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	225772	A. BUILDING _____ B. WING _____	11/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR ISLAND HOME	EAST CREEK ROAD NANTUCKET, MA 02554

(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) COMPLETE DATE
F000	INITIAL COMMENTS Complaint Survey Event I.D. 8VH011 A Complaint Survey was conducted on 11/9/17 during the Facility's annual Recertification Survey. Based on record/document review and staff interview, the Complaint is determined to be Valid. (Please refer to F-309.) A recertification survey was conducted 11/08/17 through 11/09/17 and the following deficiencies were cited:	F000		
F152 SS=D	RIGHTS EXERCISED BY REPRESENTATIVE CFR(s): 483.10(b(3)-(7) (b)(3) In the case of a resident who has not been adjudged incompetent by the state court, the resident has the right to designate a representative, in accordance with State law and any legal surrogate so designated may exercise the residents rights to the extent provided by state law. The same-sex spouse of a resident must be afforded treatment equal to that afforded to an opposite-sex spouse if the marriage was valid in the jurisdiction in which it was celebrated. (i) The resident representative has the right to exercise the residents rights to the extent those rights are delegated to the representative. (ii) The resident retains the right to exercise those rights not delegated to a resident representative, including the right to revoke a delegation of rights, except as limited by State law.	F152	Resident #8s guardian, lawyer, and PCP have been notified to properly complete MOLST and have signed by all necessary parties (attachment #1). Nursing staff have been notified that resident #8 is a full code (attachment #2). A list of residents, who are full code, has been located on the Mert cart (attachment #3). Mert cart list will be updated monthly or as a residents advance directives change, per policy (attachment #4). All MOLSTs have been reviewed and moved to the front of the chart along with other advance directives and face sheets (attachment #5). Copies of MOLSTs are not permitted in order to avoid confusion; any current copies have been shredded. MOLST forms and other advance directives will be completed and properly signed by all necessary parties upon admission or ASAP, when applicable. A MOLST will not be filed in a residents chart until the MOLST is properly filled out with	12/20/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Electronically Signed	12/20/2017

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F152	Continued From page 1 (b)(4) The facility must treat the decisions of a resident representative as the decisions of the resident to the extent required by the court or delegated by the resident, in accordance with applicable law. (b)(5) The facility shall not extend the resident representative the right to make decisions on behalf of the resident beyond the extent required by the court or delegated by the resident, in accordance with applicable law. (b)(6) If the facility has reason to believe that a resident representative is making decisions or taking actions that are not in the best interests of a resident, the facility shall report such concerns when and in the manner required under State law. (b)(7) In the case of a resident adjudged incompetent under the laws of a State by a court of competent jurisdiction, the rights of the resident devolve to and are exercised by the resident representative appointed under State law to act on the residents behalf. The court-appointed resident representative exercises the residents rights to the extent judged necessary by a court of competent jurisdiction, in accordance with State law. (i) In the case of a resident representative whose decision-making authority is limited by State law or court appointment, the resident retains the right to make those decisions outside the representatives authority. (ii) The residents wishes and preferences must be considered in the exercise of rights by the representative.	F152	all required signatures. MOLST will remain in the MD book if unable to obtain MD signature on the same day of completion. The Interdisciplinary Team (IDT) meeting record was edited to reflect that. MOLSTs will be reviewed at admission, quarterly, and as needed at IDT meetings, per policy (attachment #6).	

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F152	Continued From page 2 (iii) To the extent practicable, the resident must be provided with opportunities to participate in the care planning process. This REQUIREMENT is not met as evidenced by: Based on interviews and record review, the Facility staff failed to follow State law by allowing the resident representative the right to make decisions on behalf of the resident beyond the extent required by the court for one Resident (#8) out of 10 sampled Residents. Findings include: Resident #8 was admitted to the Facility in 11/2016 with diagnoses of dementia. Review of the medical record for Resident #8 indicated that upon admission to the Facility in 11/2016 the Resident had a temporary court appointed legal guardian. In 01/2017 the legal guardian became permanent with the authority to admit the Resident to a nursing facility and to apply for health insurance benefits. The order of appointment of guardian for an incapacitated person indicated "the powers and duties of the Guardian are not limited and include all powers authorized to a guardian for an incapacitated person under G. L. c. 190B, Article V, Part III exclusive of those powers requiring specific court authorization." A review of the medical record for Resident #8 indicated a Massachusetts Medical Orders for Life-Sustaining Treatment (MOLST) form was signed by a Registered Nurse as the Health Care Agent on 10/26/17. The MOLST form indicated the Resident should not be resuscitated or intubated. A review of the	F152		

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F152	Continued From page 3 physicians orders for 10/2017 indicated Resident #8 was not to be resuscitated. Review of the Social Service progress notes indicated that on 07/10/17, the Social Worker notified the guardian that the MOLST form was not valid as the guardianship did not include court authority for end of life directives. A note from the Social Worker on 08/18/17 indicated that the Town of Nantucket Human Services was consulted and concluded the MOLST was not valid and the Resident's code status should be a Full Code (attempt resuscitation.) An interview was conducted with Nurse #1 on 11/9/17 at 11:05 A.M. The Nurse was asked what procedures would be followed if Resident #8 were to be found in cardiac arrest. Nurse #1 said she would check for the MOLST form in the Resident's medical record. Nurse #1 was observed to open the medical record and turn to the MOLST form for Resident #8. The Nurse said that based on the MOLST form, she would not perform Cardio Pulmonary Resuscitation. The Social Worker and the Director of Nurses (DON) were interviewed on 11/9/17 at 11:30 A.M. The Social Worker said the guardian had not submitted paperwork to the court to expand guardianship to include end of life decisions. The Social Worker was unsure why a new MOLST form, indicating Resident #8 was a full code, was not initiated by the Facility. The DON said she was unsure why the MOLST was in the chart or why the physician's order indicated do not resuscitate, as the management team was aware that the previous signed MOLST form was not valid.	F152		
F225 SS=D	INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS	F225	A nurses meeting was held on 12/13/17 in-servicing staff on the need to investigate	12/20/17

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F225	Continued From page 4 CFR(s): 483.12(a)(3)(4)(c)(1)-(4) 483.12(a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily	F225	any unknown origin of bruising immediately (attachment #2). Staff is aware that they must notify the DON and Administration with any incident relating to unknown origin. The incident report documentation form has been edited to address this requirement (attachment #7). Safety meetings are now to be held two times a month (prior it was held once a month). This will allow the safety committee to review incident reports in a timely manner and implement change when applicable. Morning rounds have been implemented and will begin on 12/20/17 at 830am. These meetings will be held Monday through Friday for all department heads and nursing staff to attend. This will provide staff with a dedicated time to discuss daily changes, incidents, admission/discharges, etc. in order for all departments to provide residents with the highest quality of care (attachment #8).	

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F225	Continued From page 5 injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. (2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interviews and record review, the facility staff failed to investigate following a report of a bruise of unknown origin for one Resident (#7) out of a total sample of 10 Residents. Findings include: Review of the Facility policy for resident incident/accidents indicated that the Facility was to investigate and prevent future incidents of potential mistreatment or abuse of residents, including but not limited to bruises of undetermined cause. Resident #7 was admitted to the Facility in	F225		

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F225	Continued From page 6 07/2017 with a diagnosis of dementia. A review of the medical record indicated a nursing progress note for Resident #7 on 09/18/17 at 6:00 A.M. noted the Resident was combative with caregivers, throwing objects and was not redirected easily. The following nurses note on 09/18/17 indicated that multiple bruises were noted on the forearm by daughter, bruises appeared to be old and intact and of unknown origin. The Surveyor requested the investigation for the bruise of unknown origin from the Director of Nurses (DON) on 11/09/17. The DON provided the surveyor with a one page incident/accident report dated 09/18/17 at 4:30 P.M. The report indicated the occurrence type was injury of unknown origin. The description indicated the Resident had multiple dark bruises to bilateral upper extremities of unknown origin. The report had an action taken to prevent recurrence of distance supervision. The DON was interviewed on 11/9/17 at 11:40 A.M. The DON said after reviewing the record on this date the nurses note indicated the Resident was combative with care the evening before. The DON said that an investigation had not been completed at the time of the bruising. The DON said she could not explain why the investigation was not complete.	F225		
F309 SS=G	PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING CFR(s): 483.24, 483.25(k)(l) 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive	F309	A nursing education meeting was held on 8/31/2017, with the Director of Palliative and Supportive Care of Nantucket (PASCON), Charlene Thurston RN APN. Discussion was had on when to make the referral to PASCON, signs and symptoms of end of life, pain management, psychosocial considerations to end of life	12/20/17

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F309	Continued From page 7 and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the residents comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review, document review, and staff interview, the Facility failed to ensure that for one Resident (#10), of a total sample of 10 Residents, that a dying Resident's pain was adequately assessed and treated with the narcotic analgesic Morphine Sulfate, in	F309	care, and incorporating the family into end of life care/decisions (attachment #9). A nurses meeting was held on 12/13/2017, all nursing staff were in serviced on the need to provide care/services for the highest well being (attachment #2). Discussion held in relation to following end of life care plans tailored to the individual resident and family needs (attachment #10). New OIH guidelines for required documentation for end of life assessments will be implemented. Nursing staff will be in serviced on all new tools/required documentation guidelines, to begin 12/22/2017. All new tools/required documentation guideline packets will be added to admission packets (attachment #11). These tools include: a tool to assist the nursing staff in recommending a PASCON consult. If a resident meets the guidelines upon admission or at any point in the duration of their stay at OIH, nursing staff will contact the residents clinician and obtain on order for consult; a tool has to assist nursing in pain management; a tool to assist nursing in non-pharmacologic interventions for psychosocial, spiritual, and physical pain; and a tool has been created to assist nursing in educating residents and families on Pain and End of Life Care.	

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F309	Continued From page 8 accordance with accepted Professional Standards of Nursing practice, a Physician's order for PRN (as needed) Morphine Sulfate, and numerous requests by the Resident's family for the nurse to administer morphine sulfate to relieve the Resident's pain. Findings included: Resident #10 was admitted in 07/2010 with diagnoses which included Alzheimer's Disease, other depressive episodes, GERD (Gastroesophageal Reflux Disease), hypertension, and age-related osteoporosis. According to the most recent MDS, signed as being completed 4/28/17, the Resident experienced short and long-term memory deficits and severely impaired cognitive skills for daily decision making. The MDS indicated that the Resident was totally dependent for all ADLs (activities of daily living), was incontinent of bowel and bladder, and received scheduled pain medications. Record Review revealed that on 7/7/17, the Physician ordered a consult for Palliative Care for end of life comfort measures, morphine sulfate 1 mg sc (subcutaneously) every 1 hour PRN (as needed) for moderate pain or respiratory distress, and morphine sulfate 2 milligram (mg) sc every 1 hour PRN for severe pain or respiratory distress. The Resident's discharge record, and the Facility's investigation of alleged neglect of the Resident's pain, and other actions by the Charge Nurse on 7/8/2017, were reviewed on 11/9/17 during the Facility's annual recertification survey. The Facility's investigation, dated 9/18/17,	F309		

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F309	Continued From page 9 indicated the Charge Nurse failed to properly assess/document the Resident's pain and respiratory status and refused to administer morphine sulfate when approached by the family regarding their concern over the Resident being in acute pain/respiratory distress. The investigation indicated on 7/8/17 at 9:30 P.M., the family returned to the Facility to be with the Resident and requested that the Charge Nurse administer morphine sulfate to the Resident due to the Resident's "increased restlessness and discomfort." The investigation indicated that the Charge Nurse told two family members that the Resident did not need morphine and she refused to administer it. The investigation indicated that the Charge Nurse did not go into the room to assess the Resident. The Charge Nurse brought in a Tylenol suppository sometime around 10:00 P.M. but the administration was not documented on the MAR (Medication Administration Record). The investigation indicated that at 10:15 P.M., a family member arrived at the Facility and requested to speak with the Charge Nurse. The family member asked the Charge Nurse to give the Resident morphine sulfate for pain control. The Charge Nurse again refused the family member's request saying the Resident received Tylenol and did not need morphine because he/she was not using accessory muscles and she would not give any medication. The investigation indicated the Charge Nurse refused to call the Physician when requested by the family member. The Charge Nurse refused to call the Resident's Physician and told the family member, "the phone is right there, you can call the doctor". The investigation indicated that a CNA (certified nursing assistant) on duty	F309		

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F309	Continued From page 10 at the time asked the family member what the problem was. The family member said, "I feel my dying (family member) is suffering and not getting the care he/she needs." The Charge Nurse told the family member that the Resident did not need morphine because she was not in distress. There was no documented evidence that the Charge Nurse went into the Resident's room to assess his/her pain level or clinical status. The Facility investigation indicated that more verbal exchanges occurred between the family member and the Charge Nurse, at which time the Charge Nurse yelled at the family member to stop questioning her nursing judgment. The Charge Nurse reportedly kicked the family member out of the nurses station. The family member said to the Charge Nurse, "I am the patient's family member; I should call the cops." The family member went back to the Resident's room. Another family member then went to the nurse's station to speak to the Charge Nurse about pain control for the Resident. The investigation indicated that the Charge Nurse ignored the other family member's request for pain control. Again, there was no evidence that the Charge Nurse went back to the Resident's room to assess the Resident, or to address the other family member's concern over the Resident's pain, and request for pain medication. The investigation indicted the other family member then called the Acting DON (Director of Nursing). The Acting DON instructed the other family member to contact the Resident's Physician, which she did. The Physician told the other family member that she would call the Charge Nurse.	F309		

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F309	Continued From page 11 The investigation indicated that the Police arrived to the Facility and informed the family member that the nursing staff had requested she be removed from the building. The Police advised the family that the Resident may get better care if he/she went to the Hospital. The investigation indicated that the family decided to transfer the Resident to the Hospital since they had lost confidence in the Facility's ability to provide adequate care to the Resident. The investigation also indicated that from the time the two family members arrived at 8:20 P.M., until 12:00 midnight, a CNA did not come to help with the care of the Resident. Review of the MAR on 11/9/17, revealed that no Tylenol or morphine sulfate were administered on 7/8/17. On 7/8/17 from 3:00 P.M. to 7:00 P.M., the nurse on duty prior to the Charge Nurse wrote, "Significant Change in condition, 88-90 % (oxygen saturation) on RA (room air). 2 liters per minute oxygen initiated with oxygen saturation over 92%. PR (per rectum) Valium given per MD order seizure vs. muscle rigidity/spasm. The Nursing Supervisor and Administrator were made aware of the Resident's condition by the nurse. The nurse wrote that at that time the family were not willing to add scopolamine or morphine to the plan of care. On 7/8/17 to 7/9/17 from 7:00 P.M. to 7:00 A.M., the Charge Nurse wrote that Tylenol 650 mg suppository was administered at 9:30 P.M. for a "temp of 99 and congestion." The Charge Nurse wrote that "increase request for morphine denied d/t (due to) no s/sx (signs or symptoms) of use	F309		

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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) COMPLETE DATE
F309	Continued From page 12 of accessory muscles, increase respiratory rate, adventitious breath sound or facial grimacing." The Charge Nurse failed to document what time she assessed the Resident, whether additional clinical assessments were performed, the Resident's vital signs, to include the Resident's respiratory rate, oxygen saturation, use of oxygen, mental status, skin color and appearance, or other signs and/or symptoms of pain or respiratory distress typically performed by a nurse during an assessment for pain and/or respiratory status. The investigation indicated that on 7/9/17 at 12:20 A.M., the Resident was transferred to the local hospital where he/she was assessed with aspiration pneumonia, end-stage dementia, and was admitted to the Palliative Care unit. The Resident was given a scopolamine patch (used to decrease oral secretions) and administered morphine. The Resident expired at the Hospital on 7/11/17. Interview with the Administrator on 11/9/17 at 1:30 P.M., confirmed that the Charge Nurse was terminated for her actions on 7/8/17 and 7/9/17, and for not following multiple Facility Policies, including her failure to provide adequate assessment, pain control/nursing care to the Resident, and for failing to show care and compassion to the dying Resident's family.	F309		
F425 SS=E	PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH CFR(s): 483.45(a)(b)(1) (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.	F425	A nursing meeting was held on 12/13/2017, all nursing staff were informed of the annual state survey findings and tags associated with the survey (attachment #2). The Medication Administration Policy has been updated to reflect the need to monitor, date, and document all opened medications and vaccines that need refrigeration	12/20/17

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225772	A. BUILDING _____ B. WING _____	11/09/2017

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F425	Continued From page 13 (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (1) Provides consultation on all aspects of the provision of pharmacy services in the facility; This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the Facility failed to ensure at Pharmaceutical Services provided by the Facility met the needs of the Residents. Inspection of the Facility medication room revealed expired medications. Findings included: The Facility medication room was inspected on 11/9/17 in the presence of Nurse #1. The following observations were made: 1. Four bottles of insulin (1 bottle of Levemir, 1 bottle of Novolog, 2 bottles of Lantus) were observed in the medication refrigerator, not dated when opened. It was impossible to determine when the vials were opened or if they had gone past the 28-day limitation of use after opening. 2. One bottle of Tubersol (Protein Purified Derivative) was open but not dated when opened. An additional bottle of Tubersol was opened on 9/24/17. Per interview with Nurse #2, the bottle of Tubersol should have been discarded after 30 days.	F425	(attachment #12). Refrigerated medications and vaccines will be label with appropriate signage, dated and logged on the new temperature log tool (attachment #13). In addition to the twice daily temp checks, refrigerated medications and vaccines will be monitored and documented on a weekly basis. Nursing staff will be in serviced on all updates to the Medication Administration Policy, once addressed at the next medical directors meeting, along with the new procedure for the refrigerated medications and vaccines temperature log. DON is to review temp log documentation on a monthly basis.	
F500 SS=D	OUTSIDE PROFESSIONAL RESOURCES-ARRANGE/AGRMNT	F500	Resident #6 was admitted to the nursing facility on 11/11/14. Upon admission an	12/20/17

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F500	Continued From page 14 CFR(s): 483.70(g)(1)(2)(i)(ii) (g) Use of outside resources. (1) If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility must have that service furnished to residents by a person or agency outside the facility under an arrangement described in section 1861(w) of the Act or an agreement described in paragraph (g)(2) of this section. (2) Arrangements as described in section 1861(w) of the Act or agreements pertaining to services furnished by outside resources must specify in writing that the facility assumes responsibility for- (i) Obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility; and (ii) The timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, the Facility failed to ensure that there was an arrangement for services provided by an outside agency and that these services be included in the medical plan of care for 1 sampled Resident (#6) of 4 receiving Palliative Care services from a total sample of 10 residents. Findings include: 1. For Resident #6, the Facility did not have any documented information of the Palliative	F500	IDT meeting was held on 11/13/14, a referral was requested by the responsible party for palliative care for pain management. An MD order for consultation was written on 11/18/14 and an MD progress note indicates PASON visit 12/1/14. The initial consult for palliative care was 11/20/14. Palliative care continued periodically when pain interventions were needed. Gaps in consult notes and visits were due to pain control being adequately managed. See attached for consult notes, MD orders, social service notes, nurse notes (attachment #14). Consults to palliative care will be added to the physician order sheets for all residents being seen by PASCON, palliative services (routinely and as needed). An audit was done on 12/18/17 for all residents receiving palliative care services to ensure it is noted on the physician orders. The IDT meeting record was updated to ensure all consult orders will be monitored and checked quarterly, and as needed, at IDT (attachment #6).	

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F500	Continued From page 15 services provided through consultation and onsite visitation to the Resident. Resident #6 was admitted for long term care with diagnoses of osteoarthritis and hip pain, history of congestive heart failure, stroke, macular degeneration and blindness. The quarterly Minimum Data Set (MDS) assessment, dated 8/11/17, indicated Resident #6 was alert and oriented (BIMS 15/15), requires total care for all activities of daily living, on bed rest and scheduled pain medication with a developing skin pressure area. The medical record included evidence that Resident #6 deferred decision making to and with a family representative. Discussion with a Resident representative on 11/8/17 mentioned that Resident #6 was receiving hospice/palliative care services and had been pleased with previous recommendations for pain control. Record review on 11/9/17, failed to include any documentation including a physician's order, or documentation from members of the Palliative services team who provide consultation, services and care plan interventions. Review of the facility's admission packet included End of Life Programs, Palliative and Supportive Care which is described as a team based approach to treat illness that focuses on a person's physical, emotional and spiritual needs and supporting their families. Palliative care is for residents with serious illness regardless of age, treatment status or life expectancy that can be provided in any setting: office, home, hospital or nursing home.	F500		

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F500	Continued From page 16 During interview on 11/9/17, the Director of Nurses said that the Palliative Care providers offer consultation and visitation to residents at the facility. However, the Director of Nurses was unaware of documentation of consultation reports and visitation records for the palliative services provided in the facility. Although the medical progress notes indicated discussion with health care agent for care decisions and interventions, there was no written agreement or documentation of services being provided by the outside services to Resident #6 in the facility to ensure consent, collaboration of services and optimal quality care.	F500		

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