

When the surveyor's investigation shows systemic noncompliance with F848, indicating a complete disregard or unawareness of the requirements, such as agreements, which make no provision for the selection of a neutral arbitrator or convenient venue, CMS has the following expectations (in addition to the requirements for POCs listed above) with regard to the accepted POC:

- The POC must ensure that all arbitration agreements allow for the selection of a neutral arbitrator and convenient venue; and
- There must be a process to ensure records are retained for 5 years.

## **F849**

*(Rev. 229; Issued: 04-25-25; Effective: 04-25-25; Implementation: 04-28-25)*

### **§483.70(n) Hospice services.**

**§483.70(n)(1) A long-term care (LTC) facility may do either of the following:**

- (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices.**
- (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer.**

**§483.70(n)(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.**
  - (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 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(n)(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:**
  - (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(n)(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.**

#### **DEFINITIONS §483.70(n)**

**“Hospice care”** means a comprehensive set of services described in Section 1861(dd)(1) of the Social Security Act, identified and coordinated by an interdisciplinary group (IDG) to provide for the physical, psychosocial, spiritual, and emotional needs of a terminally ill patient and/or family members, as delineated in a specific patient plan of care. (42 CFR §418.3) **NOTE:** These services are provided by a Medicare-certified hospice.

**“Hospice Attending Physician”** - This clarifies that a doctor of medicine, osteopathy or nurse practitioner, if meeting the listed requirements, may function as the “attending physician” in a hospice. The hospice regulations do not provide for a physician assistant to function as the hospice attending physician. §418.3 Definitions. For the purposes of this part — “Attending physician” means a —

- (1)(i) Doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he or she performs that function or action; or
- (ii) Nurse practitioner who meets the training, education, and experience requirements as described in §410.75 (b) of this chapter.
- (2) Is identified by the individual, at the time he or she elects to receive hospice care, as having the most significant role in the determination and delivery of the individual's medical care.

In a nursing home, a physician’s assistant may not act as the hospice attending physician, however, the resident’s attending physician at the nursing home may delegate tasks to a physician’s assistant per F714 - §483.30(e)(1).

**“Palliative care”** - means patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs and to facilitate patient autonomy, access to information, and choice. (§418.3)

**“Terminally ill”** - means that the individual has a medical prognosis that his or her life

expectancy is 6 months or less if the illness runs its normal course. (§418.3)

**“Bereavement counseling”** - means emotional, psychosocial, and spiritual support and services provided before and after the death of the patient to assist with issues related to grief, loss, and adjustment. (§418.3)

#### **GUIDANCE §483.70(n)**

##### **Provision of Hospice Services In A Nursing Home**

As described in §483.70(n)(1)(i),(ii), there is no requirement that a nursing home allow a hospice to provide hospice care and services in the facility. If a nursing home has made arrangements with one or more hospices to provide services in the nursing home, there must be a written agreement describing the responsibilities between each hospice and the nursing home prior to the hospice initiating care for a resident who has elected the hospice benefit. The written agreement applies to the provision of all hospice services for any nursing home resident receiving services from the specific hospice and does not need to be rewritten for each resident.

If the nursing home has a written agreement(s) with one or more hospice provider(s), it must, in accordance with F581-§483.10(g)(16), inform each resident before, or at the time of admission, and periodically during the resident’s stay, of hospice, among other services, available in the nursing home. If the nursing home has an agreement with more than one hospice, this information must be provided to the resident/designated representative in order to allow choice of the hospice provider he/she prefers.

If a resident chooses a hospice that does not have an agreement with the nursing home:

- The nursing home may establish a written agreement with the hospice and allow the hospice provider to provide hospice services in the nursing home; or
- The nursing home must assist the resident, when the resident requests, in transferring to a nursing home of his/her choice that has an agreement or will arrange for the provision of hospice services with a hospice; or in relocating to a non-nursing home setting (e.g. inpatient hospice unit, private home, or residential/assisted living facility) that uses the hospice of his/her choice; or
- The resident may choose not to elect the hospice benefit and continue to reside in the nursing home with the attending physician/practitioner of their choice and receive nursing home care and services.

If the nursing home or the hospice terminates the written agreement, the nursing home:

- Must provide assistance to affected residents in contacting or selecting another hospice provider(s) with which the nursing home has or will enter into a written agreement; or

- When the resident requests, assist the resident in transferring to a nursing home of his/her choice that has an agreement or will enter into an agreement for the provision of hospice services; or in relocating to a non-nursing home setting (e.g. inpatient hospice unit, private home, or residential/assisted living facility) that uses the hospice of his/her choice; or
- The resident may choose to revoke the hospice benefit and continue to reside in the nursing home with the attending physician/practitioner of their choice and receive nursing home care and services.

**NOTE:** When a resident/designated representative requests and/or initiates a discharge to another facility or location, the nursing home is not required to provide a notice of discharge and/or transfer as it is not a nursing home initiated transfer/discharge. This applies in the situation, in which there is no written agreement for hospice services, and/or the resident chooses a hospice with which the nursing home does not have a written agreement, and the nursing home chooses not to establish such an agreement.

### **Nursing Home Ensures Professional Standards and Timeliness of Services**

As described in §483.70(n)(2)(i) the nursing home must ensure that services provided by the hospice (including the individuals providing the services) meet professional standards and principles, that the services and care meet the assessed needs of each resident, and that the hospice is certified for participation in the Medicare program. (Refer to F675 and F658.) The nursing home and hospice must assure that all physician/practitioners meet State licensure requirements and are working within their scope of practice and professional State licensure requirements.

The nursing home staff must monitor the delivery of care in order to assure that the hospice provides services to the resident in a way that meets his/her needs in a timely manner including:

- Observation of interactions and care provided by the hospice staff sufficient to assure that the hospice services meet the professional standards of care;
- Interviews with the resident/designated representative regarding hospice care and services; and
- Review of the resident's record for pertinent documentation regarding the delivery of hospice care.

For example, if a resident has an increase in pain that is not being managed by the current interventions, or if current interventions may be causing adverse consequences that are distressing to the resident, the requirement that the nursing home ensure the provision of timely hospice services would include notifying the hospice of the resident's change in condition so that the hospice, in consultation with the nursing home and the resident's attending physician/practitioner, can reassess the resident and with input from the

resident/designated representative, change the plan of care, as indicated, to assure the resident receives the treatment necessary to achieve his/her optimal comfort level.

### **Signed Written Agreement with Hospice Prior to Provision of Care**

As described in §483.70(n)(2)(ii)(A), the written agreement must be signed by authorized representatives of the hospice and the nursing home prior to the provision of hospice services.

The hospice retains primary responsibility for the provision of hospice care and services, based upon the resident's assessments and choices. According to hospice regulations at §418.100(c)(2) - "Nursing services, physician services, and drugs and biologicals (as specified in §418.106) must be made routinely available on a 24-hour basis, 7 days a week. Other covered services must be available on a 24-hour basis when reasonable and necessary to meet the needs of the patient and family." Other covered services include counseling (including spiritual, dietary and bereavement), social work, hospice aide, volunteer, and homemaker services, physical therapy, occupational therapy, and speech-language pathology services, short-term inpatient care, drugs, biologicals, and medical appliances related to the palliation and management of the terminal illness and related conditions. (§418.112(c)(6))

### **Hospice Plan of Care**

As described in §483.70(n)(2)(ii)(B), when a hospice patient is a resident of a nursing home, the hospice must establish the hospice plan of care in coordination with the nursing home, the resident's nursing home attending physician/practitioner, and to the extent possible, the resident/designated representative.

In order to provide continuity of care, the hospice and the nursing home must collaborate in the development of a coordinated plan of care for each resident receiving hospice services. The structure of the plan of care is established by the nursing home and the hospice. The coordinated plan of care must identify the provider responsible for performing each or any specific services/functions that have been agreed upon. The plan of care may be divided into two portions, one maintained by the nursing home and the other maintained by the hospice. The nursing home and the hospice must be aware of the location and content of the coordinated plan of care (which includes the nursing home portion and the hospice portion) and the plan must be current and internally consistent in order to assure that the needs of the resident for both hospice care and nursing home care are met at all times.

The nursing home must designate a member of the nursing home's interdisciplinary team who is responsible for working with hospice to coordinate care for the resident. (See §483.70(n)(3)(i) below.) In addition, different nursing home staff, who are knowledgeable regarding the resident's care, may also work with hospice staff in the development of the plan of care. The hospice coordinator must provide ongoing coordination and collaboration with the nursing home coordinator, the resident's

attending physician/practitioner and the resident/designated representative regarding changes to the resident's plan(s) of care.

Based on the shared communication between the hospice and the nursing home, the coordinated plan(s) of care should reflect the identification of:

- Diagnoses;
- A common problem list;
- Palliative interventions;
- Palliative goals/objectives;
- Responsible discipline(s);
- Responsible provider(s); and
- Resident/designated representative choices regarding care and goals.

### **Nursing Home Responsibilities**

As described in §483.70(n)(2)(ii)(C), the nursing home retains primary responsibility for implementing those aspects of care that are not related to the duties of the hospice. The nursing home's services must be consistent with the plan of care developed in coordination with the hospice, and the nursing home must offer the same services to its residents who have elected the hospice benefit as it furnishes to its residents who have not elected the hospice benefit. Therefore, the hospice patient residing in a nursing home should not experience any lack of services or personal care because of his or her status as a hospice patient. This includes what would normally be provided to a resident in the nursing home, including but not limited to the following: conducting the comprehensive assessments which includes the Resident Assessment Instrument (RAI), providing personal care, activities, medication administration, required physician visits, monthly medication regimen review, support for activities of daily living, social services as appropriate, nutritional support and services, and monitoring the condition of the resident. The nursing home must maintain an environment in which there are no inappropriate signs posted in residents' rooms or in staff work areas visible by other residents and/or visitors that include confidential clinical or personal information, such as information about hospice services. (Refer to F550, Dignity.)

### **Communication Process between Nursing Home and Hospice**

As described in §483.70(n)(2)(ii)(D), the written agreement must specify a process for communicating necessary information regarding the resident's care between the nursing

home and the hospice 24-hours a day, 7-days a week including how these communications will be documented.

Both the hospice and the nursing home may document physician orders in the resident's nursing home record. Orders are to be dated and signed in accordance with Federal requirements (Refer to F711 – physician orders) and any applicable State laws. There is no Federal regulation that prohibits nursing home staff from taking orders for care from the hospice physician. Any changes to orders initiated by the hospice should be communicated to the resident's attending physician/practitioner in a timely manner. The nursing home must communicate with the hospice regarding orders provided by the resident's attending physician/practitioner in the nursing home, if he/she is not the resident's designated physician on the hospice team. Prior to plan of care or order changes the hospice physician and the resident's attending physician/practitioner may need to collaborate to address an emergent change in the resident's condition and to assure the resident's needs are met. If there is a conflict between orders given by hospice and the resident's attending physician/practitioner, there must be communication between the nursing home and the hospice regarding the issue. This communication should include the nursing home medical director and the hospice medical director as well as other pertinent staff as needed.

### **Notifying Hospice Regarding Clinical Changes**

As described in §483.70(n)(2)(ii)(E), the written agreement must include a provision that the nursing home will immediately contact and communicate with the hospice staff regarding any significant changes in the resident's status, clinical complications or emergent situations. Situations include, but are not limited to, changes in cognition or sudden unexpected decline in condition, a fall with a suspected fracture or adverse consequences related to a medication or therapy, or other situations requiring a revision to the plan of care. The immediate notification to hospice does not change the requirement that a nursing home must also immediately notify the resident's attending physician/practitioner. Prior to plan of care or order changes, the hospice and the resident's attending physician/practitioner may need to collaborate to address this change and to assure that the resident's immediate and ongoing treatment and care needs are met in accordance with the resident's decisions and advance directives regarding end of life care are met, including situations which could require a potential transfer to an acute care setting. This decision making must be consistent with the resident's wishes and most current version of advance directive, if any. (Refer to F578) If there is a conflict between the nursing home and the hospice regarding the course of hospice care or level of service, there must be communication between the nursing home and the hospice regarding the issue. This communication should include the nursing home medical director and the hospice medical director as well as other pertinent staff, as needed.

### **Hospice Determines Level of Hospice Services**

As described in §483.70(n)(2)(ii)(F), the written agreement must state that the hospice assumes responsibility for professional management of the resident's hospice services

provided, in accordance with the hospice plan of care and the hospice conditions of participation, and make any arrangements necessary for hospice-related inpatient care in a participating Medicare/Medicaid facility (§418.112(b)).

The agreement must also include language that the hospice assumes the responsibility for determining the level of hospice services. Any substantive changes in the level of hospice services must be developed by the hospice and these changes must be reflected in the coordinated plan of care. These changes should be made in collaboration with the resident/designated representative, the resident's attending physician/practitioner, and nursing home staff.

### **Nursing Home Responsibilities for Personal Care and Nursing Needs in Coordination with Hospice**

As described in §483.70(n)(2)(ii)(G), the provisions of the written agreement must delineate how the care and needs will be provided based upon the resident's identified needs.

It is the nursing home's responsibility to continue to furnish 24-hour room and board care, meeting the resident's personal care and nursing needs. Services provided must be consistent with the plan of care developed in coordination with the hospice Interdisciplinary Group (IDG).

### **Delineation of Hospice Responsibilities**

As described in §483.70(n)(2)(ii)(H), to comply with this requirement, the written agreement must contain a clear statement that the hospice assumes responsibility for determining the appropriate course of hospice care to be provided and delineate the services that the hospice is required to provide to the resident (not already covered by the nursing home through the provision of room and board and services to meet the resident's personal care and nursing needs as required by §483.70(n)(2)(ii)(G).

When the resident elects the hospice benefit, the resident may choose to specify his/her nursing home attending physician/practitioner as the hospice attending physician. If the resident does not choose his/her nursing home attending physician, he/she may select another physician/practitioner as the hospice attending physician.

The hospice IDG in collaboration with the resident's nursing home attending physician/practitioner is responsible for the palliation and management of specified aspects of care, based on the agreement. The agreement identifies the process for developing the plan of care in collaboration with the resident's attending physician/practitioner and includes the process to be followed to reconcile disagreements between the resident's attending physician/practitioner and hospice physician.

**NOTE:** The nursing home regulations at F710 - Physician Supervision), requires that "The facility must ensure that another physician supervises the medical care of residents

when their attending physician is unavailable.” According to the hospice CoPs at §418.64(a) and (a)(3) - Standard: Physician services, “The hospice medical director, physician employees, and contracted physician(s) of the hospice, in conjunction with the patient's attending physician, are responsible for the palliation and management of the terminal illness and conditions related to the terminal illness...(3) If the attending physician is unavailable, the medical director, contracted physician, and/or hospice physician employee is responsible for meeting the medical needs of the patient.”

The written agreement must identify how the nursing home will obtain information regarding the provision of medical care including medication information from the hospice, and should include the identification of hospice non-physician practitioners who, according to State law, may provide orders for medical care of the resident.

### **Nursing Home Responsibilities for Administration of Prescribed Therapies**

As described in §483.70(n)(2)(ii)(I), the written agreement must include the provision that the LTC facility personnel may administer therapies where permitted by State law and as specified by the LTC facility as noted in the coordinated plan of care.

### **Report to Hospice any Alleged Violations of Mistreatment, Neglect, Verbal, Mental, Sexual, and Physical Abuse Including Injuries of Unknown Source and/or Misappropriation of Property by Hospice Personnel**

As described in §483.70(n)(2)(ii)(J), the nursing home must follow all of the requirements within §483.12(a)(b) and (c), Free From Abuse...(F600-610) for the prevention, identification, protection, reporting and investigation of allegations of abuse, neglect, verbal, mental, sexual abuse, mistreatment and injuries of unknown source. This also includes prohibiting taking and/or posting photos or recordings that are demeaning and or humiliating to a nursing home resident or the use of an authorized photo or recording in a demeaning/humiliating manner. The privacy and confidentiality of the resident's care and records must be maintained. (Refer to F583 - Privacy and Confidentiality).

The nursing home must also notify the hospice administrator of any such allegations involving hospice employees and contractors and anyone else providing services on behalf of the hospice and the outcome of its investigation.

**NOTE:** The hospice must follow the requirements as indicated in the Federal regulations at §418.52(b)(4)(i-iv) for reporting, investigating and taking appropriate corrective actions.

### **Responsibilities for Bereavement Services for Nursing Home Staff**

As described in §483.70(n)(2)(ii)(K), the death of the resident may have a direct impact on identified nursing home staff. The written agreement should specify when the nursing home should provide information to the hospice regarding nursing home staff that may benefit from bereavement services. The written agreement between the hospice and the nursing home should specify how bereavement services will be coordinated and

operationalized by the hospice provider for nursing home staff. The written agreement must include a description of the nursing home's role in providing such services. These services should be individualized based on the resident involved and the staff involvement in their care. In the case of several hospices offering services in a nursing home, each hospice's written agreement must include the provision regarding bereavement services for staff as noted above.

**NOTE:** According to the hospice CoPs at §418.64(d) - Counseling services must include, but are not limited to, the following: (1) - Bereavement counseling. The hospice must: (ii) "Make bereavement services available to the family and other individuals in the bereavement plan of care up to 1 year following the death of the patient. Bereavement counseling also extends to residents of a SNF/NF or ICF/MR when appropriate and identified in the bereavement plan of care."

### **Nursing Home Designee(s) Responsibilities**

As described in §483.70(n)(3)(i)-(v), the nursing home must identify and designate, in writing, an employee of the nursing home to assume the responsibilities for collaborating and coordinating activities between the nursing home and the hospice. The nursing home employee 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 nursing home coordinator should be familiar with hospice philosophy and practices. The nursing home should provide the name of the designated nursing home staff member to the resident/representative for ongoing communication regarding care or concerns. If the designated employee is not available, the nursing home may delegate this function to another nursing home employee who meets the requirements identified above. It should be noted that in nursing homes contracting with more than one hospice, the nursing home may designate more than one/different employees to serve as coordinator with the respective hospice(s). Due to the complex clinical needs of a resident who is in the terminal stages of life, the interdisciplinary team member must have the ability to assess the resident or have access to someone who has the ability to assess the resident.

The communication process established should include a system for the designated interdisciplinary team member to obtain the information as identified at §483.70(n)(3) (iv) A-G. The resident's nursing home record must have evidence of this information.

The designated employee is responsible for assuring that orientation is provided to hospice staff.

This orientation is meant to address the overall facility environment including policies, rights, record keeping and forms requirements. It is important for the nursing home to document and have available information regarding hospice staff orientation.

**NOTE:** Refer to §418.112(f). In addition to the orientation that nursing homes must provide to hospice staff, hospices must provide orientation to nursing home staff

providing care for hospice patients. The orientation requirements while separate regulations for both the nursing home and hospice, should be a collaborative effort to assure that the hospice employees provide services and care effectively in the nursing home and that the hospice ensures that the nursing home staff understands the basic philosophy and principles of hospice care. If a nursing home has written agreements with multiple hospice providers, the nursing home should collaborate with each hospice to assure that the nursing home staff are familiar with specific policies and procedures for each individual hospice. It may not be necessary for each hospice to provide information to nursing home staff regarding the hospice philosophy and principles of care if the nursing home staff has received this information and are aware of the philosophy and principles of care.

### **Provision of Current, Coordinated Plan of Care**

As described in §483.70(n)(4), the intent of this regulation is to ensure coordination of care between the nursing home and the hospice in order to assure that the most current plans of care for each resident have been coordinated, individualized and identify what each entity will provide.

### **KEY ELEMENTS OF NONCOMPLIANCE**

To cite deficient practice at F849, the surveyor's investigation will generally show that the facility failed to do any one of the following:

- Develop a written agreement with the Medicare-certified hospice prior to hospice services being provided to a resident; **or**
- Establish 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; **or**
- In accordance with the written agreement to immediately notify the hospice about a significant change in the resident's condition, or the presence of clinical complications that suggest a need to alter the plan of care, or a need to transfer the resident from the facility or of the resident's death; **or**
- To 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; **or**
- 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; **or**

- Delineate the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff.

If there are concerns with the implementation of care or services by the hospice provider, then the survey team must refer the complaint to the State agency responsible for oversight of hospice, identifying the specific resident(s) involved and the concerns identified.

## **INVESTIGATIVE SUMMARY**

Use the Hospice and End of Life Care and Services Critical Element (CE) Pathway, along with the interpretive guidelines when determining if the facility meets the requirements for providing care and services for a resident receiving hospice services, in accordance with professional standards of practice, the coordinated person-centered care plan. In addition, the services must be and based upon the requirements included in the written agreement between the nursing home and hospice.

### **Summary of Investigative Procedure**

Briefly review the most recent comprehensive assessments, coordinated care plan and orders to identify whether the facility has recognized, assessed, provided interventions and implemented care and services according to professional standards of practice, in order to meet the resident's hospice care needs. This information will guide observations and interviews to be made in order to corroborate concerns identified. In addition, investigate to assure that there are sufficient numbers of trained, qualified and competent staff to provide the interventions identified for a resident receiving hospice care and services. If concerns are identified, review the appropriate sections of the written agreement above.

If the resident has been in the facility for less than 14 days (before completion of all the Resident Assessment Instrument (RAI) is required), review the baseline care plan which must be completed within 48 hours to determine if the facility is providing appropriate care and services based on information available at the time of admission. In addition, review to determine whether the comprehensive care plan is evaluated and revised based on the resident's response to interventions.

**NOTE:** *In addition to actual or potential physical harm, always observe for visual cues of psychosocial distress and consider whether psychosocial harm has occurred when determining severity level (See Guidance on Severity and Scope Levels and Psychosocial Outcome Severity Guide located in the Survey Resources zip file located at <https://www.cms.gov/medicare/provider-enrollment-and-certification/guidanceforlawsandregulations/nursing-homes>).*

If a concern is identified during the survey regarding hospice care and/or the timeliness of the hospice services, the survey team should review how the nursing home's QAA committee is monitoring the provision of hospice services, such as monitoring the

response by the hospice for the timely provision of care, including onsite visits by hospice staff during a crisis or change in the resident's condition.

If noncompliance is identified related to the written agreement, cite at F849. If noncompliance is identified related to quality of care, cite at F685, Quality of Care.

## **DEFICIENCY CATEGORIZATION**

- **Examples of Level 4, immediate jeopardy to resident health and safety, include, but are not limited to:**
  - - The failure of the facility to assure that the resident received hospice care and services based upon a written agreement with a Medicare-certified hospice. For example, a deficiency was cited at Severity Level 4, at F697, when the resident has severe uncontrolled pain, or F675, acute respiratory distress and at F849, the facility fails to contact and consult with the hospice as per the written agreement for a change in condition.
    - The facility failed to establish a written agreement with a Medicare-certified hospice that was allowed to provide hospice services in the nursing home. In this example, a deficiency was cited at Severity Level 4, at F697, when the resident was administered medication for pain management by the hospice, and due to lack of coordination, the nursing home, unaware of the administration of the medication, also administered pain medication resulting in an overdose of opioids and hospitalization due to acute respiratory failure, and at F849, the facility failed to establish a written agreement with a Medicare-certified hospice that was allowed to provide hospice services in the nursing home, resulting in the lack of coordination.
- **Examples of Level 3 - Actual harm (physical or psychological) that is not immediate jeopardy include but are not limited to:**
  - The failure of the facility to assure that the resident received hospice care and services based upon a written agreement with a Medicare-certified hospice. For example, a deficiency was cited at Severity Level 3, at F697, when the resident has experienced pain that compromised his/her function (physical and/or psychosocial) and/or ability to reach his/her highest practicable well-being as a result of the facility's failure to recognize or address the situation, or failure to develop, implement, monitor, or modify a pain management plan to try to meet the resident's needs. For example, the pain was intense enough that the resident experienced recurrent insomnia, or reduced ability to move and perform ADLs, or a decline in mood or reduced ability to communicate/socialize with family and/ or participation in activities; and at F849, the facility failed to contact and consult with the hospice as per the written agreement for reviewing the resident's care plan for pain management.
  - At F849, the facility failed to establish a written agreement with a Medicare-

certified hospice that was allowed to provide hospice services in the nursing home. In addition, the facility failed to contact and consult with the hospice for concerns related to significant changes in the resident's physical condition or need to alter the plan of care which is a component of the written agreement regulation. For example, a deficiency was cited at Severity Level 3, at F697, when a resident experienced significant episodic pain (that was not all-consuming or overwhelming but was greater than minimal discomfort to the resident) related to care/treatment such as prior to wound care, exercise or physical therapy. The facility failed to involve the hospice and failed to develop, implement, monitor, or modify pain management interventions.

- **Examples of Level 2 - No actual harm with a potential for more than minimal harm that is not immediate jeopardy include but are not limited to:**

- The failure of the facility to assure that the resident received hospice care and services based upon a written agreement with a Medicare-certified hospice. For example, a deficiency was cited at Severity Level 2, at F697, when the resident was on a pain management program utilizing opioids. The resident was experiencing episodic minimal discomfort and the facility failed to consult with the hospice regarding the bowel management plan as identified in the coordinated plan of care. The facility was cited at F849 for failure to contact and consult with the hospice as per the written agreement for communicating with the hospice for review and possible revision of the resident's care plan.
- At F849, the facility failed to establish a written agreement with a Medicare-certified hospice that was allowed to provide hospice services in the nursing home. In addition, the facility failed to contact and consult with the hospice for concerns related to a need to alter the plan of care which is a component of the written agreement regulation. For example, a deficiency was cited at Severity Level 2, at F697, when a resident experienced daily or less than daily discomfort with no compromise in physical, mental, or psychosocial functioning as a result of the facility's failure to adequately recognize or address the pain management. The resident was able to participate in ADL's and/or activities of choice. The facility failed to involve the hospice in developing, implementing, monitoring, or modifying pain management interventions.
- The facility failed to assure that the written agreement met one or more of the regulatory specifications resulting in the potential for negative resident outcomes.

- **An example of Level 1 - No actual harm with a potential for minimal harm includes but is not limited to:**

- There are components of the written agreement that were not met but they may have minimal impact to the resident. Failure to meet these elements will