Department of Veterans Affairs State Veterans Home Survey Report

This survey report and the information contained herein, resulted from the State Veterans Home (SVH) Survey as a Summary Statement of Deficiencies. (Each Deficiency Must be Preceded by Full Regulatory or applicable Life Safety Code Identifying Information.) Title 38 Code of Federal Regulations Part 51 is applied for SVHs applicable by level of care.

General Information:

Facility Name: Ambrosio Guillen Texas State Veterans Home

Location: 9650 Kenworthy St., El Paso, TX 79924

Onsite / Virtual: Onsite

Dates of Survey: 12/19/22 through 12/22/22

NH / DOM / ADHC: NH

Survey Class: Annual

Total Available Beds: 160

Census on First Day of Survey: 148

VA Regulation Deficiency	Findings
	Initial Comments: A VA Annual Survey was conducted from December 19, 2022 through December 22, 2022 at the Ambrosio Guillen Texas State Veterans Home. The survey revealed the facility was not in compliance with Title 38 CFR Part 51 Federal Requirements for State Veterans Homes.
§ 51.43 (e) Drugs and medicines for certain veterans. As a condition for receiving drugs or medicine under this section or under §17.96 of this chapter, the State must submit to the VA medical center of jurisdiction a completed VA Form 10-0460 with the corresponding prescription(s) for each eligible veteran. **Level of Harm** – No Actual Harm, with potential for minimal harm **Residents Affected** - Many	The facility was unable to demonstrate submission to the VA medical center of jurisdiction of a completed VA Form 10-0460 for each eligible resident. The findings include: Based on interviews and record review, the facility obtained medications from the VA of jurisdiction for seven (7) residents who met eligibility under 38 CFR §51.43. During interviews and record review, the facility failed to complete and submit VA Form 10-0460 as required for all seven (7) residents. During interviews with Administrative Staff A, Administrative Nurse A, Licensed Nurse A, Consultant Staff A, Consultant Staff B, and Administrative Staff B on 12/20/22, it was reported that the facility was not utilizing VA Form 10-0460 for any eligible residents whose medications were provided by the VA of jurisdiction.
§ 51.110 (b) (2) Frequency. Assessments must be conducted—	Based on observation, interview, and record review, the facility failed to conduct a comprehensive assessment for one (1) of 21

(i) No later than 14 days after the date of admission; (ii) Promptly after a significant change in the resident's physical, mental, or social condition; and (iii) In no case less often than once every 12 months. **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Few	sampled residents (Resident #11) who demonstrated a significant improvement in self-performance of activities of daily living (ADLs) after admission to the facility. The findings include: Observation of Resident #11, during breakfast service on 12/20/22, found the resident moving both upper extremities while eating. Review of Resident #11's clinical record revealed they were admitted to the facility on [DATE], after having sustained a Cerebrovascular Accident (CVA), which resulted in weakness affecting their left upper and lower extremities. According to the Admission Minimum Data Set assessment (MDS) with an Assessment Reference Date (ARD) of [DATE], Resident #11 required the extensive assistance of two (2) or more staff members to move around in bed and transfer between the bed and the chair. Resident #11 did not walk in their room or the corridor during the seven (7) day assessment reference period preceding the ARD. Resident #11 was also noted to have functional limitations in range of motion to the upper and lower extremities with impairment on one (1) side of their upper and lower extremities. According to the Quarterly MDS with an ARD of [DATE], which was completed three (3) months after admission to the facility, Resident #11 required only the limited assistance of one (1) staff member to move around in bed and transfer between the bed and the chair. Resident #11 was able to walk in their room with staff supervision and no physical assistance. Resident #11 was also noted to have no functional limitations in range of motion to either upper or lower extremity. During an interview with Licensed Nurse B and Licensed Nurse C at 3:35 p.m. on 12/22/22, Licensed Nurse B agreed that, since their admission to the facility, Resident #11 had demonstrated a significant improvement in self-performance of bed mobility, transfer, and ambulation, and no longer had impairments in functional range of motion to either upper or lower extremity. Licensed Nurse B further agreed that an off-cycle Significant Change in Status MDS should have been performed before, or instead of, the [DATE], Quarterly MDS.
§ 51.110 (e) (2) Comprehensive care plans. A comprehensive care plan must be— (i) Developed within 7 calendar days after completion of the comprehensive assessment;	Based on review of facility policy, record review, and interview, the facility failed to review and revise the Care Plan of Resident #21, one (1) of 24 sampled residents, after they suffered a fall with an injury. The findings include:

(ii) Prepared by an interdisciplinary team, that includes the primary physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and (iii) Periodically reviewed and revised by a team of qualified persons after each assessment. **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Few	Review of facility policy titled, "Fall Prevention and Reduction Program," Revised March, 2022 revealed: "7. A Care Plan for 'At Risk for Injury/Falls' will be developed, reviewed, and implemented upon admission, readmission, and change in condition, quarterly and as needed. Care Plan will be updated after a fall with a new intervention." Review of the clinical record revealed Resident #21 was admitted to the facility on [DATE], with diagnoses including Dementia, End Stage Heart Failure, Hypertensive Heart, Chronic Kidney Disease, and Major Depressive Disorder. Review of the Care Plan revealed Resident #21 was at risk for falls/injury. Review of the Progress Notes revealed Resident #21 had a witnessed fall on [DATE]. On [DATE], Resident #21 was sent out to the hospital after developing pain and swelling to their right forearm. Resident #21 returned to the facility on [DATE], with a hard cast placed due to a broken forearm. The facility's Inter-disciplinary Team (IDT) met to review the fall on [DATE]. The committee's recommendation was for Resident #21 to have an x-ray, which had already been completed. No new interventions to prevent reoccurrence of falls were added to Resident #21's Care Plan. In an interview on 12/21/22, at 1:50 p.m., the facility's Consultant Staff A stated that getting an x-ray was not an appropriate intervention to prevent reoccurrence of a fall.
§ 51.110 (e) (3) Comprehensive care plans. The services provided or arranged by the facility must— (i) Meet professional standards of quality; and (ii) Be provided by qualified persons in accordance with each resident's written plan of care **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Few	Based on observation, interview, and record review, the facility failed to provide appropriate treatment and services for three (3) of 21 sampled residents reviewed for medication administration documentation (Residents #13, #14, and #17). The findings include: Record review of the facility policy titled, "General Dose Preparation and Medication Administration," dated 12/01/07, revealed: "1. Facility staff should comply with Facility policy, Applicable Law and State Operations Manual when administering medications…6. After medication administration, Facility staff should take all measures required by Facility policy and Applicable Law, including, but not limited to the following: 6.1. Document necessary medication administration/treatment information (e.g., when medications are opened, when medications are given, injection site of a medication, if medications are refused, PRN medications, application sight) on appropriate forms."

	1. Record review of Resident #13's face sheet, reviewed on 12/22/22, revealed the resident was admitted to the facility on [DATE], with diagnoses including but not limited to: Essential Hypertension, Type 2 Diabetes Mellitus, Peripheral Vascular Disease, and Pulmonary Heart Disease. Record review of Resident #13's Active Orders revealed the following orders: - "Lisinopril Tablet Give 10 MG [milligrams] by mouth in the morning related to ESSENTIAL (PRIMARY) HYPERTENSION (I10) check b/p [blood pressure] if less than 110/60 pulse < 60 do not give, notify MD If medication Is not given x 3 Days," with an order start date of [DATE]. - "Vistaril Capsule 25 MG (hydrOXYzine Pamoate) Give 25 mg by mouth two times a day for agitation and anxiety related to RESTLESSNESS AND AGITATION (R45.1)," with an order start date of [DATE]. Record review of Resident #13's [DATE] Medication Administration Record (MAR), dated [DATE], revealed: -For the order: "Lisinopril Tablet Give 10 mg by mouth in the morning related to ESSENTIAL (PRIMARY) HYPERTENSION (I10) check b/p if less than 110/60 pulse < 60 do not give, notify MD If medication Is not given x 3 Days," the resident was documented as being administered the medication against physician prescribed parameters for the following days: [DATE] (Pulse was 58), [DATE] (Pulse was 57), [DATE] (Pulse was 58), [DATE] (Pulse was 54), [DATE] (Pulse was 58), and [DATE] (BP was 102/57). - For the order "Vistaril Capsule 25 mg (hydrOXYzine Pamoate) Give 25 mg by mouth two times a day for agitation and anxiety related to RESTLESSNESS AND AGITATION (R45.1)." it was revealed for the scheduled administration time of 8:00 p.m., on [DATE], there was a blank space with no indication that the medication was administered/refused/held/etc. 2. Record review of Resident #14's face sheet, reviewed on 12/22/22, revealed the resident was admitted to the facility on [DATE], with diagnoses including but not limited to: Dementia, Hyperlipidemia, and Hypothyroidism. Record review of Resident #14's Active Orders revealed the following orders:

	- "Simvastatin Tablet 20 MG Give 1 tablet by mouth one time a day related to HYPERLIPIDEMIA, UNSPECIFIED (E78.5)," with an order start dated of [DATE]. - "Calcium Tablet 600 MG Give 1 tablet by mouth two times a day for Supplement," with an order start date of [DATE]. - "Namenda Tablet 10 MG (Memantine HCl) Give 1 tablet by mouth two times a day related to UNSPECIFIED DEMENTIA, UNSPECIFIED SEVERITY, WITHOUT BEHAVIORAL DISTURBANCE, PSYCHOTIC DISTURBANCE, MOOD DISTURBANCE, AND ANXIETY (F03.90)," with an order start date of [DATE]. Record review of Resident #14's [DATE] MAR, dated [DATE], revealed for the resident's orders of Namenda Tablet 10 mg two (2) times a day, Calcium Tablet 600 mg two (2) times a day, and Simvastatin Tablet 20 mg one (1) time a day, that the evening scheduled administration time, on [DATE], for all three (3) of these medications was left blank, with no indication that the medication was administered/refused/held/etc. 3. Record review of Resident #17's face sheet, reviewed on 12/22/22, revealed the resident was admitted to the facility on [DATE], with diagnoses including but not limited to: Essential Hypertension, Dementia, and Mixed Hyperlipidemia. Record review of Resident #17's Active Orders revealed the following orders: - "amLODIPine Besylate Tablet 2.5 MG Give 1 tablet by mouth one time a day related to ESSENTIAL (PRIMARY) HYPERTENSION (I10) Hold if BP < 120 and/or pulse < 50. Notify PCM if held > 3 days," with an order start dated of [DATE]. Record review of Resident #17's [DATE] MAR, dated [DATE], revealed: -For the order "amLODIPine Besylate Tablet 2.5 MG Give 1 tablet by mouth one time a day related to ESSENTIAL (PRIMARY) HYPERTENSION (I10) Hold if BP < 120 and/or pulse < 50. Notify PCM if held > 3 days," the resident was documented as having been administered the medication against physician prescribed parameters for the following days: [DATE] (BP was 119/62), administered but should have been held; [DATE] (BP was 131/96), held but should have been administered; [DATE] (BP was 110/68), administered but should have been held; and [DATE] (BP was 118/94), administered but should have been held.

	During an interview, on 12/21/22, at 9:03 a.m., Administrative Nurse B confirmed after reviewing Resident #13's [DATE] MAR that the resident's Lisinopril was not given following the physician's prescribed blood pressure and/or pulse parameters; and that Certified Nurse Aide A was the medication aide responsible for administering the medication to the resident on the days in question. Administrative Nurse B also confirmed there was a blank space on [DATE], at the 8:00 p.m., time for the Resident #13's order for Vistaril. Administrative Nurse B reported Certified Nurse Aide B was the medication aide on duty during the evening shift of [DATE]. Administrative Nurse B confirmed, after reviewing Resident #17's [DATE] MAR, that the resident's Amlodipine was not given following the physician's prescribed blood pressure and/or pulse parameters; and that Certified Nurse Aide A was the medication aide responsible for administering the medication to the resident on the days in question. Administrative Nurse B confirmed that medication administering staff should follow physician prescribed parameters and should document the administration/refusal/held/etc., for the each order the resident had been ordered and not left blank. During an interview, on 12/21/22, at 9:10 a.m., Administrative Nurse B called Certified Nurse Aide B to ask if Vistaril had been administer for Resident #13 on [DATE], and, if so, why it was not documented for the administration. Per Administrative Nruse B, Certified Nurse Aide B stated they had administered Resident #13's Vistaril on [DATE], at 8:00 p.m., and must have failed to document that it was administered. During an interview, on 12/21/22, at 9:20 a.m., Certified Nurse Aide A confirmed that they administered Resident #13's Lisinopril and Resident #17's amlodipine. Certified Nurse Aide A confirmed they should have held Resident #13's Lisinopril on [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE], because the resident's blood pressure and/or pulse met the criteria to be held instead of administered. Certified Nurse Aide A confirmed they were trained on how to follow the physician's parameters and now sees that the medication shouldn't have been administered. Certified Nurse Aide A further confirmed they should have followed the correct procedures to hold or administer per the physician's parameters and had administered Resident #17's amlodipine on [DATE], [DATE], [DATE], and [DATE]. Certified Nurse Aide A later stated that maybe they had mis-documented the administration of the medication, because the resident did

	refuse medications frequently and may have refused the medications. During an interview, on 12/21/22, at 9:37 a.m., with Administrative Nurse B and Certified Nurse Aide B on the phone, Administrative Nurse B reported Certified Nurse Aide B confirmed they administered the Calcium, Simvastatin, and Namenda to Resident #14 on [DATE], and that they must have forgotten to sign them as administered.
§ 51.140 (h) Sanitary conditions. The facility must: (1) Procure food from sources approved or considered satisfactory by Federal, State, or local authorities; (2) Store, prepare, distribute, and serve food under sanitary conditions; and (3) Dispose of garbage and refuse properly. **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Many	Based on observation, record review, and interview, the facility failed to serve food in accordance with professional standards for one (1) of one (1) [LOCATION] reviewed for food service safety, when Dietary Staff A and Dietary Staff B did not practice proper hand hygiene when serving the lunch meal. This practice affected 141 of 148 residents in the facility. The findings include: Record review of the facility policy titled, "Employee Sanitation," dated 10/1/18, revealed under the section on “Hand Washing,” that: “Employees must wash their hands and exposed portions of their arms at designated hand washing facilities at the following times…VII. After engaging in other activities that contaminate the hands.” In addition, the policy revealed under “Use of Gloves,” that staff should: “d. Change gloves…ii. After touching items, utensils or equipment not related to task…vi. When leaving the food preparation area for any reason.” Observation of the lunch meal service, on 12/21/22, at 10:54 a.m., revealed the start of the plating for the lunch meal service, with Dietary Staff A and Dietary Staff B working on the steam table tray line. Dietary Staff A was plating the entrée, sides, and bread, while Dietary Staff B checked the plated items for accuracy to each resident’s meal ticket, and added the drinks, soups, and condiments. Record review of the menu for Wednesday 12/21/22, revealed the residents were to receive baked chicken with mango salsa, Mexican corn, refried beans, a flour tortilla, and a Tres Leche cake. Observation of the lunch meal service, on 12/21/22, at 10:58 a.m., revealed Dietary Staff A wearing a glove on their left hand and the right hand was without a glove. While plating food items, Dietary Staff A used the gloved hand to obtain a flour tortilla and place it on a resident’s plate, which was resting on a heated underliner on an insulated bottom (to help keep the plate warm).

	Observation of the lunch meal service, on 12/21/22, at 11:14 a.m., revealed Dietary Staff A, with the same gloved hand, moved a wheeled cart that was used to store plastic insulated dome lids and bottoms. Dietary Staff A, with the gloved hand, opened the lid of the two (2) stack heater for underliners and began assembling the underliners and insulated bottoms. After assembling a few underliners and insulated bottoms, Dietary Staff A pushed the cart back to where they were serving from and resumed placing a flour tortilla on the next plate with underliner and insulated bottom. The surveyor asked Dietary Staff A if they should change their gloves after touching the cart and going back to serve the residents' ready to eat flour tortillas. Dietary Staff A stated "yes," they should have changed their glove. Dietary Staff A then apologized, removed the glove, and put on another glove without washing their hands or sanitizing their hands. Dietary Staff A then grabbed and looked through the meal tickets for the next plates to be prepared, with the hand still gloved. During an interview, on 12/21/22, at 11:20 a.m., Dietary Staff C, when asked how the dietary staff were to use gloves, stated that dietary staff did not have to wear gloves while serving on the steam table line, but they could use gloves to serve ready to eat foods or they could use tongs. Dietary Staff C stated that, if a glove was going to be worn to serve the ready to eat food, it was for single use only to serve that food item, and should be taken off when moving to another task. Dietary Staff C agreed that, if Dietary Staff A was serving the resident's tortillas with a gloved hand and then moved to touch a cart and open the warmer's lids, they should have changed the gloved hand before returning to continue meal service. Dietary Staff C stated they would get Dietary Staff A tongs to use instead of gloves. Observation of the lunch meal service, on 12/21/22, at 11:44 a.m., revealed Dietary Staff B was working on the tray line when they pulled down their shirt in the back and front; they then continued to put drinks on the tray and put the completed tray on the meal distribution enclosed cart. On 12/21/22, at 11:47 a.m., the surveyor asked Dietary Staff B if they were supposed to wash their hands after touching their clothes. Dietary Staff B confirmed they were supposed to wash their hands and went to wash their hands.
§ 51.200 (a) Life safety from fire. (a) Life safety from fire. The facility must meet the applicable provisions of NFPA	**Smoke Barriers and Sprinklers** Based on observation and interview, the facility failed to install sprinklers in accordance with the code. The deficient practice

101, Life Safety Code and NFPA 99, Health Care Facilities Code. **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Some	affected one (1) of 10 smoke compartments, staff, and 25 residents. The facility had a capacity for 160 beds with a census of 148 on the first day of the survey. The findings include: Observation during the building inspection tour, on 12/19/22, at 3:29 p.m., of the [LOCATION] secured unit revealed a sprinkler spray pattern was obstructed by a plastic barrier hanging from the ceiling less than four (4) inches away and extending down several feet from the bottom of the sprinkler deflector in the corridor. Additional observation revealed a section of the corridor would not be sprinkler protected due to the plastic barrier, as prohibited by section 8.5.5.2 of NFPA 13, Standard for the Installation of Sprinkler Systems. An interview with Maintenance Staff A, on 12/19/22, at 3:29 p.m., revealed the facility was not aware the plastic barrier was obstructing the sprinkler spray pattern. The census of 148 was verified by Administrative Staff A on 12/19/22. The findings were acknowledged by Administrative Staff A and Maintenance Staff A during the exit interview on 12/20/22. **Actual NFPA Standard: NFPA 101, Life Safety Code (2012)** **19.3.5.1** Buildings containing nursing homes shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7, unless otherwise permitted by 19.3.5.5. **9.7** Automatic Sprinklers and Other Extinguishing Equipment **9.7.1** Automatic Sprinklers. **9.7.1.1*** Each automatic sprinkler system required by another section of this Code shall be in accordance with one of the following: (1) NFPA 13, Standard for the Installation of Sprinkler Systems Actual NFPA Standard: NFPA 13, Standard for the Installation of Sprinkler Systems (2010) **8.1.1*** The requirements for spacing, location, and position of sprinklers shall be based on the following principles: (1) Sprinklers shall be installed throughout the premises. **8.5.5** Obstructions to Sprinkler Discharge. **8.5.5.2*** Obstructions to Sprinkler Discharge Pattern Development. **8.5.5.2.1** Continuous or noncontinuous obstructions less than or equal to 18 in. (457 mm) below the sprinkler deflector that prevent the pattern from fully developing shall comply with 8.5.5.2. **8.5.5.2.2** Sprinklers shall be positioned in accordance with the minimum distances and special requirements of Section 8.6 through Section 8.12 so that they are located sufficiently away

	from obstructions such as truss webs and chords, pipes, columns, and fixtures.
§ 51.210 (m) (1) Level B Requirement Laboratory services. (1) The facility management must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet all applicable certification standards, statutes, and regulations for laboratory services. (ii) If the facility provides blood bank and transfusion services, it must meet all applicable certification standards, statutes, and regulations. (iii) If the laboratory chooses to refer specimens for testing to another laboratory, the referral laboratory must be certified in the appropriate specialties and subspecialties of services and meet certification standards, statutes, and regulations. (iv) The laboratory performing the testing must have a current, valid CLIA number (Clinical Laboratory Improvement Amendments of 1988). The facility management must provide VA surveyors with the CLIA number and a copy of the results of the last CLIA inspection. (v) Such services must be available to the resident seven days a week, 24 hours a day. **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Few	Based on interviews and record reviews, the facility failed to obtain laboratory services as ordered by the physician for one (1) of 21 residents (Resident #23) reviewed for compliance with labs from a total sample of 21 residents. The findings include: Record review of the facility policy titled, "Laboratory Services," dated October, 2012 revealed: "1. Laboratory services will be ordered by the physician. 2. Laboratory services will be completed on the date specified by the physician or on the next scheduled lab day, if a specific date is not identified. 3. STAT laboratory services will be specified per physician's orders." Record review of Resident #23's face sheet, reviewed on 12/22/22, revealed the resident was admitted to the facility on [DATE]. The face sheet also revealed Resident #23's medical diagnoses included: Hypertensive Heart Disease with Heart Failure, Peripheral Vascular Disease, Nonrheumatic Mitral (Valve) Insufficiency and Chronic Atrial Fibrillation. Record review of Resident #23's Discharge MDS, dated [DATE], revealed the resident had an unplanned discharge with return anticipated from the facility to an acute hospital. Record review of Resident #23's Nursing Progress Notes revealed the following notes: - On [DATE], at 4:09 p.m., it was noted: "New orders from [Licensed Nurse D] for elevated WBCs STAT 2 view CXR and UA and CS. Orders placed into PCC informed 400 hall nurse to call both orders in [Administrative Nurse] is aware." - On [DATE], at 12:09 p.m., it was noted: "Resident was given an order for a State UA and culture on [DATE]. Orders were not collected that shift. This nurse followed up with lab and was reported that no labs were called in or collected. This nurse called chest XRAY company to follow up and placed the stat order at this time. Followed up with [Licensed Nurse D] who states yes to please place the orders. Orders placed and collected at this time. Lab here to collect UA with culture." Record review of Resident #23's medical record did not reveal a chest x-ray (CXR), urine analysis (UA) or culture and sensitivity CS having been collected/filled on [DATE], after the Licensed Nurse D's order was placed.

	During an interview, on 12/21/22, at 2:53 p.m., Licensed Nurse E reported that they were not working for the facility when Resident #23 was a resident at the facility, but Administrative Nurse C was still there, and would be the best nursing staff member to speak with about the resident. During an interview, on 12/21/22, at 3:15 p.m., Administrative Nurse C confirmed they were working at the facility when Resident #23 was a resident. Administrative Nurse C confirmed Resident #23's Licensed Nurse D placed and order for STAT CXR, UA and CS that was not completed until two (2) days later, on [DATE]. Administrative Nurse C reported the order was not completed.
§ 51.210 (o) (1) Clinical records. (1) The facility management must maintain clinical records on each resident in accordance with accepted professional standards and practices that are— (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized. **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Few	Based on interviews and record reviews, the facility failed to maintain clinical records that were complete, accurate, readily accessible, and systematically organized for one (1) of three (3) sampled residents (Resident #16) reviewed for hospice services. The findings include: Record review of the facility's policy titled, "Hospice," dated October, 2021 revealed: "1. The physician, facility staff and resident/responsible party will discuss the referral to hospice. 2. When the resident is considered hospice appropriate, a physician's order will be written for the hospice referral and services. 3. The hospice referral will be made and documented in the medical record. 4. Significant change MDS to be completed." Record review of Resident #16's hospice provider with the facility, dated [DATE], revealed under the section "Responsibilities of the Hospice," a section titled, "information/documentation provided to Facility on admission and on-going," that included: - "Most recent hospice plan of care - Hospice election form and any advance directives specific to each resident. - Physician certification and recertification of the terminal illness specific to each patient - Hospice medication information specific to each patient - Hospice physician and attending physician orders specific to each patient - Copies of clinical notes after each visit"

	Record review of Resident #16's face sheet, reviewed on 12/22/22, revealed the resident initially admitted to the facility on [DATE], and was readmitted on [DATE]. The face sheet also revealed Resident #23's medical diagnoses included: Alzheimer's Disease, Malignant Neoplasm of Prostate, and Acute Respiratory Failure with Hypoxia. Record review of Resident #16's Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of [DATE], revealed the resident had a Brief Interview for Mental Status (BIMS) score of zero (0), which indicated the resident was severely cognitively impaired. Record review of Resident #16's medical record revealed the special instructions of: "Resident was admitted to [hospice] on [DATE]." Record review of Resident #16's comprehensive Care Plan, dated [DATE], revealed the problem of "Bereavement: Anticipatory grief secondary to expected decline of resident. Requires hospice care. Admitted to [hospice provider] on [DATE] for a diagnosis of Alzheimer's Disease." During an interview during the initial tour, on 12/19/22, at 11:20 a.m., Licensed Nurse F reported Resident #16 was receiving hospice services. During an observation, on 12/21/22, at 9:51 a.m., Administrative Nurse B took the surveyor to the area where the binders for residents receiving hospice services were kept. Administrative Nurse B confirmed they could not find a hospice binder for Resident #16. Administrative Nurse B reported Resident #16 should have a hospice binder there and said that they would call the hospice provider to get the information delivered.