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STONEYBROOK RETIREMENT COMMUNITY	2025 LITTLE KITTEN AVENUE MANHATTAN, KS 66503

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F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey and Complaint Investigation #165850. The 2567 was electronically sent to the facility on 09/29/21. A revised 2567 was electronically sent to the facility on 10/21/21.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.	F 550		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 09/29/2021

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.

§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 36 residents. The sample included 13 residents. Based on observation, record review, and interview, the facility failed to promote care in a manner to maintain and enhance dignity and respect, when staff attempted to obtain Resident (R)10's pulse at the dining room table, with 10 other residents in full view of the procedure.

Findings included:

- On 09/21/21 at 12:05 PM, observation revealed R10 seated in reclining broda (a pressure reducing chair that tilts and reclines) chair, and Certified Nurse Aide (CNA) assisted the resident to eat lunch. Certified Medication Aide (CMA) S approached the resident at the dining room table and attempted to get a pulse reading from her left little finger without success. Continued observation revealed CMA S removed the resident's sock on her left foot and attempted to obtain her pulse reading from the left little toe and was unable to obtain a reading. CMA S explained to the resident she had to give her a medication that required her to get the resident's pulse.

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F 550	Continued From page 2 On 09/27/21 at 11:00 AM, Administrative Nurse D verified staff should not obtain the residents pulse reading in the dining room and it was a dignity issue. The undated facility's "Resident Rights" policy, recorded each resident shall have the right to personal privacy and confidentiality of personal and clinical records. Privacy shall be provided during medical and nursing treatment, written and telephone communications, personal cares, visits, meetings of family and resident groups. The facility failed to promote care for R10 in a manner to maintain and enhance dignity and respect.	F 550		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each	F 582		

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resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate.
(i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.
(ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.
(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.
(iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility.
(v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 36 residents. The sample included 13 residents, with three unsampled residents reviewed for Medicare Liability Notices. Based on record review and interview, the facility failed to provide the resident

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(or their representative) the Advance Beneficiary Notice for skilled services for Resident (R) 21, R137, and R138 and the Notice of Medicare Non-Coverage for R21 and R138.

Findings included:

- The "Medicare Advance Beneficiary Notice (ABN)" informed the beneficiary that Medicare may or may not pay for future skilled therapy services and provided a cost estimate of continued services. The form included option for the beneficiary to (1) receive specified therapy listed, and bill Medicare for an official decision on payment. I understand Medicare does not pay, I will be responsible for payment, but can appeal to Medicare. (2) receive therapy listed, but do not pay Medicare, I am responsible for payment for services. (3) I do not want the listed therapy services.

The "Notice of Medicare Non-Coverage (NOMNC)" informed the beneficiary when their Medicare covered skilled nursing facility services ended.

The "CMS 10055 (ABN)" form was not provided to R137 or the resident's representative.

The facility documented the "CMS 10123 and 10055" forms were not provided to R21 and R138 or their representatives.

The undated facility's "Beneficiary Notices" policy, documented the facility would ensure that proper notification of beneficiary rights to resident's when skilled services end per federal guidelines. The Skilled Nursing Facility ABN and NOMNC are communication tools required by CMS to ensure

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F 582	Continued From page 5 residents and their families are aware of when Medicare services would be discontinued or when Medicare will likely not pay for a service. The facility failed to provide the resident (or their representative) the ABN and NOMNC form when discharged from skilled services for R21, R137, and R138, placing the resident's risk to make uninformed decisions for their skilled services.	F 582		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility had a census of 36 residents. The sample included 13 residents, with seven reviewed for accidents. Based on observation, record review, and interview, the facility failed to provide adequate supervision and assistance to prevent accidents for two of seven sampled residents, Resident (R) 16, who caught her hand in a bed rail, R23, who had to be lowered to the ground while transferred from a sit to stand lift, and failed to ensure the chemicals were inaccessible to the 10 cognitively impaired, independently mobile residents who resided in the facility. Findings included:	F 689		

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- R16's "Quarterly Minimum Data Set" (MDS), dated 07/19/21, documented the resident had impaired cognition and required extensive assistance of two staff for transfers, bed mobility, toileting, had unsteady balance, and no functional impairment.

The "Fall Care Area Assessment" (CAA), dated 04/03/21, documented the resident was at risk for falls due to cognition and impaired mobility.

The revised "Fall Care Plan," dated 09/19/21, originally dated 03/31/21, directed staff to check on the resident frequently when in bed to make sure the resident did not roll out of bed or try to transfer herself from the bed.

The "Bed Mobility Device Assessment," dated 03/16/21, documented the resident used a bed cane device to enable bed mobility and did not prevent the resident from getting in and out of bed. The assessment further documented the resident used the bed cane to assist the resident to sit on the edge of her bed and staff had no concerns with the use of the cane device.

The "Nurse's Note," dated 06/06/21 at 07:30 AM, documented the resident was found half way out of bed with her right hand caught in bed rail and her face was on the mattress. The note further stated the nurse aide had moved the resident prior to the nurse entering her room. The note documented the resident had a small bruise on the back of her right hand, no other injuries noted, and the nurse wrapped the rail with a sheet for resident safety. The Nurse's Note lacked documentation of an investigation regarding the resident's hand being caught in the bed rail.

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On 09/22/21 at 09:33 AM, observation revealed the resident's bed had a scooped mattress (a special mattress with raised sides which may be used as a fall prevention measure), fall mat beside the bed, and no bed rails.

On 09/22/21 at 11:30 AM, Certified Nurse Aide (CNA) M stated the resident does not have any bed rails and stated he was unaware of any incidents regarding the resident and bed rails.

On 09/23/21 at 11:36 AM, Administrative Nurse D stated the incident was not investigated and stated the cane bed rail was taken off right away. Administrative Nurse D further stated the incident should have been investigated and educated the nursing staff to make sure an incident was filled out and an investigation started.

On 09/27/21 at 10:55 AM, Licensed Nurse (LN) G stated when there was a fall or incident, a risk management form was completed for an investigation to begin and stated the resident had not had any bed rails on for a long time.

The facility's "Occurrences" policy, dated 11/28/17, documented the facility would ensure each resident received adequate supervision of assistive devices to reduce the risk of occurrences and all residents would be assessed for fall risk and those determined to be at risk would have interventions implemented. The interventions would be reviewed periodically and would be revised or additional ones added as needed. Any accident or occurrence would be thoroughly investigated to rule out abuse and neglect and determine a root cause. The appropriate interventions would be developed based on the root cause analysis.

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The facility failed to ensure cognitively impaired R16 received adequate supervision and investigate when the resident's hand was caught in a bed rail, placing the resident at risk for further injury.

- R23's "Quarterly MDS," dated 08/05/21, documented the resident had impaired cognition and required extensive assistance of two staff for bed mobility, transfers, and did not ambulate. The MDS further documented the resident had unsteady balance, no functional impairment, and had two or more non-injury falls.

The "Fall CAA," dated 02/04/21, documented the resident had several recent falls and needed assistance with a lift for transfers.

The "Fall Care Plan," dated 09/02/21, originally dated 06/25/20, directed staff to provide two person transfer assistance with a sit to stand lift (a mobility device used to transfer residents from a seated position to a standing position when unable to do so on their own) due to the resident's inability to stand up straight on her own. The update, dated 09/02/21, directed staff to use two staff assistance for sit to stand lift transfer and if weaker, use a hoyer lift (an assistive device that allows residents to be transferred from one place to another) with two staff assistance.

The "Fall Risk Assessment," dated 05/06/21 and 09/14/21 documented the resident a high fall risk.

The "Change in Condition Evaluation Report" (CIC) dated 06/24/21 at 04:10 PM, documented the resident was observed lying on the floor with her back on the CNA's legs, the CNA had started

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to transfer the resident from her wheelchair to bed with the sit to stand lift when she noticed that the resident was sliding out of the sling. The CIC report further documented the CNA got behind the resident and lowered her to the floor. The report documented the resident did not receive any injuries and the CNA was educated on proper use of the sit to stand lift and the use of two staff at all times.

The "CIC Report," dated 09/02/21 at 9:25 AM, documented the resident was on the floor in the shower room. The nurse entered the shower room and observed the resident seated on her buttocks in front of the tub with the sit to stand in front of her. The CNA reported when she transferred the resident, her arm slipped out of the sling and the CNA lowered her to the floor. The resident was assessed without injury.

On 09/22/21 at 10:11 AM, observation revealed the resident seated in her wheelchair with a sling (used with the lift to transfer the resident) underneath her. CNA M and CNA O attached the sling to the hoyer lift and transferred the resident to her bed.

On 09/22/21 at 10:11 AM, CNA O stated the resident had a few falls because she tried to be independent, stated she was unsure about any falls while using the sit to stand lift, and stated they used two staff when transferring the resident with the lift.

On 09/27/21 at 10:55 AM, LN G stated staff used a lift for the resident to transfer because she tried to get up alone and would fall and stated two staff are to assist the resident with the lift.

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On 09/27/21 at 02:00 PM, Administrative Nurse D verified the care plan directed staff to use two staff when transferring the resident with the lift and verified there were not two certified staff assisting the resident with a lift transfer when she was lowered to the floor. Administrative Nurse D stated the resident should have be assessed for the hoyer lift.

The facility's "Mechanical Lift Use" policy, dated 11/28/17, documented the facility will utilize both sit to stand and sling lifts for resident transfers in situations where the resident was unable to safely and adequately bear weight and maneuver from one surface to another. The sit to stand lift would be used when a resident was able to bear weight and to hold onto the arm bar of the lift. Once the resident was positioned and secured with the sling, the resident was lifted into position. The sling lift would be used when a resident was unable to bear weight and/or could not hold onto the sling or control body movements.

The facility failed to ensure cognitively impaired R23's environment remained as free of accident hazards as possible when staff lowered the resident to the floor twice while using the sit to stand lift to transfer the resident, placing the resident at risk for injury.

- On 09/21/21 at 09:00 AM, observation during initial facility tour revealed an unlocked spa door on Kitten Hall across from the nurse's station. Further observation revealed the door contained a keypad needed to open the door, that was unlocked. The spa room contained the following; Two, One-quart bottles of Diversey Virex Tuberculin disinfectant cleaner.

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F 689	Continued From page 11 One, 32-ounce spray bottle of Clorox Bleach Germicidal Cleaner, One, 8 fluid ounces, bottle of Pet Pro Oxy urine Eliminator One, one-quart bottle of Diversey Crew Heavy Duty toilet bowl cleaner One, one-quart spray bottle of Glance nonammoniated, multi surface glass cleaner All of the item's labels documented "keep out of reach of children," "Hazardous if swallowed, can cause significant burns to skin and eyes." On 09/21/21 at 09:35 PM, Licensed Nurse (LN) G verified the spa room should have been locked and chemicals were to be stored in a locked secure location. On 09/27/21 at 03:30 PM, Administrative Nurse D verified the spa door was always to remain locked and chemicals needed to be kept behind a locked door. Administrative Nurse D stated the facility had 10 cognitively impaired independently mobile residents. The facility's "Storage of Chemicals" policy, dated 01/26/21, stated the facility is to ensure that all products are labeled and stored in a manner that eliminates risk of improper use and should be stored in a locked area. The facility failed to store hazardous chemicals in a safe environment, placing 10 cognitively impaired independently mobile residents at risk for injury	F 689		
F 727 SS=D	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse	F 727		

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§483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week.

§483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis.

§483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 36 residents. The sample included 13 residents. Based on observation, record review, and interview, the facility failed to use the services of a registered nurse for at least eight consecutive hours a day, seven days a week, as the charge nurse for the 36 residents who resided in the facility.

Findings included:

- Review of the "Registered Nursing Staffing Schedule" for June, July, August and September 2021, recorded the facility lacked a Registered Nurse on the following days:
September 4th, 5th, 11th, 12th, 18th and 19th
August 1st, 7th, 8th, 14th, 15th, 21st, 22nd, 28th, and 29th.
July 3rd, 4th, 10th, 11th, 17th, 18th, 24th, and 25th
June 5th, 6th, 12th, 13th, 19th, 20th, 26th, and 27th

On 09/21/21 at 08:30 AM, observation revealed 36 residents resided in the facility.

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STONEYBROOK RETIREMENT COMMUNITY	2025 LITTLE KITTEN AVENUE MANHATTAN, KS 66503

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 727	Continued From page 13 On 09/27/21 at 11:00 AM, Administrative Staff D verified the facility did not have a Registered Nurse in the building or working as a charge nurse for the above documented dates. Upon request the facility failed to provide a policy regarding daily Registered Nurse coverage. The facility failed to provide a registered charge nurse for the 36 residents who resided in the facility, without utilizing the DON, placing the facility and residents at risk for inadequate nurse guidance and leadership.	F 727		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to	F 761		

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F 761	Continued From page 14	F 761		

abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 36 residents. The sample included 13 residents. Based on observation, interview, and record review, the facility failed to discard Resident (R) 26's insulin (hormone which allowed cells throughout the body to uptake glucose) pen that had expired, and failed to discard the Tuberculin (a protein extracted from tuberculosis {an infectious bacterial disease characterized by the growth of nodules in tissue, especially the lungs} to determine if a person had been exposed to tuberculin) vaccine vial that had expired.

Findings included:

- On 09/21/21 at 08:40 AM, observation of the medication cart for Wildcat and half of Kitten Hall, revealed R26's Levemir (a long acting insulin that can work for around 24 hours or longer) flex pen with an expiration date of 09/14/21 (6 days).

On 09/21/21 at 08:45 AM, observation of the refrigerator in the medication room revealed one 5 milliliter (ml) vial of tuberculin had expired 07/02/2021.

On 09/21/21 at 08:50 PM, Licensed Nurse (LN) H verified R26 received insulin daily, and the resident received insulin from the insulin flex pen on 09/20/21. LN H verified the Tuberculin vial was outdated and she would discard and get a new vial.

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F 761	Continued From page 15 On 09/27/21 at 11:00 AM, Administrative Nurse D stated the nurses were to date the insulin pens/vials when opened, label with the resident's name, and discard expired medications. Upon request the facility failed to provide an Insulin storage policy. The "Medication Administration Policy," dated March 2011, documented vials and ampules of injectable medications are used in accordance with the manufactures recommendations or the provider pharmacy's direction for storage, use, and disposable. Vials and ampules that are sent from the provider pharmacy in a box or container with the label on the outside are kept in that box or container. The initials of the first person to use the vial and the date opened are recorded on multi dose vial. Open medication will either be discarded immediately after use or in compliance with the manufacture storage requirements, The facility failed to discard R26's Levemir flex insulin pen and the outdated vial of tuberculin, placing the residents at risk for receiving ineffective medications.	F 761		
F 849 SS=D	Hospice Services CFR(s): 483.70(o)(1)-(4) §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the	F 849		

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F 849	Continued From page 16	F 849		

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

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

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F 849	Continued From page 17 (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions. (I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility. (J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice	F 849		

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

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

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F 849	Continued From page 19 (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is not met as evidenced by: The facility had a census of 36 residents. The sample included 13 residents with one reviewed for hospice (a type of health care that focuses on the terminally ill patient's pain and symptoms and attending to their emotional and spiritual needs at the end of life) services. Based on observation, record review and interview, the facility failed to ensure a coordinated plan of care, which coordinated care and services provided by the	F 849		

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facility with the care and services provided by hospice, was developed and available for Resident (R) 5.

Findings included:

- R5's "Physician's Order Sheet", dated 08/25/21, revealed diagnosis of dementia (progressive mental disorder characterized by failing memory, confusion), senile degeneration of the brain, and Adult Failure to Thrive (includes not doing well, feeling poorly, weight loss, poor self-care that could be seen in elderly individuals).

The "Admission Minimum Data Set" (MDS), dated 06/15/21, recorded the resident had severely impaired cognition. The MDS further indicated the resident required extensive one staff assistance with bed mobility, transfers, walking in room, locomotion on and off the unit. The resident received as needed pain medication and had frequent pain. The MDS documented the resident received Hospice services.

The "Physician's Order," dated 06/09/21, directed the staff to provide hospice services for the resident.

Review of the medical records revealed the 06/09/21 initiated hospice assessment, and care plan was not available for the facility staff to reference. Upon the Surveyor's inquiry, Administrative Nurse D requested the hospice nurse provide initial hospice assessment, including the plan of care to the facility. The hospice nurse stated he/she had provided the information to the facility; however, the facility did not have it with the residents scanned in information or at the nurse's station.

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F 849	Continued From page 21 On 09/23/21 at 01:00 PM, observation revealed the resident lying in bed, eyes closed, with his wife on the fall mat next to him. On 09/27/21 at 11:00 AM, Administrative Nurse D verified hospice completes an assessment on admission to the hospice services, and a care plan according to the resident's care needs. Administrative Nurse D verified she expected the plan of care to be scanned into the resident's chart for facility staff to know what the facility provided, and what services hospice provided. The "Hospice" policy, dated 06/08/21, documented a written "Plan of Care" (POC) would be established and maintained. The POC would be completed and updated by the attending physician, medical director, physician designee and the hospice interdisciplinary team. These POC reviews would be documented and the plan will include assessment of the hospice resident's needs and identification of services to be provided. Including management of discomfort and symptom relief. The plan will state in detail the scope and frequency of services needed to meet the hospice patient and caregivers needs. Hospice attends facility care conference and resident's caregiver meetings as deemed necessary. Hospice will be responsible for the professional's management and the coordination of the plan of care. The facility failed to obtain the hospice records, assessment and plan of care for R5, who received hospice services, placing him at risk for inappropriate end of life care.	F 849		