when concerns are identified. Identified trends or concerns will be discussed in the morning meeting (Monday-Friday)for the next 8 weeks and during the monthly QA meetings for 3 months and periodically thereafter when issues arise with the committee making recommendations as needed. The Director of Nursing is responsible for compliance of F 677. Compliance date: 3/1/19.	

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F 677	Continued From page 7	F 677		

bathing was to be provided but did not indicate showers were to be provided by the hospice staff. Hospice NA #2 further stated Resident # 59 was to receive showers from facility staff. Hospice NA # 2 indicated the facility staff usually asked her if bed bath was provided for Resident #59 and walked away. Hospice NA # 2 was unsure if the resident was provided showers.

During an interview on 1/31/19 at 10:00 AM, Nurse # 9 stated the facility staff were responsible for providing showers. Nurse # 9 further stated she did not receive any report related to Resident # 59 not provided any showers. Nurse # 9 indicated even if Resident # 59 was provided bed bath by the hospice NA, the facility staff should provide showers on the scheduled shower days. Nurse # 9 stated if Resident # 59 had refused showers than it should be reported to the nurse in charge and documented in resident care tracker.

During an interview on 1/31/19 at 10:15 AM, NA # 14 stated she usually worked on the first shift (Monday - Friday) at the facility and had never given Resident # 59 a shower on scheduled shower days. NA # 14 further stated the Resident # 59 was scheduled for showers on Tuesday and Friday. NA # 14 indicated the resident was taken care by hospice NA during the first shift and was provided a bed bath by Hospice NA. She further indicated hospice staff would provide bed bath and dress the resident before the shift began and the NA would wash Resident # 59 hair if needed. She indicated she was not sure why resident did not receive any showers. NA was also aware that Resident # 59 was the only resident who did not receive showers from hospice staff.

During an interview on 1/31/19 at 10:20 AM, the

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F 677	Continued From page 8 Director of Nursing (DON) stated Resident # 59 should be offered showers on scheduled shower days by the facility NA and refusal should be notified to nurse in charge. DON also stated hospice staff and facility staff should communicate with each other so that showers were provided as scheduled. During a telephone interview on 1/31/19 at 12:08 PM, NA # 16 stated, he usually worked first shift and Resident# 59 was assigned to him. NA #16 stated he did not give the resident a shower or provide dressing as the hospice staff completed these tasks. NA # 16 stated it was his understanding showers were provided by hospice staff. He further stated it was only earlier this week when he was made aware Resident # 59 did not receive showers from hospice staff but from facility staff. During an interview on 2/1/19 at 12:57 PM. Administrator stated it was her expectation facility nursing staff provide showers to residents as scheduled. She further stated that care provided should be communicated between hospice and facility staff, verbally and with documentation.	F 677		
F 849 SS=E	Hospice Services CFR(s): 483.70(o)(1)-(4) §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the	F 849		3/1/19

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F 849	Continued From page 9	F 849		

resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer.

§483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements:
(i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services.
(ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following:
(A) The services the hospice will provide.
(B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter.
(C) The services the LTC facility will continue to provide based on each resident's plan of care.
(D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day.
(E) A provision that the LTC facility immediately notifies the hospice about the following:
(1) A significant change in the resident's physical, mental, social, or emotional status.
(2) Clinical complications that suggest a need to alter the plan of care.
(3) A need to transfer the resident from the facility for any condition.

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F 849	Continued From page 10 (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions. (I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility. (J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice	F 849		

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administrator immediately when the LTC facility becomes aware of the alleged violation.
(K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff.

§483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident.
The designated interdisciplinary team member is responsible for the following:
(i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services.
(ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family.
(iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians.
(iv) Obtaining the following information from the hospice:

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 849	Continued From page 12 (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is not met as evidenced by: Based on observation, staff and family interviews, and record review the facility failed to maintain communication and coordination of services provided by Hospice and facility personnel to ensure showers were provided as scheduled for 1 of 1 sampled residents (Resident #59) reviewed for hospice. The findings included:	F 849	White Oak Manor-Burlington will ensure communication and coordination of services provided by hospice and facility staff. Resident #59 will be offered showers on the scheduled shower days by the facility nursing staff. The Hospice aide communication sheet was placed in	

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	345301	A. BUILDING _____ B. WING _____	C 02/01/2019

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F 849	Continued From page 13 Resident #59 was admitted to the facility on 11/30/18 with diagnosis that included dementia, major depression disorder, insomnia, chronic kidney disease, atrial fibrillation, thyroid disorder and chronic pain. Review of the physician orders for hospice was dated 12/3/18. Review of the admission Minimum Data Set (MDS) dated 12/6/18 indicated Resident # 59 had severely impaired cognition, needed limited assistance of one staff for transfers, toileting, dressing and personal hygiene and extensive assistance of one staff for bathing. The MDS Assessment indicated the resident was on hospice care. Resident #59' s plan of care updated 12/6/18 included the focus area of hospice care. The goal indicated the resident would be comfortable throughout hospice care. Interventions include coordinate care with hospice team and coordinate with the hospice team to assure residents experiences as little pain as possible. Review of the hospice care plan dated 12/19/18 revealed the Hospice nurse aide assignment sheet was to be included with the care plan documentation. However, the hospice NA assignment sheet was not found in Resident# 59's medical chart. During a family interview and observation on 1/29/19 at 9:10 AM, Resident # 59's family member indicated the facility and hospice staff were providing Activity of Daily Living (ADL) care to the resident. Family member was unsure if	F 849	resident #59's medical record. Charts and care plans were audited for all Hospice residents. Hospice aide communication sheets and care plans in place. Shower sheets being completed by facility staff on residents scheduled shower days with refusals being documented by the charge nurse in a nurses note and on shower sheets by the facility aides. A communication form for the hospice aides and the facility aides has been placed in a binder on each unit to ensure communication on ADL and shower care provided to each hospice resident. The nursing staff were re-educated prior to 3/1/19 on residents with hospice services on the care the hospice aides provide and where to find and complete the communication form. Staff also re-educated on providing scheduled showers and reporting of refusals. This education was completed by the Staff Development Coordinator. Any PRN staff will be educated prior to resident care on their next shift. Newly hired nursing staff will be educated on ADL care and communication form during orientation by the Staff Development Coordinator. The Director of Nursing, Assistant Director of Nursing and Staff Development Coordinator will monitor completion of the communication form and ADL care weekly for 12 weeks and as needed thereafter as issues arise.	

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F 849	Continued From page 14 resident's care was communicated between hospice and facility staff. Family member was concerned that showers were not provided to the resident on scheduled days. Observation of the Resident # 59's, at the time of this family interview, revealed his hair appeared to be shinny and oily. During an interview on 1/30/19 at 11:10 AM, Hospice Nurse aide (NA)#2 stated Resident# 59 was provided hospice care from Monday through Friday. Hospice NA # 2 further stated according to the resident's hospice NA assignment sheet the resident received baths from hospice staff and the facility staff was responsible for providing the resident's scheduled showers. During an interview on 1/31/19 at 10:00 AM, Nurse # 9 indicated there was no hospice NA assignment sheet in Resident #59 's medical chart. Nurse # 9 further stated the facility NA's could not access the resident's medical chart and were not aware what was documented related to the care provided by the hospice NA. Nurse # 9 further stated that both the hospice and the facility nurse aides need to be communicating with each other and there seemed to be a miscommunication between them regarding who was to provide Resident #59's scheduled showers twice a week. During an interview on 10/31/19 at 10:18 AM, Nurse aide (NA) # 14 stated Resident # 59 was under hospice care during the first shift. NA further stated the resident's shower days were Tuesdays and Friday and was not sure why showers were not provided. NA indicated Resident # 59 was dressed and bathed by hospice early and was ready before the morning	F 849	Concerns or trends are discussed during morning meetings (Monday-Friday) for the next 12 weeks and during the monthly QA meetings for the next 3 months and as needed thereafter with the QA Committee making recommendations for changes as indicated. The Director of Nursing is responsible for ongoing compliance of F849. Compliance date: 3/1/19.	

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F 849	Continued From page 15	F 849		

shift started.

During an interview on 1/31/19 at 12:08 PM, NA # 16 stated resident was bathed and dressed by hospice staff. NA #16 was unaware that facility staff provided showers to Resident # 59. NA # 16 stated it was always his understanding that hospice staff gave resident showers.

During an interview on 2/1/19 at 9: 54 AM, Hospice Nurse #3 stated the Hospice NA follows the hospice NA care guide/ assignment and documents services provided in resident chart. She further stated the resident's medical chart should include a hospice aide assignment sheet that specifies the care that is to be provided by hospice nurse aides. Hospice Nurse #3 further stated this hospice care guide/ assignment sheet would be helpful for facility staff to refer to, so they would know what care needs the hospice NA is responsible for completing. She confirmed the Hospice NA care guide/assignment was not in Resident # 59's medical chart as it should be.

During an interview on 1/31/19 at 10:20 AM, the Director of Nursing (DON) stated Resident # 59 should be offered showers on scheduled shower days by the facility NA. The DON also stated hospice staff and facility staff should communicate with each other so that showers were provided as twice a week as scheduled.

During an interview on 2/1/19 at 12:57 PM, the Administrator stated it was her expectation that a hospice resident's care be coordinated between hospice staff and facility staff. She further stated that care provided should be communicated between both parties verbally and with documentation. She indicated she expected the

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F 849	Continued From page 16 hospice documentation to be available in the medical chart for resident's care so staff would be aware of their responsibilities in caring for the resident.	F 849		